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# Kentucky Medicaid Provider Manual

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# I. Overview

## **About WellCare**

WellCare Health Plans, Inc., doing business as WellCare of Kentucky, Inc., (WellCare) provides managed care services targeted exclusively to government-sponsored health care 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. As of December 31, 2010, WellCare served approximately 2.2 million members. Effective July 7, 2011, WellCare has contracted with the Kentucky Cabinet for Health and Family Services, Department for Medicaid Services (the Department) to provide Medicaid and Children's Health Insurance Plan (CHIP) managed care services in seven of the state's eight regions beginning October 1, 2011. 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.

## **Purpose of this Manual**

This Provider Manual is intended for WellCare-contracted (participating) Medicaid providers providing health care service(s) to WellCare members enrolled in a WellCare Medicaid Managed Care plan. This manual serves as a guide to the policies and procedures governing the administration of WellCare's Medicaid plans and is an extension of and supplements the Provider Participation Agreement (Agreement) between WellCare and health care providers, who include, without limitation: physicians, hospitals and ancillary providers (collectively, Providers). **This manual is available on WellCare's website on [www.kentucky.wellcare.com/Provider/ProviderManuals](http://www.kentucky.wellcare.com/Provider/ProviderManuals).** A paper copy, at no charge, may be obtained upon request by contacting Customer Service or your Provider Relations representative.

In accordance with the Policies and Procedures clause of the Agreement, participating WellCare Medicaid providers must abide by all applicable provisions contained in this manual. Revisions to this manual reflect changes made to WellCare's policies and procedures. Revisions shall become binding thirty (30) days after notice is provided by mail or electronic means, or such other period of time as necessary for WellCare to comply with any statutory, regulatory, contractual and/or accreditation requirements. As policies and procedures change, updates will be issued by WellCare in the form of Provider Bulletins and will be incorporated into subsequent versions of this manual. Provider Bulletins that are state specific may override the policies and procedures in this manual.

## **WellCare's Medicaid Managed Care Plans**

WellCare has contracted with the Kentucky Cabinet for Health and Family Services, Department for Medicaid Services (Department) to provide Medicaid and CHIP managed care services in seven of the Commonwealth of Kentucky's (Commonwealth) eight regions. These products are offered in select markets to allow flexibility and offer a distinct set of benefits to fit member needs in each area. Please refer to the Quick Reference Guide for product information which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

## **Eligibility**

Eligibility for Kentucky's Medicaid program is solely determined by the Department. Upon determination of eligibility, Kentucky Medicaid recipients will be enrolled with a Medicaid Managed Care plan, provided the following conditions are met:

- The individual must reside within a Medicaid Managed Care Region; and
- The individual must qualify to receive Medicaid assistance under one of the aid categories defined by the Department.

Individuals eligible for Kentucky Medicaid can be categorized into two groupings:

- (1) Families and Children; and
- (2) Aged, Blind or Disabled (ABD).

The Families and Children population is comprised of children, pregnant women, and caretaker relatives. The ABD population is comprised mostly of individuals with disabilities or those who are sixty-five (65) years or older.

Eligible Medicaid recipients to be enrolled into a Medicaid Managed Care Organization (MCO), such as WellCare, include Families and Children, Pregnant Women, Aged, Blind, and Disabled eligible as well as children enrolled in the Kentucky children's Health Insurance Program (KCHIP). Certain Medicaid eligibles including dual eligibles, foster care children and disabled children may be voluntarily enrolled in a Medicaid MCO, but may not be enrolled on a mandatory basis without a waiver from the Centers for Medicare and Medicaid services (CMS).

For more information on Medicaid assistance, refer to the Kentucky Department for Medicaid Services website at <http://chfs.ky.gov/dms/>

### **Core Benefits and Services**

As of the date of publication of this manual, the following core benefits and services (Covered Services) are provided to WellCare's Kentucky Medicaid members:

- Alternative Birthing Center Services;
- Ambulatory Surgical Center Services;
- Chiropractic Services;
- Community Mental Health Center Services;
- Dental Services, including Oral Surgery, Orthodontics and Prosthodontics;
- Durable Medical Equipment, including Prosthetic and Orthotic Devices, and Disposable Medical Supplies;
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening and special services;
- Emergency Medical Services;
- End Stage Renal Dialysis Services;
- Family Planning Clinic Services in accordance with federal and state law and judicial opinion;
- Hearing Services, including Hearing Aids for Members Under Age twenty-one (21);
- Home Health Services;
- Hospice Services (non-institutional only);
- Impact Plus Services;
- Independent Laboratory Services;
- Inpatient Hospital Services;
- Inpatient Mental Health Services;
- Meals and Lodging for Appropriate Escort of Members;
- Medical Detoxification as defined in 907 KAR 1:705;
- Medical Services, including but not limited to, those provided by Physicians, Advance Practice Registered Nurses, Physicians Assistants and Federally

Qualified Health Center Services ( FQHCs), Primary Care Centers and Rural Health Clinics;

- Organ Transplant Services not Considered Investigational by the Food and Drug Administration (FDA);
- Other Laboratory and X-ray Services;
- Outpatient Hospital Services;
- Outpatient Mental Health Services;
- Prescription medications, including those for Mental/Behavioral Health and limited Over-the-Counter (OTC) medications;
- Podiatry Services;
- Preventive Health Services, including those currently provided in Public Health Departments, FQHCs/Primary Care Centers and Rural Health Clinics;
- Psychiatric Residential Treatment Facilities (Level I and Level II);
- Routine Drug Screening; and,
- Specialized Case Management Services for Members with Complex Chronic Illnesses (includes adult and child targeted case management).

### **EPSDT Covered Services**

The following medically necessary health care, diagnostic services, preventive services, rehabilitative services, treatment and other measures described in 42 USC Section 1396d(a), to all members under the age of twenty-one (21) will be provided:

- Inpatient Hospital Services;
- Outpatient Services; Rural Health Clinics; FQHCs;
- Other Laboratory and X-Ray Services;
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services; Family Planning Services and Supplies;
- Physicians Services; Medical and Surgical Services furnished by a Dentist;
- Medical Care by Other Licensed Practitioners;
- Home Health Care Services;
- Private Duty Nursing Services;
- Clinic Services;
- Dental Services;
- Physical Therapy and Related Services;
- Prescribed Drugs including Mental/Behavioral Health Drugs, Dentures, and Prosthetic Devices; and Eyeglasses;
- Other Diagnostic, Screening Preventive and Rehabilitative Services;
- Nurse-Midwife Services;
- Hospice Care;
- Case Management Services;
- Respiratory Care Services;
- Services provided by a certified pediatric nurse practitioner or certified family nurse practitioner (to the extent permitted under state law);
- Other Medical and Remedial Care specified by the Department; and
- Other Medical or Remedial Care recognized by the Department but which are not covered in the plan including services of Christian Science Nurses, Care and Services provided in Christian Science Sanitariums and Personal Care Services in a recipient's home.

For the most up-to-date information on Covered Services, refer to the Department's administrative regulations, 907 KAR, on the Department's website at <http://www.lrc.ky.gov/kar/TITLE907.HTM>.

## **Provider Services**

Providers may contact the appropriate departments at WellCare by referring to the Quick Reference Guide which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

Provider Relations representatives are available to assist in many requests for participating WellCare providers. Contact your local market office for assistance, or call the Provider Service number located on your Quick Reference Guide to request a Provider Relations representative contact you.

## **Key Features and Benefits**

Through WellCare's website [www.kentucky.wellcare.com](http://www.kentucky.wellcare.com), providers will have access to a variety of easy-to-use tools created to streamline day-to-day administrative tasks. The on-line tools allow providers the opportunity to research routine. All participating providers who create a log-in and password using WellCare's Provider Identification (Provider ID) number can leverage the following features:

### **Claims Submission Status and Inquiry**

- Submit a claim
- Check the status of a claim
- Customize and download reports

**Member Eligibility and Co-pay Information** – Verify member eligibility and obtain specific co-pay information.

**Authorization Requests** – Providers may submit authorization requests online, attach clinical documentation and check authorization status. Providers may also print and/or save copies of the authorization form.

**Pharmacy Services & Utilization** – View and download a copy of WellCare's preferred drug list, see drug recalls, access pharmacy utilization reports and obtain information about WellCare pharmacy services.

**Provider News** – View and download the latest announcements to all providers.

**Provider Inbox** – A provider-specific inbox to receive notices and key reports regarding claims, eligibility inquiries and authorization requests.

**Provider & Pharmacy Look-Up** – Search the online WellCare Provider Directory by geographic location and medical specialty to refer members to in-network services.

**Provider Manuals** – A complete copy of WellCare's Provider Manual is available online, including all of the necessary forms and educational materials. For more information, refer to the Quick Reference Guide which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

## **Your Registration Advantage**

The WellCare website allows providers to have as many administrative users as needed and can tailor views, downloading options and email details. Providers



may also set-up individual sub-accounts for their staff, and keep separate billing and medical accounts. Once registered for WellCare's secure portal website, providers should retain log-in and password information securely for future reference.

### **How to Register**

To register as a provider, refer to the website at [www.kentucky.wellcare.com](http://www.kentucky.wellcare.com) under the *Provider* tab. Additional information can be found in our *Provider Resource Guide* and *Provider How-To Guide*, both located on the web.

## **II. Provider and Member Administrative Guidelines**

### **Provider Administrative Overview**

This section is an overview of guidelines for which all participating WellCare Medicaid Managed Care providers are accountable. Please refer to the Provider Participation Agreement (Agreement) or contact your Provider Relations representative for clarification of any of the following.

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

- Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973;
- Agree to cooperate with WellCare in its efforts to monitor compliance with its Medicaid contract(s) and/or the Kentucky Department for Medicaid Services (Department) rules and regulations, and assist us in complying with corrective action plans necessary for us to comply with such rules and regulations;
- Retain all agreements, books, documents, papers, and medical records related to the provision of services to WellCare members as required by state and federal laws;
- Provide Covered Services in a manner consistent with professionally recognized standards of health care. [42 C.F.R. § 422.504(a)(3)(iii).];
- Use physician extenders appropriately. Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNP) should provide direct member care within the scope or practice established by the rules and regulations of the Commonwealth and WellCare guidelines;
- Assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations;
- Clearly identify physician extender title (examples: MD, DO, ARNP, PA) to members and to other health care professionals;
- Honor at all times any member request to be seen by a physician rather than a physician extender;
- Administer, within the scope of practice, treatment for any member in need of health care services;
- Maintain the confidentiality of member information and records;
- Respond promptly to WellCare's request(s) for medical records in order to comply with regulatory requirements;
- Ensure that: (a) all employed physicians and other health care practitioners and providers comply with the terms and conditions of the Agreement between

provider and WellCare; (b) to the extent physician maintains written agreements with employed physicians and other health care practitioners and providers, such agreements contain similar provisions to the Agreement; and (c) physician maintains written agreements with all contracted physicians or other health care practitioners and providers, which agreements contain similar provisions to the Agreement;

- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene;
- Communicate timely clinical information between providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to WellCare, the member or the requesting party at no charge, unless otherwise agreed;
- Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen;
- Not discriminate in any manner between WellCare Medicaid members and non-WellCare Medicaid members;
- Not deny, limit or condition the furnishing of treatment to any WellCare Medicaid member on the basis of any factor that is related to health status, including, but not limited to the following: a) medical condition, including mental as well as physical illness; b) claims experience; c) receipt of health care; d) medical history; e) genetic information; f) evidence of insurability, including conditions arising out of acts of domestic violence; or g) disability;
- Freely communicate with and advise members regarding the diagnosis of the member's condition and advocate on member's behalf for member's health status, medical care and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are covered services;
- Identify members that are in need of services related to children's health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation or substance abuse. If indicated, providers must refer members to WellCare-sponsored or community-based programs;
- Must document the referral to WellCare-sponsored or community-based programs in the member's medical record and provide the appropriate follow-up to ensure the member accessed the services.

### **Excluded or Prohibited Services**

Providers must verify patient eligibility and enrollment prior to service delivery. WellCare is not financially responsible for non-covered benefits or for services rendered to ineligible recipients. Certain covered benefits, 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 Kentucky Medicaid plan, and for which WellCare is not financially responsible. These services may be paid for by the Department on a fee-for-service basis or other basis. Providers are required to determine eligibility and Covered Services prior to rendering services. In the event the service(s) is(are) excluded, you must submit reimbursement for services directly to the Department. In the event the service(s) is(are) prohibited,



neither WellCare nor the Department is financially responsible. For more information on prohibited services, refer to the Department's website at <http://chfs.ky.gov/dms/>.

### **Responsibilities of All Providers**

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

### **Living Will & Advance Directive**

Members have the right to control decisions relating to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life. 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 will and advance directives. This allows them to designate another person to make a decision should they become mentally or physically unable to do so.

Information regarding living will and advance directives should be made available in provider offices and discussed with the members. Completed forms should be documented and filed in members' medical records.

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

### **Provider Billing & Address Changes**

Prior notice to your Provider Relations representative or Customer Service 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.

### **Provider Termination**

In addition to the provider termination information included in the Agreement, you must adhere to the following terms:

- Any contracted provider must give at least ninety (90) days prior written notice (one hundred eighty (180) days for a hospital) to WellCare before terminating your relationship with WellCare "without cause," unless otherwise agreed to in writing. This ensures that adequate notice may be given to WellCare members regarding your participation status with WellCare. Please refer to your Agreement for the details regarding the specific required days for providing termination notice, as you may be required by contract to give more notice than listed above; and
- Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month.

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

**Note:** WellCare will notify in writing all appropriate agencies and/or members prior to the termination effective date of a participating Primary Care Physician (PCP), hospital, specialist or significant ancillary provider within the service area as required by Kentucky Medicaid program requirements and/or regulations and statutes.

### **Out-of-Area Member Transfers**

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

### **Members with Special Health Care Needs**

Individuals with Special Health Care Needs (ISHCN) include members with the following conditions:

- Mental retardation or related conditions;
- Serious chronic illnesses such as HIV, schizophrenia or degenerative neurological disorders;
- Disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes;
- Children and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care; and
- Related populations eligible for SSI.

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

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

For more information on Utilization Management for Individuals with Special Health Care Needs (ISHCN), refer to *Section V, Utilization Management, Case Management and Disease Management*.

### **Responsibilities of Primary Care Physicians (PCP)**

The following is a summary of responsibilities specific to Primary Care Physicians (PCPs) who render services to WellCare members. These are intended to supplement the terms of the Agreement, not replace them.

- See members for an initial office visit and assessment within the first ninety (90) days of enrollment in WellCare;
- Coordinate, monitor and supervise the delivery of medically necessary primary and preventive care services to each member, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for members under the age of twenty-one (21);
- Coordinate, monitor and supervise the delivery of primary care services to each member;
- Provide appropriate referrals of potentially eligible women, infants and children to the Women, Infant and Children (WIC) program for nutritional assistance;
- Screen all newborn members for those disorders specific in the Commonwealth's metabolic screen;
- Provide or arrange for coverage of services, consultation or approval for referrals twenty-four (24) hours per day, seven (7) days per week. To ensure accessibility and availability, PCPs must provide one of the following:
  - A 24-hour answering service that connects the member to someone who can render a clinical decision or reach the PCP;
  - Answering system with option to page the physician for a return call within a maximum of thirty (30) minutes; or
  - An advice nurse with access to the PCP or on-call physician within a maximum of thirty (30) minutes.
- The PCP must adhere to the standards of timeliness for appointments and in-office waiting times for various types of services that take into consideration the immediacy of the member's needs;
- WellCare shall monitor providers against these standards to ensure members can obtain needed health services within the acceptable appointments and in-office waiting times and after-hours. Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare;

|                      |              |
|----------------------|--------------|
| PCP - Urgent         | < 24 hours   |
| PCP - Routine        | < 30 days    |
| Specialist - Urgent  | < 48 hours   |
| Specialist – Routine | < 30 days    |
| Wait Times           | < 30 minutes |

- 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 a HEDIS® (Health Plan Employer Data and Information Set) service;
- Submit encounters. For more information on encounters, refer to *Section III. Claims*;

- Ensure members utilize network providers. If unable to locate a participating WellCare provider for services required, contact Health Services for assistance. Refer to the state-specific Quick Reference Guides which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide); and
- Comply with and participate in corrective action and performance improvement plan(s).

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

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

- Providing all needed initial, periodic and inter-periodic EPSDT health assessments, diagnosis and treatment to all eligible members in accordance with Kentucky Medicaid administrative regulation 907 KAR 1:034 and the periodicity schedule provided by the American Academy of Pediatrics (AAP);
- Referring the member to an out-of-network provider for treatment if the service is not available within WellCare's network;
- Providing vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines;
- Providing vaccinations in conjunction with EPSDT/Well Child visits. Providers are required to use vaccines available without charge under the Vaccine for Children (VFC) program for Medicaid children eighteen (18) years old and younger;
- Addressing unresolved problems, referrals and results from diagnostic tests including results from previous EPSDT visits;
- Requesting a prior authorization for a medically necessary EPSDT special services in the event other health care, diagnostic, preventive or rehabilitative services, treatment or other measures described in 42 U.S.C. 1396d(a) are not otherwise covered under the Kentucky Medicaid Program;
- Monitoring, tracking and following up with members:
  - Who have not had a health assessment screening, and
  - 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; and
- Assisting members with transition to other appropriate care for children who age-out of EPSDT services.

Providers will be sent a monthly membership list which specifies the health assessment eligible children who have not had an encounter within one-hundred twenty (120) days of joining WellCare or are not in compliance 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 and corrective action plans will be required for providers who are below eighty (80) percent compliance with all elements of the review.

For more information on EPSDT Covered Services, refer to *Section I: Overview*. For more information on the Kentucky Medicaid EPSDT periodicity schedule and/or the Kentucky Medicaid administrative regulation 907 KAR 1:034, refer to the Department's

website at <http://chfs.ky.gov/dms/>. For more information on the periodicity schedule based on the American Academy of Pediatrics guidelines, refer to the AAP website at <http://www.aap.org/healthtopics/immunizations.cfm>.

### **Primary Care Offices**

Primary Care Physicians (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, Customer Service, Health Services and Marketing and Sales departments; as well as the tools and resources available on WellCare's website at [www.kentucky.wellcare.com/Provider](http://www.kentucky.wellcare.com/Provider); and
- Information on WellCare network providers for the purposes of referral management and discharge planning.

### **Closing of Physician Panel**

When requesting closure of your panel to new and/or transferring WellCare members, PCPs must:

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

### **Covering Physicians/Providers**

In the event that participating providers are temporarily unavailable to provide care or referral services to WellCare members, providers should make arrangements with another WellCare-contracted Medicaid (participating) and credentialed provider to provide services on their behalf, unless there is an emergency.

Covering physicians should be credentialed by WellCare, and are required to sign an agreement accepting the negotiated rate and agreeing to not balance bill WellCare members. For additional information, please refer to *Section VI, Credentialing*.

In non-emergency cases, should you have a covering physician/provider who is not contracted and credentialed with WellCare, contact WellCare for approval. For more information, refer to the Quick Reference Guide which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

### **Termination of a Member**

A WellCare provider may not seek or request to terminate his/her relationship with a member, or transfer a member to another provider of care, based upon the member's medical condition, amount or variety of care required or the cost of covered services required by WellCare's member.

Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. The provider should provide adequate documentation in the member's medical record to support his/her efforts to develop and maintain a satisfactory provider and member relationship. If a satisfactory relationship cannot be established or maintained, the provider shall continue to provide medical care for the 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.

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

The provider should complete a *Request for Transfer of Member* form, attach supporting documentation and fax the form to WellCare's Customer Service. A copy of the form is available on WellCare's website at [www.kentucky.wellcare.com/Provider/FormsandDocuments](http://www.kentucky.wellcare.com/Provider/FormsandDocuments).

### **Domestic Violence & Substance Abuse Screening**

PCPs should identify indicators of substance abuse or domestic violence. Sample screening tools for domestic violence and substance abuse are located on the WellCare's website at [www.kentucky.wellcare.com/Provider/CCGs](http://www.kentucky.wellcare.com/Provider/CCGs).

### **Smoking Cessation**

PCPs should direct members who smoke and wish to quit smoking to call WellCare's Customer Service and ask to be directed to the Case Management department. A case manager will educate the member on national and community resources that offer assistance, as well as smoking cessation options available to the member through WellCare.

### **Adult Health Screening**

An adult health screening should be performed by a physician 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.

## **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 receive a Member Handbook within five (5) calendar days of receiving the notice of enrollment from WellCare. WellCare will mail all enrolled members a Member Handbook annually thereafter.

## **Enrollment**

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

Upon enrollment 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 health care providers. Information found on the member identification card may include the member's name, identification number, plan type, PCP's name and telephone number, co-payment information, health plan contact information and claims filing address. Possession of the member identification card does not guarantee eligibility or coverage. Providers are responsible for ascertaining the current eligibility of the cardholder.

## **Eligibility Verification**

A member's eligibility status can change at any time. Therefore, all providers should consider requesting and copying a member's identification card, along with additional proof of identification such as a photo ID, and file them in the patient's medical record.

Providers may do one of the following to verify eligibility:

- Access the WellCare website at [www.kentucky.wellcare.com](http://www.kentucky.wellcare.com);
- Access WellCare's Interactive Voice Response (IVR) system. You will need your Provider ID number to access member eligibility; and/or
- Contact the Customer Service 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 your Agreement for additional details.

## **Member Rights and Responsibilities**

WellCare members, both adults and children, have specific Rights and Responsibilities. These are included in the Member Handbook.

WellCare members have the right to:

- Have information provided in a way that works for them including information that is available in alternate languages and formats;
- Be treated with fairness, respect, and dignity;
- See WellCare providers, get Covered Services and get their prescriptions filled in a timely manner;
- Privacy and to have their personal health information (PHI) protected;
- Get information about WellCare, WellCare's network of providers, their drug coverage and costs, their Covered Services, and their rights and responsibilities;



- Know their treatment choices and participate in decisions about their health care;
- Talk openly about care they need for their health, regardless of cost or benefit coverage, as well as choices and risks involved;
- Use advance directives (such as a living will or a power of attorney);
- Make complaints and ask WellCare to reconsider decisions WellCare has made; and
- Make recommendations about WellCare's rights and responsibilities policies.

WellCare members also have certain responsibilities. These include the responsibility to:

- Become familiar with their coverage and the rules they must follow to get care as a member;
- Tell WellCare if they have any other health insurance coverage or prescription drug coverage in addition to WellCare;
- Tell their PCP and other health care providers that they are enrolled in WellCare;
- Give their PCP and other providers the information they need to care for them, and to follow the treatment plans and instructions that they and their providers agree upon;
- Ask their PCP and other providers if they have any questions and to explain their treatment in a way they understand;
- Act in a way that supports the care given to other patients and helps the smooth running of their doctor's office, hospitals and other offices;
- Pay their plan premiums and any co-payments or coinsurance they owe for the covered services they get. Members must also meet their other financial responsibilities as described in the Member Handbook; and
- Inform WellCare of any questions, concerns, problems or suggestions by calling the Customer Service phone number listed in their Member Handbook.

### **Assignment of Primary Care Physician**

Kentucky Medicaid members enrolled in a WellCare Medicaid plan must choose a PCP or they will be assigned to a PCP within WellCare's network. To ensure quality and continuity of care, the PCP is responsible for arranging all of the member's health care needs from providing primary care services to coordinating referrals to specialists and providers of ancillary or hospital services.

### **Changing Primary Care Physicians**

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

### **Women's Health Specialists**

PCPs may also provide routine and preventive health care services that are specific to female members. If a female member selects a PCP who does not provide these services, she has the right to direct in-network access to a women's health specialist for covered services related to this type of routine and preventive care.

### **Hearing- Impaired, Interpreter and Sign Language Services**

Hearing-impaired, interpreter and sign language services are available to WellCare members through WellCare's Customer Service. PCPs should coordinate these services for WellCare members and contact Customer Service if assistance is needed. Please refer to the Quick Reference Guides for the Customer Service telephone numbers which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuides](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuides).

# III. 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 which may be found on WellCare's website at: [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

## **Timely Claims Submission**

Unless otherwise stated in the Provider Participation Agreement (Agreement), provider must submit claims (initial, corrected and voided) within twelve (12) months (or six (6) months from the Medicaid or primary insurance payment date, whichever is later) from the date of service for outpatient services and the date of discharge for inpatient services (Hospital Services Manual Section IX Transmittal #17 page 9.3). 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 Agreement for filing Clean Claims.

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

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

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

- Strategic National Implementation Process (SNIP) Rejection Letter; and
- A copy of the Provider's billing screen.

## **Tax ID and NPI Requirements**

WellCare requires the payer-issued Tax ID and NPI on all claims submissions. 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 Centers for Medicare and Medicaid Services (CMS) website at [www.cms.hhs.gov](http://www.cms.hhs.gov). More information on Tax ID is available on WellCare's website at: [www.kentucky.wellcare.com/claims/default](http://www.kentucky.wellcare.com/claims/default).

## **Taxonomy**

Providers must submit claims with the correct taxonomy code consistent with Provider Demographic Information for the Covered Services being rendered in order to be reimbursed at the appropriate rate. WellCare may reject the claim or pay it at the lower reimbursement rate if the taxonomy code is incorrect or omitted.

## **Preauthorization number**

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

## **National Drug Codes (NDC)**

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

### **Strategic National Implementation Process (SNIP)**

All claims and encounter transactions submitted via paper, Direct Data Entry (DDE) or electronically will be validated for transaction integrity/syntax based on the Strategic National Implementation Process (SNIP) guidelines. The SNIP validations used by WellCare to verify transaction integrity/syntax are available on WellCare's website at [www.kentucky.wellcare.com/Provider/FormsandDocuments](http://www.kentucky.wellcare.com/Provider/FormsandDocuments).

If a claim is rejected for lack of compliance with WellCare's claim and encounter submission requirements, the rejected claim should be resubmitted within timely filing limits. For more information on Encounters see page 19.

### **Claims Submission Requirements**

Providers using electronic submission shall submit all claims to WellCare or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 837 electronic format, or a CMS 1500 and/or UB-04, or their successors. Claims shall include the Provider's NPI, Tax ID and the valid Taxonomy code that most accurately describes the services reported on the claim. 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. Provider also acknowledges and agrees that at no time shall members be responsible for any payments to the provider with the exception of member expenses and/or non-covered services. For more information on paper submission of claims, refer to the Quick Reference Guide which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide). For more information on Covered Services under WellCare's Kentucky Medicaid plans, refer to WellCare's website at [www.kentucky.wellcare.com/medicaid/our\\_plans](http://www.kentucky.wellcare.com/medicaid/our_plans).

### **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 4010A, or its successor. For more information on EDI implementation with WellCare, refer to the Wellcare Companion Guides which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/ClaimsUpdates](http://www.kentucky.wellcare.com/Provider/ClaimsUpdates).

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 WellCare Job Aids and Resource Guides, which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/JobAidsandResourceGuide](http://www.kentucky.wellcare.com/Provider/JobAidsandResourceGuide).

A unique WellCare Payer ID was included in your 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 which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

## **HIPAA Electronic Transactions and Code Sets**

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

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

For more information on EDI implementation with WellCare, refer to the Wellcare Companion Guides which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/ClaimsUpdates](http://www.kentucky.wellcare.com/Provider/ClaimsUpdates).

## **Paper Claims Submissions**

For more timely processing of claims, Providers are encouraged to submit electronically. Claims not submitted electronically may be subject to penalties in the Agreement. For assistance in creating an EDI process, contact WellCare's EDI team by referring to the Quick Reference Guide which may be found on Well Care's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide). If permitted under the Agreement and until the provider has the ability to submit electronically, paper claims (UB-04 and CMS-1500, or their successors) must contain the required elements and formatting described below:

- Paper claims must only be submitted on original (red ink on white paper) claim forms.
- Any missing, 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 claims submission:
  - **The information must be aligned within the data fields and must be:**
    - Typed;
    - In black ink;
    - Large, dark font such as, PICA, ARIAL 10-, 11- or 12-point type; and
    - In capital letters.
  - **The typed information must not have:**
    - Broken characters;
    - Script, italics or stylized font;
    - Red ink;
    - Mini font; or
    - Dot matrix font.

## **Claims Processing**

### **Readmission**

WellCare may choose to review claims if data analysis deems it appropriate. WellCare may review hospital admissions on a specific member if it appears that two (2) or more admissions are related based on the data analysis. Based upon the claim review (including a review of medical records if requested from the provider) WellCare will make all necessary adjustments to the claim, including recovery of payments which are not supported by the medical record. Providers who do not submit the requested medical records, or who do not remit the overpayment amount identified by WellCare, may be

subject to a recoupment. Per the Hospital Services Manual, Transmittal #19 page 4.2, readmissions within thirty (30) days are reimbursable when an acute exacerbation of an existing condition occurs or when an entirely new condition develops.

### **72-Hour Rule**

WellCare follows the CMS guidelines for Outpatient Services Treated as Inpatient Services (including by not necessarily limited to: Outpatient Services Followed by Admission Before Midnight of the Following Day, Preadmission Diagnostic Services, and Other Preadmission Services). Please refer to the CMS Claims Processing Manual for additional information.

### **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 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 medical records that relate to the claim. Providers may request reconsideration of any adjustments produced by these claims editing software programs by submitting a timely request for reconsideration to WellCare. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.

### **Prompt Payment**

Refer to your Agreement. In addition, WellCare will comply with the Prompt-Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and 99-123, as may be amended.

### **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 Explanation of Benefits. 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 and delegated providers (IPAs) with the necessary information to allow them to submit encounter data to WellCare. If encounter data does not meet the Service Level Agreements (SLA) for timeliness of submission, completeness or accuracy, the Department has the ability to impose significant financial sanctions on WellCare. WellCare requires all delegated vendors and

delegated providers to submit encounter data, even if they are reimbursed through a capitated arrangement.

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

- Encounters submission will be weekly
- Capitated entities will submit within ten (10) calendar days of service date
- Non-capitated entities will submit within ten (10) calendar days of the paid date

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

### **Accurate Encounters Submission**

All encounter transactions submitted via DDE or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines as per the state requirements. SNIP Levels 1 through 7 shall be maintained. Once WellCare receives a delegated vendor's or provider's encounters, the encounters are loaded into WellCare's Encounters System and processed. The encounters are subjected to a series of SNIP editing to ensure that the encounter has all the required information and that the information is accurate.

For more information on WEDI SNIP Edits, refer to their Transaction Compliance and Certification white paper at [http://www.wedi.org/snip/public/articles/Testing\\_whitepaper082602.pdf](http://www.wedi.org/snip/public/articles/Testing_whitepaper082602.pdf). For more information on submitting encounters electronically, refer to the WellCare Companion Guides which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/ClaimsUpdates](http://www.kentucky.wellcare.com/Provider/ClaimsUpdates)

Vendors are required to comply with any additional encounters validations as defined by the State and/or CMS.

### **Encounters Submission Methods**

Delegated vendors and providers may submit encounters using several methods: electronically, through WellCare's contracted clearinghouse(s), via Direct Data Entry (DDE) or using WellCare's Secure File Transfer Protocol (SFTP) and process.

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

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

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.



A unique WellCare Payer ID was included in your 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 which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

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

Delegated vendors and providers may submit their encounter information directly to WellCare using WellCare's Direct Data Entry portal. The DDE tool can be found on the Provider Portal at <http://www.wellcare.com/provider/default>. For more information on free DDE options, refer to the *Provider Resource Guide* and/or *Provider How-To Guide*, which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/JobAidsandResourceGuides](http://www.kentucky.wellcare.com/Provider/JobAidsandResourceGuides).

### **Encounters Data Types**

There are four (4) encounter types for which delegated vendors and providers are required to submit encounter records to WellCare. Encounter records should be submitted using the HIPAA standard transactions for the appropriate service type. The four (4) encounter types are:

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

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

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

- New Encounter - A new encounter is an encounter that has never been submitted to WellCare previously.
- Voided Encounter - A voided encounter is an encounter that WellCare deletes from the encounter file and is not submitted to the state.
- Replaced or Overlaid Encounter - A replaced or overlaid encounter is 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 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 Agreement. An adjustment in payment as a result of WellCare's claims policies and/or procedures does not indicate that the service provided is a non-covered service, and members are to be held harmless for covered services.

### **Hold Harmless Dual Eligibles**

Those dual eligible members whose Medicare Part A and B member expenses are identified and paid for at the amounts provided for by Kentucky Medicaid shall not be



billed for such Medicare Part A and B member expenses, regardless of whether the amount a provider receives is less than the allowed Medicare amount or provider charges are reduced due to limitations on additional reimbursement provided by Kentucky Medicaid. Providers shall accept WellCare's payment as payment in full or will bill Kentucky Medicaid if WellCare has not assumed the Department's financial responsibility under an agreement between WellCare and the Department.

### **Claims Appeals**

The claims appeal process is designed to address claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Claim payment disputes must be submitted to WellCare in writing within thirty calendar (30) days of the date of denial of the Explanation of Payment (EOP).

Documentation consists of: (a) Date(s) of service; (b) Member name; (c) Member WellCare ID number and/or date of birth; (d) Provider name; (e) Provider tax id; (f) Total billed charges; (g) the Provider's statement explaining the reason for the dispute, and; (h) Supporting documentation when necessary (e.g. proof of timely filing, medical records).

To initiate the process, please mail to the address, or fax to the fax number, listed in your Quick Reference Guide located on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

### **Corrected Claims or Voided Claims**

Corrected and/or Voided Claims are subject to Timely Claims Submission (i.e., Timely Filing) guidelines

To submit a Corrected or Voided Claim electronically:

- For Institutional claims, provider must include the original WellCare claim number for the claim adjusting or voiding in the REF\*F8 (loop and segment) for any 7 (Replacement for prior claim) or 8 (Void/cancel of prior claim) in the standard 837 layout.
- For Professional claims, provider must have the Frequency Code marked appropriately as 7 (Replacement for prior claim) or 8 (Void/cancel of prior claim) in the standard 837 layout.

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, 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”

|                 |                                |                |  |
|-----------------|--------------------------------|----------------|--|
| 38 PAT. CNTL. # |                                | 4 TYPE OF BILL |  |
| b. MED. REC. #  |                                | 117            |  |
| 5 FED. TAX NO.  | 6 STATEMENT COVERS PERIOD FROM | 7 THROUGH      |  |

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

|                            |
|----------------------------|
| 64 DOCUMENT CONTROL NUMBER |
| 298370064                  |

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

Example:

|                                   |                    |
|-----------------------------------|--------------------|
| 22. MEDICAID RESUBMISSION<br>CODE | ORIGINAL REF. NO.  |
| 7 OR 8                            | 123456789012A33456 |

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

The Correction or Void Process involves two transactions:

1. The original 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 out for the newly submitted corrected claim.

### **Reimbursement**

If there are no site-of-service payment differentials specified on the Kentucky Medicaid website, WellCare applies the CMS site-of-service payment differentials in its fee schedules for Current Procedural Terminology (CPT) codes based on the place of treatment (physician office services versus other places of treatment).

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

- **Incidental Surgeries/Complications:** A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for extra payment. Any complicated procedure that warrants consideration for extra payment should be identified with an operative report and the appropriate modifier. A determination will be made by a WellCare Medical Director on whether the proposed complication merits additional compensation above the usual allowable amount.
- **Admission Examination:** One charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.
- **Follow-up Surgery Charges:** Charges for follow-up surgery visits are considered to be included in the surgical service charge and are not reimbursed separately. Follow-up days included in the global surgical period vary by procedure and are based on CMS policy.
- **Multiple Procedures:** Payment for multiple procedures is based on current CMS percentages methodologies. The percentages apply when eligible

multiple surgical procedures are performed under one continuous medical service, or when multiple surgical procedures are performed on the same day and by the same surgeon. 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 one-hundred (100) percent of the surgical group rate for the primary procedure and fifty (50) percent of the surgical group rate for the secondary.

- **Assistant Surgeon:** If there are no reimbursement guidelines on the Kentucky 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 methodologies. WellCare uses the American College of Surgeons (ACS) as the primary source to determine which procedures allow an assistant surgeon. For procedures that the ACS lists as “sometimes”, CMS is used as the secondary source.
- **Co-Surgeon:** If there are no reimbursement guidelines on the Kentucky Medicaid website for payment of co-surgery procedures, payment for a co-surgeon is based on current CMS percentages methodologies. In these cases, each surgeon should report his/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 Kentucky Medicaid website, WellCare follows CMS guidelines regarding modifiers and only reimburses modifiers reimbursed by CMS. Pricing modifier(s) should be placed in the first position(s) of the claim form.

### **Allied Providers**

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

### **Overpayment Recovery**

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

WellCare will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, WellCare will adhere to Kentucky Regulatory Statute 304.17A-708 and limit its notice of retroactive denial to 24 months from the payment receipt 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 retroactive denial of reimbursement 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 forty-five (45) days for the provider to send in the refund, request further information or appeal the retroactive denial.

Failure of the provider to respond within the above timeframes will constitute acceptance of the terms in the letter and will result in offsets to future payments. Once the overpaid balance has been satisfied a system generated Explanation of Payment (EOP) will be issued. In situations where future billing is not enough to offset the entire overpaid amount, a system generated EOP will not be sent identifying the negative balance. Instead, the provider will need to contact its provider representative for account information. In situations where the overpaid balance has aged more than three months, the provider may be contacted by WellCare, or its designee, to arrange payment. If the provider independently identifies an overpayment it can either a) send a corrected claim (refer to the corrected claim section of the manual), b) send a refund and explanation of the overpayment to:

WellCare Health Plans, Inc.  
8735 Henderson Road  
Renaissance 2  
Tampa, FL 33634

or contact WellCare Customer Service to arrange an off-set against future payments. For more information on contacting WellCare Customer Service, refer to the Quick Reference Guides which may be found on the WellCare website at: [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

#### **Benefits During Disaster and Catastrophic Events**

Refer to your Agreement.

## **IV. Credentialing**

### **Overview**

Credentialing is the process by which the appropriate WellCare peer review bodies of WellCare evaluate the credentials and qualifications of practitioners including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/health care delivery organizations. For purposes of this Credentialing section, all references to “practitioners” shall include providers providing health or health-related services including the following: physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/health care delivery organizations

This review includes (as applicable to practitioner type):

- Background;
- Education;
- Postgraduate training;
- Certification(s);
- Experience;
- Work history and demonstrated ability;
- Patient admitting capabilities;

- Licensure, regulatory compliance and health status which may affect a practitioner's ability to provide health care; and
- 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.

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

Please take note of the following credentialing process highlights:

Primary source verifications are obtained in accordance with state and federal regulatory agencies, accreditation and WellCare policy and procedure requirements, and include a query to the National Practitioner Data Bank.

Physicians, allied health professionals and ancillary facilities/health care delivery organizations are required to be credentialed in order to be network providers of services to WellCare members.

Satisfactory site inspection evaluations are required to be performed in accordance with state, federal, state and accreditation requirements.

After the credentialing process has been completed, a timely notification of the credentialing decision is forwarded to the provider.

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, agency shall be required to meet WellCare's criteria to ensure that the credentialing capabilities of the delegated entity clearly meet, federal and state accreditation (as applicable) and WellCare requirements.

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

### **Practitioner Rights**

Practitioner Rights are listed below and 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 e-mailed to [credentialing@wellcare.com](mailto:credentialing@wellcare.com). Upon receipt of a written request, WellCare will provide written information to the practitioner

on the status of the credentialing/re-credentialing application, generally within fifteen (15) business days. The information provided will advise of any items pending verification, needing to be verified, any non-response in obtaining verifications and any discrepancies in verification information received compared with the information provided by the practitioner.

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

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

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

#### **Right to Correct Erroneous Information and Receive Notification of the process and Timeframe**

In the event the credentials verification process reveals information submitted by the practitioner that differs from the verification information obtained by WellCare, the practitioner has the right to review the information that was submitted in support of his/her application, and has the right to correct the erroneous information. WellCare will provide written notification to the practitioner of the discrepant information.

WellCare's written notification to the practitioner includes:

- The nature of the discrepant information;
- The process for correcting the erroneous information submitted by another source;
- The format for submitting corrections;
- The 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:

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

**Drug Enforcement Administration Certificate** – Practitioners must have a current, valid DEA Certificate (as applicable to practitioner specialty), and if applicable to the state where services are performed, hold a current CDS or CSR certificate (applicable for MD/DO/DPM/DDS/DMD)

**Work History** – Practitioners must provide a minimum of five (5) years' relevant work history as a health professional.

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

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

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

**New Providers and Providers not Participating in Medicaid** – A provider is not required to participate in the Kentucky Medicaid Program as a condition of participation with WellCare's network. If a potential provider has not had a Medicaid number assigned, WellCare will obtain all data and forms necessary to enroll within the network, and include the required data in a transmission of the provider file information with the exception of the Medicaid provider number. All documentation regarding a provider's qualifications and services provided shall be available for review by the Department as defined in the Kentucky Contract or its agents at WellCare's offices during business hours upon reasonable advance notice.

**Providers that Opt-Out of Medicare** – A provider who opts-out of Medicare is not eligible to become a participating provider. An existing provider who opts-out of Medicare is not eligible to remain as a participating provider for WellCare. At the time of initial credentialing, WellCare reviews the state-specific opt-out listing maintained on the designated State Carrier's website to determine whether a provider has opted out of Medicare. Ongoing/quarterly monitoring of the opt-out website is performed by WellCare.

### **Liability Insurance**

WellCare Plan providers (all disciplines) are required to carry and continue to maintain professional liability insurance in the minimum limits as indicated below, unless otherwise agreed by WellCare in writing.

|                                  |  |
|----------------------------------|--|
| CT, GA, KY, IL, MO, NJ, NY & OH, | \$1,000,000/\$3,000,000 per provider   |
| FL & IN                          | \$250,000/\$750,000 per provider       |
| LA                               | \$100,000/\$300,000 per provider       |
| TX                               | \$200,000/\$600,000 per provider       |
| HI                               | \$1,000,000/\$3,000,000 per individual |
| HI                               | \$2,000,000/\$2,000,000 per facility   |

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



### **Site Inspection Evaluation (SIE)**

Site Inspection Evaluations (SIE's) 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; and
  - Adequacy of waiting room and examination room space.
- Medical / treatment record keeping criteria.

SIE's are conducted for:

- Unaccredited Facilities;
- State-specific initial credentialing requirements;
- State-specific re-credentialing requirements; and
- When complaint is received relative to office site criteria.

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

### **Covering Physicians**

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

### **Allied Health Professionals**

Allied Health Professionals (AHP's), both dependent and independent, are credentialed by WellCare.

Dependent AHP's include the following, and are required to provide collaborative practice information to WellCare :

- Advanced Registered Nurse Registered Nurse Practitioners (ARNP);
- Certified Nurse Nurse Midwife (CNM);
- Physician Assistant (PA); and
- Osteopathic Assistant (OA).

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

- Licensed clinical social worker;
- Licensed mental health counselor;
- Licensed marriage and family therapist;
- Physical therapist;
- Occupational therapist;
- Audiologist; and
- Speech/language therapist/pathologist.

### **Ancillary Health Care Delivery Organizations**

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

### **Re-Credentialing**

In accordance with regulatory, accreditation and WellCare policy and procedure, re-credentialing is required at least once every three (3) years.

### **Updated Documentation**

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

### **Office of Inspector General Medicare/Medicaid Sanctions Report**

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

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

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

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

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

WellCare may immediately suspend, pending investigation, the participation status of a participating provider who, in the opinion of the Medical Director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of members. In such instances, the Medical Director investigates on an expedited basis.

WellCare has a Participating Provider Dispute Resolution Peer Review Panel process in the event WellCare chooses to alter the conditions of participation of a provider based on issues of quality of care, conduct or service, and if such process is implemented, may result in reporting to regulatory agencies.

The Provider Dispute Resolution Peer Review process has two (2) 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 (3) qualified individuals of whom at least one (1) 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 (3) qualified individuals of which at least one (1) is a participating provider and a clinical peer of the practitioner that filed the dispute and the second level panel is comprised of individuals who were not involved in earlier decisions.

The following actions by WellCare entitle the practitioner affected thereby 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 thirty (30) days in which to file a written request via recorded or certified return receipt mail to access the Dispute Resolution Peer Review Panel process.

Upon timely receipt of the request, the Medical Director or his/her designee shall notify the practitioner of the date, time and telephone access number for the Panel hearing. WellCare then notifies the practitioner of the schedule for the Review Panel hearing.

The practitioner and WellCare are entitled to legal representation at the 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 (5) business days after final adjournment of the Dispute Resolution Peer Review Panel hearing, shall notify the practitioner of the results of the first level Panel hearing. In the event the findings are positive for the practitioner, the second level review shall be waived.

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

Within ten (10) calendar days of the request for a second level Peer Review Panel hearing, the Medical Director or his/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 (5) 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 s/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 *Delegated Entities* section in this provider manual for further details.

## **V. Utilization Management (UM), Case Management (CM) and Disease Management (DM)**

### **Utilization Management**

#### **Overview**

WellCare's Utilization Management (UM) program is designed to meet contractual requirements with federal regulations and the Department while providing members access to high quality, cost effective medically necessary care. For purposes of this section, terms and definitions may be contained within this section, within the Medicaid definitions section, or both.

The focus of the UM program is on:

- Evaluating requests for services by determining the medical necessity, efficiency, appropriateness and consistency with the member's diagnosis and level of care required;
- Providing access to medically appropriate, cost effective health care services in a culturally sensitive manner and facilitating timely communication of clinical information among providers;
- Reducing overall expenditures by developing and implementing programs that encourage preventive health care behaviors and member partnership;
- Facilitating communication and partnerships among members, families, providers, delegated entities and the plan in an effort to enhance cooperation and appropriate utilization of health care services;
- Reviewing, revising and developing medical coverage policies to ensure members have appropriate access to new and emerging technology; and
- Enhancing the coordination and minimizing barriers in the delivery of behavioral and medical health care services.

### **Medically Necessary Services**

The determination of whether a covered benefit or service is medically necessary shall:

- (a) Be based on an individualized assessment of the recipient's medical needs; and
- (b) Comply with the requirements established in this paragraph. To be medically necessary or a medical necessity, a covered benefit shall be:
  - Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy;
  - Appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice;
  - Provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care provider, or for cosmetic reasons;
  - 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;
  - Needed, if used in reference to an emergency medical service, to exist using the prudent layperson standard;
  - Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements for individuals under twenty-one (21) years of age; and
  - Provided in accordance with 42 C.F.R. 440.230.

WellCare's UM program includes components of prior authorization, prospective, concurrent and retrospective review activities. Each component is designed to provide for the evaluation of health care and services based on WellCare members' coverage and the appropriateness of such care and services and to determine the extent of coverage and payment to providers of care.

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

### **Criteria for UM Decisions**

WellCare's UM program uses nationally recognized review criteria based on sound scientific, medical evidence. Physicians with an unrestricted license in the Commonwealth of Kentucky with professional knowledge and/or clinical expertise in the related health care 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:

- 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

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

The review criteria and guidelines are available to the providers upon request. Providers may request a copy of the criteria used for specific determination of medical necessity by calling the Customer Service Department listed on the Quick Reference Guide which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

### **UM Process**

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

- Notifications;
- Referrals;
- Prior Authorizations;
- Concurrent Review; and/or
- Retrospective Review.

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

WellCare forms for the submission of notifications and authorization requests can be found on WellCare's website at [www.kentucky.wellcare.com/Provider/FormsandDocuments](http://www.kentucky.wellcare.com/Provider/FormsandDocuments).

### **Notification**

Notifications are communications to WellCare with information related to a service rendered to a member or a member's admission to a facility. Notification is required for:

- Notification of prenatal services which enables WellCare to identify pregnant members for inclusion into the care coordination program for pregnant members. OB providers are required to notify WellCare of pregnancies via fax using the *Prenatal Notification Form* within thirty (30) days of the initial visit. This process will expedite case management and claims reimbursement; and
- 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 received by fax or telephone and include member demographics, facility name and admitting diagnosis.

### **Referrals**

A referral is a request by a PCP for a member to be evaluated and/or treated by a specialty physician. For an initial referral, WellCare does not require authorization as a condition of payment. 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.

## Prior Authorization

Prior authorization allows for efficient use of covered health care services and ensures that members receive the most appropriate level of care, within the most appropriate setting. Prior authorization may be obtained by the member's PCP, treating specialist or facility.

Reasons for requiring prior authorization may include:

- Review for medical necessity;
- Appropriateness of rendering provider;
- Appropriateness of setting; and/or
- Case 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 WellCare's website at [www.kentucky.wellcare.com/Provider/FormsandDocuments](http://www.kentucky.wellcare.com/Provider/FormsandDocuments) or by calling WellCare.

Some prior authorization guidelines to note are:

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

The attending physician or designee is responsible for obtaining the prior authorization of the elective or non-urgent admission. Refer to the Quick Reference Guide which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide) for a list of services requiring prior authorization.

## Concurrent Review

Concurrent review activities involve the evaluation of a continued hospital, Long-Term Acute Care (LTAC) hospital, skilled nursing or acute rehabilitation stay for medical appropriateness, utilizing appropriate criteria. The concurrent review nurse follows the clinical status of the member through telephonic or onsite chart review and communication with the attending physician, hospital UM, 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 InterQual™ criteria for appropriateness of continued stay to:

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



The concurrent review process incorporates the use of InterQual™ criteria 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 notification and clinical information on the next business day after the admission, as well as upon request of the WellCare review nurse. Failure to submit necessary documentation for concurrent review may result in non-payment.

### **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 Concurrent Review Nurse works with the attending physician, hospital discharge planner, ancillary providers and/or community resources to coordinate care and post-discharge services to facilitate a smooth transfer of the member to the appropriate level of care. An Inpatient Review Nurse may refer an inpatient member with identified complex discharge needs to Transitional Care Management for in-facility outreach.

### **Transitional Care Management**

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

The Care Manager's work includes, but is not limited to, screening for member needs, education, care coordination, medication reconciliation, and referrals to community based services. Timely follow up is critical to quickly identify and alleviate any care gaps or barriers to care.

The goal of the Transitional Care Program is to assure that complex, high-risk members are discharged with a safe and effective plan in place, to promote members' health and well-being and reduce avoidable readmissions. The Transitional Care Manager will refer members with long-term needs to Case Management or Disease Management.

### **Retrospective Review**

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

There are two types of retrospective reviews which WellCare may perform:

- Retrospective Review initiated by WellCare
  - WellCare requires periodic documentation including, but not limited to, the medical record, UB and/or itemized bill, to complete an audit of the provider submitted coding, treatment, clinical outcome and diagnosis relative to a submitted claim. On request, medical records should be submitted to WellCare to support accurate coding and claims submission.
- Retrospective Review initiated by Providers

- WellCare will review post-service requests for authorization of inpatient admissions or outpatient services. The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions and taking into account the member's needs at the time of service. WellCare will also identify quality issues, utilization issues and the rationale behind failure to follow WellCare's prior authorization/pre-certification guidelines.

WellCare will give a written notification to the requesting provider and member within thirty (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 fourteen (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 your Quick Reference Guide which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuide](http://www.wellcare.com/Provider/QuickReferenceGuide).

### **Peer-to-Peer Reconsideration of Adverse Determination**

In the event of an adverse determination following a medical necessity review, Peer-to-Peer Reconsideration is offered to the treating physician on the Notice of Action communication. The treating physician is provided a toll-free number to the Medical Director Hotline to request a discussion with the WellCare Medical Director who made the denial determination. Peer-to-Peer Reconsideration is offered within three (3) business days following the receipt of the written review determination notification by the provider.

The review determination notification contains instructions on how to use the Peer-to-Peer Reconsideration process.

### **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:

- Certain diagnostic tests and procedures are considered by WellCare to routinely be part of an office visit, such as colonoscopies, hysteroscopies and plain film X-rays;
- Clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories and physician offices under a CLIA waiver do not require prior authorization. There are exceptions to this rule for specialty laboratory tests which require authorization regardless of place of service:
  - Reproductive laboratory tests;
  - Molecular laboratory tests; and
  - Cytogenetic laboratory tests.
- Certain tests described as CLIA-waived may be conducted in the physician's office if the provider is authorized through the appropriate CLIA certificate, a copy of which must be submitted to WellCare.

All services performed without prior authorization are subject to retrospective review by WellCare.

### **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;
- 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.

### **Second Medical Opinion**

A second medical opinion may be requested in any situation where there is a question related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. A second opinion may be requested by any member of the health care team, 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 health care professional within network, or a non-participating provider if there is not a participating provider with the expertise required for the condition.

### **Individuals with Special Health Care Needs**

Individuals with Special Health Care Needs (ISHCN) are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISCHN may have an increased need for healthcare or related services due to their respective conditions.

Physicians who render services to members who have been identified as having chronic or life threatening conditions should:

- Allow the members needing a course of treatment or regular care monitoring to have direct access through standing authorization or approved visits, as appropriate for the member's condition or needs:
  - To obtain a standing authorization the provider should complete the Outpatient Authorization Request form and document the need for a standing authorization request under the pertinent clinical summary area of the form.
  - The authorization request should outline the plan of care including the frequency, total number of visits and the expected duration of care.
- Coordinate with WellCare to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member; and
- Ensure that members requiring specialized medical care over a prolonged period of time have access to a specialty care provider.

- Members will have access to a specialty care provider through standing authorization requests, if appropriate.

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

| Decision timeframes   |   |                             |
|-----------------------|---|-----------------------------|
|                       | Decision  | Extension                   |
| Standard Pre-service  | Two (2) business days   | Fourteen (14) calendar days |
| Expedited Pre-service | Two (2) business days   | None                        |
| Concurrent            | Two (2) business days for initial request<br>Twenty-four (24) hours for subsequent requests | None<br>None                |
| Post service          | Thirty (30) calendar days   | Fourteen (14) calendar days |

#### Standard Service Authorization

WellCare is committed to a two (2) business day turn-around-time on requests for prior authorizations. 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 fourteen (14) calendar days if the member or the provider requests an extension, or if WellCare justifies a need for additional information and the extension is in the member's best interest.

#### Expedited 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 two (2) business days of the request. **Requests for expedited decisions for prior authorization should be requested by telephone, not fax or WellCare's website.** Please refer to the Quick Reference Guide for the appropriate contact information which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

Members and providers may file a verbal request for an expedited 24 hour decision.

#### Emergency/Urgent Care and Post Stabilization Services

Emergency services are not subject to prior authorization requirements and are available to our members twenty-four (24) hours a day, seven (7) days a week.

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.

Urgent Care means 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 forty-eight (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. Post Stabilization services are covered without prior authorization up to the point WellCare is notified that the member's condition has stabilized.

### **Transition of Care**

During the first ninety (90) 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.

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 FFS program or another managed care plan, a WellCare Review Nurse/Case Manager who is familiar with that member will provide a Transition of Care (TOC) report to the receiving plan, or appropriate contact person for the designated FFS program.

If a provider receives an adverse claim determination which they believe was a transition of care issue, the provider should fax the adverse claim determination to the Appeals Department with documentation of DCH/CMO approval for reconsideration. Refer to the Quick Reference Guide for the appropriate contact information which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

### **Authorization Request Forms**

WellCare utilizes three (3) authorization request forms and a *Prenatal Notification Form* to ensure receipt of all pertinent information and enable a timely response to your request.

The **Inpatient Authorization Request Form** is used for services such as planned elective/non-urgent inpatient, observation, and skilled nursing facility and rehabilitation authorizations. All Inpatient Authorization Request forms should be submitted via fax to the number listed on the form. Refer to the Quick Reference Guide for the appropriate contact information which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

The **Outpatient Authorization Request Form** is used for services such as follow-up consultations, consultations with treatment, diagnostic testing, office procedures, ambulatory surgery, home care services, radiation therapy, out-of-network services and transition of care. All Outpatient Authorization Request forms should be submitted via fax to the number listed on the form. Refer to the Quick Reference Guide for the appropriate contact information which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

The **Ancillary Authorization Request Form** is used for services such as Durable Medical Equipment (DME), dialysis, Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) and transition of care. All Ancillary Authorization Request forms for non-urgent/elective ancillary services should be submitted via fax to the number listed on the form. Refer to the Quick Reference Guide for the appropriate contact information which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

To ensure timely and appropriate claims payment, the form 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 are not processed and will be returned to the requesting provider. If prior authorization is not granted, all associated claims will not be paid.

A **Prenatal Notification Form** should be completed by the OB/GYN provider during the first visit and faxed to WellCare within thirty (30) days of initial visit. Notification of OB services enables WellCare to identify members for inclusion into the Prenatal Program and/or members who might benefit from WellCare's High Risk Pregnancy Program. Refer to the Quick Reference Guide for the appropriate contact information which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

### **Non-Covered Services**

The following list is representative of non-covered services and procedures, and is not meant to be exhaustive:

- Any laboratory service performed by a provider without current certification in accordance with the Clinical Laboratory Improvement Amendment (CLIA). This requirement applies to all facilities and individual providers of any laboratory service;
- Cosmetic procedures or services performed solely to improve appearance;
- Hysterectomy procedures, if performed for hygienic reasons or for sterilization only;
- Medical or surgical treatment of infertility (e.g., the reversal of sterilization, invitro fertilization, etc.);
- Induced abortion and miscarriage performed out-of-compliance with federal and Kentucky laws and judicial opinions;
- Paternity testing;
- Personal service or comfort items;
- Post mortem services;
- Services, including but not limited to drugs, that are investigational, mainly for

- research purposes or experimental in nature;
- Sex transformation services;
- Sterilization of a mentally incompetent or institutionalized member;
- Services provided in countries other than the United States, unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services;
- Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Kentucky Medicaid program regulations referenced herein;
- Services for which the Member has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage; and
- Services for substance abuse diagnoses in adults except for pregnant women, or in cases where acute care physical health services related to substance abuse or detoxification are necessarily required.

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

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.

A Certification Form for Induced Abortion or Induced Miscarriage, form MAP 235, 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 may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/FormsandDocuments](http://www.kentucky.wellcare.com/Provider/FormsandDocuments).

Claims for payment will be denied if the required consent is not attached or if incomplete or inaccurate documentation is submitted. Prior authorization is required for the administration of an abortion to validate medical necessity per federal regulations. The consent form does not need to be submitted with the request for authorization.

In addition to the above-mentioned documentation, WellCare also requires the submission of History, Physical and Operative Report and the Pathology Report with all claims that have the following ICD-9-CM codes to ensure that abortions are not being billed through the use of other procedure codes:

- 69.0 Dilation and curettage of uterus
- 69.02 Dilation and curettage following delivery or abortion
- 69.09 Other dilation and curettage
- 69.5 Aspiration curettage of uterus
- 69.52 Aspiration curettage following delivery or abortion
- 69.59 Other aspiration curettage of uterus
- 69.6 Menstrual extraction or regulation
- 69.93 Insertion of Laminaria
- 70.0 Culdocentesis
- 72.7 Vacuum extraction
- 72.71 Vacuum extraction with episiotomy
- 72.79 Other vacuum extraction
- 74.99 Other cesarean section of unspecified type
- 96.49 Genitourinary installation

The following procedure codes require abortion certifications:



- 69.01 Dilation and curettage for termination of pregnancy
- 69.51 Aspiration curettage of uterus for termination of pregnancy
- 74.91 Hysterectomy to terminate pregnancy
- 75.0 Intra-amniotic injection for abortion

### **Sterilizations**

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

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

See the **Forms and Documents** section for a copy of the required consent form MAP 250 which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/FormsandDocuments](http://www.kentucky.wellcare.com/Provider/FormsandDocuments).

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

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

The signed consent form expires one-hundred eighty (180) calendar days from the date of the member's signature.

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

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

The following is a list of ICD-9-CM procedure codes associated with sterilization. All claims with these 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.

Always Requires Sterilization Consent Form:

- 63.70 Male sterilization procedure, not otherwise specified
- 66.39 Other bilateral destruction or occlusion of fallopian tubes

If Done for Sterilization Purposes Requires Sterilization Consent Form:

- 63.7 Vasectomy and ligation of vas deferens
- 63.73 Vasectomy
- 65.6 Bilateral Salpingo-oophorectomy
- 65.61 Removal of both ovaries and tubes at same operative episode
- 65.62 Removal of remaining ovary and tube
- 66 Operations on fallopian tubes
- 66.0 Salpingostomy
- 66.2 Bilateral endoscopic destruction or occlusion of fallopian tubes
- 66.21 Bilateral endoscopic ligation and crushing of fallopian tubes
- 66.22 Bilateral endoscopic ligation and division of fallopian tubes
- 66.29 Other bilateral endoscopic destruction or occlusion of fallopian tubes
- 66.3 Other bilateral destruction or occlusion of fallopian tubes
- 66.31 Other bilateral ligation and crushing of fallopian tubes
- 66.32 Other bilateral ligation and division of fallopian tubes
- 66.4 Total unilateral salpingectomy
- 66.5 Total bilateral salpingectomy
- 66.51 Removal of both fallopian tubes at same operative episode
- 66.52 Removal of remaining fallopian tube
- 66.6 Other salpingectomy
- 66.63 Bilateral partial salpingectomy, not otherwise specified
- 66.69 Other partial salpingectomy

### **Hysterectomy**

Prior authorization is required for the administration of a hysterectomy to validate medical necessity. 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);
- Prior to the hysterectomy, the member/individual and the attending physician must sign and date the Patient's Acknowledgement of Prior Receipt of Hysterectomy Information form MAP 251.
- In the case of prior sterility or emergency hysterectomy, a member is not required to sign the consent form; and
- The provider submits the properly executed Patient's Acknowledgement of Prior Receipt of Hysterectomy Information form with the claim prior to submission to WellCare. Forms may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/FormsandDocuments](http://www.kentucky.wellcare.com/Provider/FormsandDocuments). 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 which has been completed or altered after the service was performed.

Regardless of whether the requirements listed above are met, a hysterectomy is considered a payable benefit when performed for medical necessity and not for the purpose of family planning, sterilization, hygiene or mental incompetence. The consent form does not need to be submitted with the request for authorization but does need to be submitted with the claim.

The following is a list of ICD-9-CM procedure codes associated with hysterectomies. 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.

- 68.3 Subtotal abdominal hysterectomy
- 68.4 Total abdominal hysterectomy
- 68.5 Vaginal hysterectomy
- 68.6 Radical abdominal hysterectomy
- 68.7 Radical vaginal hysterectomy
- 68.8 Pelvic evisceration
- 68.9 Other unspecified hysterectomy

### **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.

## **Case Management Program**

### **Overview**

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

WellCare trusts providers will help coordinate the placement and cost-effective treatment of patients who are eligible for WellCare Case Management Programs.

WellCare's multidisciplinary Case Management teams are led by specially trained Registered Nurse (RN) or Licensed Behavioral Health Case Managers who perform a comprehensive assessment of the member's clinical status, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the care plan. The Case Managers work collaboratively with PCPs and specialists to coordinate care for the member and expedite access to care and needed services.

WellCare's Case Management teams also serve in a supportive capacity to the PCP and assists in actively linking the member to providers, medical and behavioral services, residential, social and other support services, as needed. A provider may request case management services for any WellCare member.

The Case Management process illustrates the formation of one seamless Case Management Program and begins with member identification, and follows the member until discharge from the Program. Members may be identified for Case Management through numerous ways, including:

- (a) Referral from a member's primary care physician or other specialist;
- (b) Self-referral;
- (c) Referral from a family member;
- (d) Referral after a hospital discharge;
- (e) After completing a Health Risk Assessment (HRA), and
- (e) Data mining for members with high utilization.

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

- **Clinical Assessment and Evaluation** – a comprehensive assessment of the member is completed to determine where s/he is in the health continuum. This assessment gauges the member's support systems and resources and seeks to align them with appropriate clinical needs.
- **Care Planning** – collaboration with the member and/or caregiver to identify the best way to fill any identified gaps or barriers to improve access and adherence to the provider's plan of care.
- **Service Facilitation and Coordination** – working with community resources to facilitate member adherence with the plan of care. Activities may be as simple as reviewing the plan with the member and/or caregiver or as complex as arranging services, transportation and follow-up. Behavioral health services are coordinated with the regional Community Mental Health Center
- **Member Advocacy** – advocating on behalf of the member within the complex labyrinth of the health care system. Case Managers assist members with seeking the services to optimize their health. Case Management emphasizes continuity of care for members through the coordination of care among physicians, Community Mental Health Centers, and other providers.

Members commonly identified for WellCare's Case Management Program include:

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

## 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;
- Coronary artery disease (CAD);
- Congestive heart failure (CHF);
- Chronic obstructive pulmonary disease (COPD);
- Diabetes - adult and pediatric;
- HIV/AIDS;
- Hypertension;
- Depression; and
- Smoking Cessation

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 regards 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. In addition, WellCare makes available to providers and members general information regarding health conditions on WellCare's web site at: [www.kentucky.wellcare.com](http://www.kentucky.wellcare.com)

### **Candidates for Disease Management**

WellCare encourages referrals from providers, members, hospital discharge planners and others in the health care community.

Interventions for members identified vary depending on their level of need and stratification level. Interventions are based on industry-recognized Clinical Practice Guidelines. Members identified at the highest stratification levels receive a comprehensive assessment by a 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.

Disease-specific Clinical Practice Guidelines adopted by WellCare may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/CPGs](http://www.kentucky.wellcare.com/Provider/CPGs).

### **Access to Case and Disease Management Programs**

If you would like to refer a WellCare member as a potential candidate to the Case Management Programs or the Disease Management Program, or would like more information about one of the programs, you may call the WellCare Case Management Referral Line or complete and fax the Care Management Referral Form which can be found on WellCare's website at:

[www.kentucky.wellcare.com/Provider/Medicare\\_FormsandDocuments](http://www.kentucky.wellcare.com/Provider/Medicare_FormsandDocuments).

For more information on the Case Management Referral Line, refer to the Quick Reference Guide which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

## **VI. Quality Improvement**

### **Overview**

WellCare's Quality Improvement Program (QI Program) is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral health care and services. Strategies are identified and activities 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 that include, but are not limited to:

- Quantitative and qualitative improvement in member outcomes;
- Coordination and continuity of care with seamless transitions across health care settings/services;
- Cultural competency;
- Quality of care/service;
- Preventative health;
- Complaints/grievances;
- Network adequacy;
- Appropriate service utilization;
- Disease and Case Management;
- Behavioral Health services;
- Member and provider satisfaction; and
- Regulatory/federal/state/accreditation requirements.

The QI Program activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, Healthcare Effectiveness Data and Information Set (HEDIS®) measures, and/or medical record audits. The Quality Improvement Committee is delegated by the organization's board of directors with monitoring and evaluating the results of Program initiatives and implementing corrective action when the results are less than desired or when areas needing improvement are identified.

### **Medical Records**

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

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. Records remaining under the care, custody, and control of the physician or health care provider shall be maintained for a minimum of ten (10) years from the date of when the last professional service was provided. Providers should have procedures in place to permit the timely access and submission of medical records to WellCare upon request. Information from the medical 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 IX: Compliance*.

### **Provider Participation in the Quality Improvement Program**

Network providers are contractually required to cooperate with quality improvement activities. Providers are invited to volunteer for participation in the QI Program. Avenues for participation include committee representation, quality/performance improvement projects, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) assessments and feedback/input via satisfaction surveys, grievances, and calls to Customer Service. Provider participation in quality activities helps facilitate integration of service delivery and benefit management.

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

On an annual basis, WellCare conducts a member satisfaction survey of a representative sample of members. Satisfaction with services, quality, and access 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.



### **Patient Safety to include Quality of Care (QOC) and Quality of Service (QOS)**

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

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

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

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

### **Clinical Practice Guidelines**

WellCare adopts validated evidence-based Clinical Practice Guidelines and utilizes the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other provider may supersede Clinical Practice Guidelines, the guidelines provide clinical staff and providers with information about medical standards of care to assist in applying evidence from research in the care of both individual members and populations. The Clinical Practice Guidelines are based on peer-reviewed medical evidence and are relevant to the population served. Approval of the Clinical Practice Guidelines occurs through the Quality Improvement Committee. Clinical Practice Guidelines, to include Preventative Health guidelines, may be found on the WellCare's website at [www.kentucky.wellcare.com/Provider/CPGs](http://www.kentucky.wellcare.com/Provider/CPGs).

### **HEDIS®**

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than ninety percent (90%) of America's health plans to measure performance on important dimensions of care and service. The tool comprises seventy-one (71) measures across eight (8) domains of care, including:

- Effectiveness of care;
- Access and availability of care;
- Satisfaction with the care experience;
- Use of services;

- Cost of care;
- Health plan descriptive information;
- Health plan stability; and
- Informal health care choices.

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. Medical 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.

### **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.kentucky.wellcare.com](http://www.kentucky.wellcare.com)

## **VII. Appeals and Grievances**

### **Appeals Process**

#### **Provider**

##### **Medicaid Provider on Behalf of Self-Appeals Process**

A provider may request an appeal regarding provider 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 medical records to WellCare.

Providers have thirty (30) calendar days from the original utilization management or claim denial to file a provider appeal. Cases appealed after that time will be denied for untimely filing. If the provider feels they have filed their case within the appropriate timeframe, the provider may submit documentation showing proof of timely filing. Acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of WellCare, or similar receipt from other commercial delivery services.

WellCare has thirty (30) calendar days to review the case for medical necessity and conformity to WellCare guidelines. If the appeal is not resolved within thirty (30) days, WellCare shall request a fourteen (14) day extension from the provider. If the provider requests the extension, the extension shall be approved by WellCare.

Cases received without the necessary documentation will be denied for lack of information. It is the responsibility of the provider to provide the requested documentation within sixty (60) calendar days of the denial to re-open the case. Records and documents received after that time frame will not be reviewed and the case will remain closed.

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

### **Reversal of Denial**

If all of the relevant information is received, WellCare will make a determination within thirty (30) calendar days. 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 overturned. The provider will be notified of this decision in writing.

The provider may file a claim for payment related to the appeal, if they have not already done so. If a claim has been previously submitted and denied, it will be adjusted for payment after the decision to overturn the denial has been made. WellCare will ensure that claims are processed and comply with the 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 upheld. The provider will be notified of this decision in writing.

For denials based on medical necessity, the criteria used to make the decision will be provided in the letter. The provider may also request a copy of the clinical rationale used in making the appeal decision by sending a written request to the Appeals addresses listed in the decision letter.

### **Member**

For a member appeal, the member, member's representative, or a provider acting on behalf of the member and with the member's written consent, may file an appeal request either orally or in writing within thirty (30) calendar days of the date of the adverse organization determination.

If an appeal is filed orally via WellCare's Customer Service, the request must be followed up with a written, signed appeal to WellCare within ten (10) calendar days of the oral filing. For oral filings, the timeframes for resolution begin on the date the oral filing was received by WellCare.

If the member's request for appeal is submitted after thirty (30) calendar days, then good cause must be shown in order for WellCare to accept the late request.

Examples of good cause include, but are not limited to, the following:

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

If the member wishes to use a representative, then s/he must 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 [www.kentucky.wellcare.com/Provider/FormsandDocuments](http://www.kentucky.wellcare.com/Provider/FormsandDocuments). 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/TDD capability.

Providers do not have appeal rights through the member appeals process. However, providers have the ability to file an authorization or claim-related appeal (dispute) on their own behalf. See *Medicaid Provider on Behalf of Self -Appeals Process* above for more information.

The member, member's representative or a provider acting on the member's behalf may file for an expedited, standard pre-service or retrospective appeal determination. The request can come from the provider or office staff working on behalf of the provider. Only a provider can request a standard retrospective appeal on his/her own behalf.

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

WellCare ensures that decision-makers on appeals were not involved in previous levels of review or decision-making. When deciding any of the following: (a) an appeal of a denial based on lack of medical necessity; (b) a grievance regarding denial of expedited resolution of an appeal; or (c) a grievance or appeal involving clinical issues; the appeal reviewers will be health care professionals with clinical expertise in treating the member's condition/disease or have sought advice from providers with expertise in the field of medicine related to the request.

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:

- Expedited Request: **72 hours**
- Standard Pre-Service Request: **30 calendar days**
- Retrospective Request: **30 calendar days**

The Expedited, Standard Pre-Service and Retrospective Determination periods noted above may be extended by up to fourteen (14) calendar days if the member requests an extension or if WellCare justifies a need for additional information and documents how the extension is in the interest of the member. If an extension is not requested by the

member, WellCare will provide the member with written notice of the reason for the delay within two (2) business days of the decision to extend the timeframe.

### **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 a appeal of a determination will be considered in situations where applying the standard procedure could seriously jeopardize the member's life, health, or ability to regain maximum function, including cases in which WellCare makes a less than fully favorable decision to the member. In light of the short time frame for deciding expedited appeals, a provider does not need to be an authorized representative to request an expedited appeal on behalf of the member.

Members who orally request an expedited appeal are not required to submit a written appeal request as outlined in the Appeals *Member* section on page 52

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

### **Denial of an Expedited Request**

WellCare will provide the member with prompt oral notification within twenty-four (24) hours regarding the denial of an expedited appeal and the member's rights, and will subsequently mail to the member within three (3) calendar days of the oral notification, a written letter that:

- Explains that WellCare will automatically transfer and process the request using the thirty (30) calendar day time frame for standard appeals beginning on the date WellCare received the original request; and
- Informs the member of the right to resubmit a request for an expedited appeal and that if the member gets any provider's support indicating that applying the standard time frame for making a determination could seriously jeopardize the member's life, health or ability to regain maximum function, the request will be expedited automatically.

### **Resolution of an Expedited Appeal**

Upon an expedited appeal of an adverse determination, 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 three (3) business days after receiving a valid complete request for appeal.

### **Reversal of Denial of an Expedited Appeal**

If WellCare overturns its initial action and/or the denial, it will issue authorization to cover the requested service, and notify the member orally within three (3) business days of receipt of the expedited appeal request followed with written notification of the appeal decision.

### **Affirmation of Denial of an Expedited Appeal**

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

- Issue a Notice of Adverse Action to the member and/or appellant;
- Include in the Notice the specific reason for the appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based;
- Inform the member:

- Of their right to request a State Fair Hearing and how to do so;
- Of their right to representation;
- Of their right to continue to receive benefits pending a State Fair Hearing; and
- That they may be liable for the cost of any continued benefits if WellCare's action is upheld.

### **Standard Pre-Service Appeals Process**

A member, a member's representative or a provider on behalf of a member with the member's written consent, may file a standard pre-service appeal request either orally or in writing within thirty (30) calendar days of the date of the adverse organization determination.

If an appeal is filed orally through Customer Service, the request must be followed up with a written, signed appeal to WellCare within ten (10) calendar days of the oral filing. For oral filings, the timeframes for resolution begin on the date the oral filing was received.

Members are also provided reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing.

### **Reversal of Denial of a Standard Pre-Service Appeal**

If, upon standard appeal, WellCare overturns its adverse organization denying a member's request for a service, (pre-service request), then WellCare will issue an authorization for the pre-service request.

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

### **Affirmation of Denial of a Standard Pre-Service Appeal**

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

- Issue a Notice of Adverse Action to the member and/or appellant;
- Include in the Notice the specific reason for the appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based will be included in the notice;
- Inform the member:
  - Of their right to request a state fair hearing and how to do so;
  - Of their right to representation;
  - Of their right to continue to receive benefits pending a state fair hearing; and
  - That they may be liable for the cost of any continued benefits if WellCare's action is upheld.

### **Standard Retrospective Appeals Process**

Post-service appeals are typically requests for payment for care or services that the member has already received. Accordingly, a post-service appeal would never result in the need for an expedited review.

A member or a member's representative may file a standard retrospective appeal request either orally or in writing within thirty (30) calendar days of the date of the adverse organization determination. Members are also provided reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing.

For more information on Appointment of Representative (AOR) statements and oral filings requirements, see Appeals *Member* section on page xx.

### **Reversal of Denial of Standard Retrospective Appeal**

If, upon appeal, WellCare overturns its adverse organization determination denying a member's request for payment, then WellCare will issue its reconsidered determination and send payment for the service.

WellCare will also pay for appealed services, in accordance with state policy and regulations, if the services were furnished while the appeal was pending and the disposition reverses a decision to deny, limit or delay services.

### **Affirmation of Denial of a Standard Retrospective Appeal**

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

- Issue a Notice of Adverse Action to the member and/or appellant;
- Include in the Notice the specific reason for the appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based will be included in the notice;
  - The right to request a state fair hearing and how to do so
  - Inform the member:
    - Of their right to representation;
    - Of their right to continue to receive benefits pending a State fair hearing;
    - That they may be liable for the cost of any continued benefits if WellCare's action is upheld.

### **State Hearing for Members**

A member may request a State Fair hearing if s/he is dissatisfied with an action that has been taken by WellCare, within thirty (30) days of receiving notice of the action or within thirty (30) days of the final decision by WellCare.

All documents supporting WellCare's action must be received by the Department no later than five (5) days from the date WellCare receives notice from the Department that a State Fair Hearing has been filed. These records shall be made available to the member upon request by either the member or the member's legal counsel. The Department will provide the member with a hearing process that shall adhere to 907 KAR 1:563, 42 CFR 438 Subpart F and 42 CFR 431 Subpart E.

Failure of WellCare to comply with the State Fair Hearing requirements of the state and federal Medicaid law in regard to an action taken by WellCare or to appear and present evidence will result in an automatic ruling in favor of the member.

### **Continuation of Benefits while the Appeal and Medicaid Fair Hearing are pending**

WellCare shall continue the member's benefits if all of the following are met:



- The member or the service provider files a timely appeal of the WellCare action or the member requests a State Fair Hearing within thirty (30) days from the date on WellCare's notice of action;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized service provider;
- The time period covered by the original authorization has not expired; and
- The member requests extension of the benefits.

WellCare shall provide benefits until one of the following occurs:

- The member withdraws the appeal;
- Fourteen (14) days have passed since the date of the resolution letter, provided the resolution of the appeal was against the member and the member has not requested a State Fair Hearing or taken any further action;
- The Department issues a State Fair Hearing decision adverse to the member; and/or
- The time period or service limits of a previously authorized service has expired.

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 service 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 Department reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, WellCare will authorize or provide this appealed services promptly, as expeditiously as the member's health condition requires.

If WellCare or the Department reverses a decision to deny, limit or delay services and the member received the appealed services while the appeal was pending, WellCare will pay for those services.

## **Grievance Process**

### **Provider**

Providers have the right to file a grievance no later than thirty (30) calendar days from the date the provider becomes aware of the issue generating the grievance. Written resolution will be provided to the provider by WellCare within thirty (30) calendar days from the date the grievance is received by WellCare. If the grievance is not resolved within thirty (30) calendar days, WellCare shall orally request a fourteen (14) day extension from the provider. If the provider requests the extension, the extension shall be approved by WellCare.

A provider may not file a grievance on behalf of the member without written consent from the member as the member's representative.

WellCare will provide all providers written notice of the provider grievance procedures at the time they enter into contract.

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

## **Member**

The member or member's representative acting on the member's behalf may file a grievance. 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); and/or
  - Office conditions.
- Services provided by WellCare including, but not limited to:
  - Hold time on telephone;
  - Rudeness of staff;
  - Involuntary disenrollment from WellCare; and/or
  - Unfulfilled requests.
- Access availability including, but not limited to:
  - Difficulty getting an appointment;
  - Wait time in excess of one (1) hour; and/or
  - Handicap accessibility.

A member or a member's representative, including the legal guardian of a minor member or incapacitated adult, a provider acting on behalf of the member, with written consent, may file a grievance request either orally or in writing within thirty (30) calendar days of the date of the incident or when the member was made aware of the incident.

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.

If the member wishes to use a representative, then s/he must 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 [www.kentucky.wellcare.com/Provider/FormsandDocuments](http://www.kentucky.wellcare.com/Provider/FormsandDocuments)

## **Grievance Submission**

An oral grievance request shall be filed through an established toll-free number with the WellCare Customer Service Department. 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 provider grievance shall be mailed directly to WellCare's Grievance Department.

For contact information in which to submit oral and/or written appeals requests, please refer to the state-specific Quick Reference Guides which may be found on WellCare website at <http://www.kentucky.wellcare.com/Provider/QuickReferenceGuides>.

## **Grievance Resolution**

WellCare will acknowledge the member's standard grievance in writing within five (5) business days from the date the grievance is received by WellCare. Upon receipt of the resolution, a letter will be mailed to the member within thirty (30) calendar days from the date the grievance is received by WellCare. This resolution letter may not take the place of the acknowledgment letter, unless a decision is reached before the written

acknowledgement is sent, then one letter shall be sent which includes the acknowledgement and the decision letter.

The acknowledgement letter will include:

- Name and telephone number of the Grievance Coordinator; and
- Request for any additional information, if needed to investigate the issue.

The resolution letter will include:

- The results/findings of the resolution;
- All information considered in the investigation of the grievance; and
- The date of the grievance resolution.

### **State Hearing for Members**

If a member is dissatisfied with the grievance decision reached by WellCare, the member may request a State Fair hearing within thirty (30) days of receiving the grievance resolution letter.

All documents supporting WellCare's decision must be received by the Department no later than five (5) days from the date WellCare receives notice from the Department that a State Fair Hearing has been filed by the member. These records shall be made available to the member upon request by either the member or the member's legal counsel. The Department will provide the member with a hearing process that shall adhere to 907 KAR 1:563, 42 CFR 438 Subpart F and 42 CFR 431 Subpart E.

Failure of WellCare to comply with the State Fair Hearing requirements of the Commonwealth and federal Medicaid law in regard to an action taken by WellCare or to appear and present evidence will result in an automatic ruling in favor of the member.

### **Grievance and Appeal Files**

All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the Department or its designee, upon request, for review. Grievance or appeal files shall be retained for ten (10) years following the final decision by WellCare, HSD, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

Files will contain sufficient information to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the member of receipt of the grievance or appeal, all correspondence between WellCare and the member, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the member, and all other pertinent information.

Documentation regarding the grievance shall be made available to the member, if requested.

## **VIII. Delegated Entities**

### **Overview**

WellCare oversees the provision of services provided by the delegated entity and/or sub-delegate, and is accountable to the federal and state agencies, including the Department, for the performance of all delegated functions. It is the sole responsibility of WellCare to monitor and evaluate the performance of the delegated functions to ensure

compliance with regulatory requirements, contractual obligations, accreditation standards and WellCare policies and procedures.

**Compliance:**

WellCare's compliance responsibilities extend to delegated entities, including, without limitation:

- Compliance Plan;
- HIPAA Privacy & Security;
- Fraud, Waste & Abuse Training;
- Cultural Competency Plan; and
- Disaster Recovery and Business Continuity.

Refer to *Section IX. Compliance* for additional information on compliance requirements.

WellCare ensures compliance through the delegation oversight process and the Delegation Oversight Committee (DOC). The DOC and its committee representatives:

- Ensure that all delegated entities are eligible for participation in the Medicaid and Medicare programs;
- Ensure that WellCare has written agreements with each delegated entity that specifies the responsibilities of the delegated entity and WellCare, reporting requirements, and delegated activities in a clear and understandable manner;
- Ensure that the appropriate WellCare associates have properly evaluated the entity's ability to perform the delegated activities prior to delegation;
- Provide formal, ongoing monitoring of the entity's performance at least annually, including monitoring to ensure quality of care and quality of service is not compromised by financial incentives;
- Impose sanctions up to and including the revocation and/or termination of delegation if the delegated entity's performance is inadequate;
- Assure the delegated entity is in compliance with the requirement in 42 CFR 438;
- Assure that each delegated subcontract:
  - Identifies the population covered by the delegated subcontract;
  - Specifies the amount, duration and scope of services to be provided by the delegated subcontractor;
  - Specifies the term and the procedures and criteria for termination;
  - Specifies that delegated subcontractors use only Commonwealth of Kentucky participating Medicaid providers in accordance with the Kentucky Contract;
  - Makes full disclosure of the method and amount of compensation or other consideration to be received from WellCare;
  - Provides for monitoring by WellCare of the quality of services rendered to Members, in accordance with the Kentucky Contract;
  - Where the delegated subcontractor agrees to provide Covered Services, contain no provision that provides incentives, monetary or otherwise, for the withholding from members of medically necessary Covered Services;
  - Contains a prohibition on assignment, or on any further subcontracting, without the prior written consent of the subcontractor;
  - Contains an explicit provision that the Commonwealth is the intended third party beneficiary of the delegated subcontract and, as such, the Commonwealth is entitled to all remedies entitled to third party beneficiaries under law;
  - Specifies that delegated subcontractor agrees to submit encounter records in the format specified by the Commonwealth so that WellCare

can meet the Commonwealth's specifications required by the Kentucky Contract;

- Incorporates all the provisions of the Kentucky Contract to the fullest extent applicable to the service or activity delegated pursuant to the delegated subcontract, including without limitation, the obligation to comply with all applicable federal and Commonwealth law and regulations, including but not limited to, KRS 205.8451-8483, all rules, policies and procedures of Finance and the Department as defined in the Kentucky Contract, and all standards governing the provision of Covered Services and information to members, all QI Program requirements, all record keeping and reporting requirements, all obligations to maintain the confidentiality of information, all rights of Finance, the Department, the Office of the Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations, all indemnification and insurance requirements, and all obligations upon termination;
- Provides for WellCare to monitor the delegated subcontractor's performance on an ongoing basis, including those with accreditation; the frequency and method of reporting to WellCare, the process by which WellCare evaluates the delegated subcontractor's performance; and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually;
- Specifies that a delegated subcontractor with NCQA®, URAC or other national accreditation shall provide WellCare with a copy of its current certificate of accreditation together with a copy of the survey report;
- Provides a process for the delegated subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action;
- Specifies the remedies up to and including, revocation of the delegated subcontract available to WellCare if the delegated subcontractor does not fulfill its obligations; and
- Contains provisions that suspected fraud and abuse be reported to WellCare.

## **IX. Compliance**

### **WellCare Compliance Program**

#### **Overview**

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 as to the performance of work by WellCare, WellCare employees, contractors (including delegated entities) and business partners in an ethical and legal manner. All providers, including provider employees and provider sub-contractors and their employees, are required to comply with WellCare compliance program requirements, including:

- WellCare's compliance training requirements including but 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 disciplinary actions to address violations.
- Corporate Integrity Agreement (CIA) Training
  - Effective April 26, 2011, WellCare's CIA with the Office of the Inspector General (OIG) of the United States Department of Health and Human Services (HHS) requires that WellCare maintain and build upon its existing Compliance Program and corresponding training.
  - Under the CIA, the degree to which individuals must be trained depends on their role and function at WellCare.
- HIPAA Privacy & Security Training
  - To encompass privacy and security requirements in accordance with the federal standards established pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
  - Must include, but not limited to:
    - Uses and Disclosures of PHI;
    - Member Rights; and
    - Physical and technical safeguards.
- Fraud, Waste and Abuse (FWA) Training
  - Must include, but not limited to:
    - Laws and regulations related to fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback statute, HIPAA, etc.);
    - Obligations of the provider including provider employees and provider 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 providers serve.
- Disaster Recovery and Business Continuity
  - Development of a Business Continuity Plan that includes the documented process of continued operations of the delegated functions in the event of a short term or long term interruption of services.

Providers, including provider employees and/or provider sub-contractors, must report to WellCare any suspected fraud, waste or abuse, misconduct or criminal acts by WellCare, or any provider, including provider employees and/or provider sub-contractors, or by WellCare members. Reports may be made anonymously through the WellCare fraud hotline at (866) 678-8355.

Details of the corporate ethics and compliance program may be found on WellCare's website at <http://www.wellcare.com/AboutUs/default>.

# Code of Conduct and Business Ethics

## **Overview**

WellCare has established a [Code of Conduct and Business Ethics](http://www.wellcare.com/AboutUs/default) 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 <http://www.wellcare.com/AboutUs/default>.

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](http://www.wellcare.com/AboutUs/default). Participating providers and other contractors of WellCare are encouraged to report compliance concerns and any suspected or actual misconduct. Report suspicions of Fraud Waste & Abuse by calling the WellCare FWA Hotline at (866) 678-8355.

## **Fraud, Waste, and Abuse**

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

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

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

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

To report suspected fraud and abuse, please refer to your Quick Reference Guide which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide) or call our confidential and

toll-free WellCare compliance hotline. Details of the corporate ethics and compliance program, and how to contact the WellCare fraud hotline, may be found on WellCare's website at <http://www.wellcare.com/AboutUs/default>.

### **Site Inspection Evaluations**

Site Inspection Evaluations (SIE's) 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; and
  - Adequacy of waiting room and examination room space.
- Medical / treatment record keeping criteria.

SIE's are conducted for:

- Unaccredited Facilities;
- State-specific initial credentialing requirements;
- State-specific re-credentialing requirements; and
- When complaint/grievance quality criteria thresholds are met.

In those states where initial SIE's are not a requirement for credentialing, there is ongoing monitoring of member complaints. SIE's are conducted for those sites that are at or exceed the complaint threshold of three (3) in a rolling six (6) month period. SIE's may be performed for an individual complaint or quality of care concern if the severity of the issue is determined to warrant an onsite review. For more information on credentialing requirements, refer to *Section IV: Credentialing*.

### **Confidentiality of Member Information & Release of Records**

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

Every provider practice is required to provide members with information regarding their privacy practices and to the extent required by law, with their Notice of Privacy Practices (NPP). Employees who have access to member records and other confidential information are required to sign a Confidentiality Statement.

Some examples of confidential information include:

- Medical records;
- Communication between a member and a provider regarding the member's medical care and treatment;
- All personal and/or 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 Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) testing that is protected under federal or state law.

The NPP informs the member of their rights under HIPAA and how the provider and/or WellCare may use or disclose the members' PHI. HIPAA regulations require each covered entity, such as health care providers, to provide a NPP to each new patient or member.

Member medical records must be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.

The member's medical record is the property of the provider who generates the record. However, each member or their representative is entitled to one (1) free copy of his/her medical record. Additional copies shall be made available to members at cost. Medical records shall generally be preserved and maintained for a minimum of five (5) years unless federal requirements mandate a longer retention period (i.e. immunization and tuberculosis records are required to be kept for a person's lifetime).

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/patient identification information, on each page;
- Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship information;
- Date of data entry and date of encounter;
- Provider identification by name;
- Allergies, adverse reactions and any known allergies shall be noted in a prominent location;
- Past medical history, including serious accidents, operations, illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e. documentation of chickenpox);
- Identification of current problems;
- The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering provider's initials or other documentation indicating review;
- Documentation of immunizations pursuant to 902 KAR 2:060;
- 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 or Department for Public Health pursuant to 902 KAR 2:020;
- Follow-up visits provided secondary to reports of emergency room care;
- Hospital discharge summaries;
- Advanced Medical Directives, for adults;
- All written denials of service and the reason for the denial; and
- Record legibility to at least 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 clinical encounters:

- History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;
- Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits; and
- Plan of treatment including:
  - Medication history, medications prescribed, including the strength, amount, directions for use and refills; and
  - Therapies and other prescribed regimen; and
  - Follow-up plans including consultation and referrals and directions, including time to return.

### **Disclosure of Information**

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

For more information on how to request this information, members may contact WellCare's Customer Service using the toll-free telephone number found on the member's ID card. Providers may contact WellCare's Customer Service by referring to the Quick Reference Guide which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

## **Cultural Competency Program and Plan**

### **Overview**

The purpose of the Cultural Competency program is to ensure that WellCare meets the unique, diverse needs of all members, to provide that the associates of WellCare value diversity within the organization, and to see that members in need of linguistic services have 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 that have potential cultural or linguistic barriers for which alternative communication methods are needed;

- Utilize culturally sensitive and appropriate educational materials based on the member's race, ethnicity and primary language spoken;
- Make resources available to meet the unique language barriers and communication barriers that exist in the population;
- Help providers care for and recognize the culturally diverse needs of the population;
- Provide education to associates on the value of the diverse cultural and linguistic differences in the organization and the populations served; and
- Decrease health care disparities in the minority populations we serve.

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

The components of WellCare's Cultural Competency program include:

#### Data Analysis

- Analysis of claims and encounter data to identify the health care needs of the population; and
- Collection of member data on race, ethnicity and language spoken.

#### Community-based Support

- Outreach to community-based organizations which support minorities and the disabled in ensuring that the existing resources for members are being utilized to their full potential.

#### Diversity

- Non-discriminating – WellCare providers may not discriminate with regard to race, religion or ethnic background when hiring associates;
- Recruiting – Providers are expected to recruit diverse talented associates in all levels of management; and
- Multilingual – WellCare recruits bilingual associates for areas that have direct contact with members to meet the needs identified, and encourages providers to do the same.

#### Diversity of Provider Network

- Providers are inventoried for their language abilities and this information is made available in the Provider Directory so that members can choose a provider that speaks their primary language; and
- Providers are recruited to ensure a diverse selection of providers to care for the population served.

#### Linguistic Services

- Providers will identify members that 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 will be provided by vendors with such expertise and are coordinated by WellCare's Customer Service Department; and
- 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 phone calls to the member. The toll-free TTY/TDD number can be found on the member identification card.

### **Provider Education**

- WellCare's Cultural Competency Program provides a Cultural Competency Checklist to assess the provider office's Cultural Competency;
- For more information and to access the Survey on the Cultural Competency Program, refer to WellCare's website at [www.kentucky.wellcare.com/FormsandDocuments](http://www.kentucky.wellcare.com/FormsandDocuments);
- Providers must adhere to the Cultural Competency program as set forth above.

<sup>1</sup> *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, U.S. Department of Health and Human Services, Office of Minority Health, December 2000.

<sup>2</sup> *Planning Culturally and Linguistically Appropriate Services: A Guide for Managed Care Plans*, Centers for Medicare and Medicaid Services and Agency for Healthcare Research and Quality, 2003

<sup>3</sup> Title VI of the Civil Rights Act specifically requires that managed care organizations provide assistance to persons with limited English proficiency, where a significant number of the eligible population is affected. Department of Justice regulations (28 CFR Section 42.405(d)(1)) state: "Where a significant number or proportion of the population eligible to be served or likely to be directly affected by a federally assisted program ... needs service or information in a language other than English in order effectively to be informed of or to participate in the program, the recipient shall take reasonable steps, considering the scope of the program and the size and concentration of such population, to provide information in appropriate languages to such persons. This requirement applies with regard to written material of the type which is ordinarily distributed to the public."

## **X. 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 those services provided by non-participating providers. Wellcare uses Interqual™ criteria, a well-known and nationally accepted guideline for assessing level of care criteria for behavioral health.

For complete information regarding benefits, exclusions and authorization requirements, or in the event you need to contact WellCare's Customer Service for a referral to a behavioral health provider, refer to your Quick Reference Guide which may be found on WellCare's website at [www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide).

### **Responsibilities of Behavioral Health Providers**

WellCare monitors providers against these standards to ensure members can obtain needed health services within the acceptable appointments waiting times. The provisions below are applicable only to behavioral health providers and do not replace the provisions set forth in *Section II: Member and Provider Administrative Guidelines* for medical providers. Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare.

|  |            |
|--|------------|
| BH Provider – Emergent                 | < 24 hours |
| BH Provider – Urgent                   | < 48 hours |
| BH Provider – Post Inpatient discharge | < 7 days   |
| BH Provider – Routine                  | < 14 days  |

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 (7) days from the date of discharge.

In the event that a member misses an appointment, the behavioral health provider must contact the member within twenty-four (24) hours to reschedule.

Behavioral health providers are expected to assist members in accessing emergent, urgent, and routine behavioral services as expeditiously as the member's condition requires. Members also have access to a toll free behavioral crisis hotline that is staffed twenty-four (24) hours a day. The behavioral crisis phone number is printed on the member's card and is available on our website.

For information about WellCare's Case Management and Disease Management programs, including how to refer a member for these services, please see *Section V: Utilization Management (UM), Case Management (CM) and Disease Management (DM)*.

### **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 health care services if and when they are licensed to do so within the scope of their practice. Behavioral providers are required to use the DSM-IV multi-axial classification when assessing the member for behavioral health services and document the DSM-IV 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 PCP's at the time of discharge from an inpatient hospitalization (WellCare recommends faxing the discharge instruction sheet, or a letter summarizing the hospital stay, to the PCP). Please send this communication, with the

properly signed consent, to the members identified PCP noting any changes in the treatment plan on the day of discharge.

We strongly encourage open communication between PCPs and behavioral health providers. If a member's medical or behavioral condition changes, WellCare expects that both 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.

### **Behavioral Health Advisory Council**

WellCare values the input of our behavioral health members, advocates and providers. A behavioral health advisory council has been established in order to assure that services and programs meet the needs and expectations of the behavioral health community. We encourage our providers to participate by providing feedback and input to the advisory council. Information regarding the advisory council will be made available on our website at [www.kentucky.wellcare.com](http://www.kentucky.wellcare.com).

## **XI. 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);
- Drug Evaluation Review (DER) Process;
- Mandatory Generic Policy;
- Step Therapy (ST);
- Quantity Level Limit (QL);
- Pharmacy Lock-In Program; and
- Network Improvement Program (NIP)

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

- Follow national standards of care guidelines for treating conditions i.e., National Institutes of Health (NIH) Asthma guideline, Joint National Committee (JNC) VII Hypertension guidelines;
- 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.

To contact WellCare's Pharmacy department, please refer to the Quick Reference Guide which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuide](http://www.wellcare.com/Provider/QuickReferenceGuide).

### **Preferred Drug List**

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

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

The PDL can be found on our website at [www.kentucky.wellcare.com](http://www.kentucky.wellcare.com). Any changes to the list of pharmaceuticals and applicable pharmaceutical management procedures are communicated to providers at least annually via the following:

- Quarterly updates in provider and member newsletters;
- Website updates; and/or
- Pharmacy and provider communication that detail any major changes to a particular therapy or therapeutic class

### **Additions and Exceptions to the Preferred Drug List**

To request consideration for inclusion of a drug to WellCare's PDL, providers may write or fax WellCare, explaining the medical justification. For more information on requesting additions and exceptions, refer to the *Drug Evaluation Review Process* on page 73.

### **Generic Medications**

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

Generic drugs must be dispensed by the pharmacist when available as the therapeutic equivalent to a brand name drug. Exceptions to the mandatory generic policy require medical justification when therapeutic equivalents are available. A DER form should be completed when requiring an exception. Clinical justification as to why the generic alternative is not appropriate for the member should be included with the DER form.

For more information on the DER process, including how to access the DER form, see *Drug Evaluation Review Process* on page 73.

### **Injectable and Infusion Services**

Select self-injectable and infusion drugs are covered under the outpatient pharmacy benefit. Most self-injectable products and all infusion drug requests require a DER using the Injectable Infusion Form.

Approved self-injectable and infusion drugs are covered when supplied by contracted retail pharmacies and infusion vendors. Please contact the Pharmacy department regarding criteria related to specific drugs. The specific J-codes of any self-injectable products that do not require authorization when given in a doctor's office are included in the No Auth Required CPT Codes List document located in the Forms and Documents section of the website.



Refer to WellCare's website at [www.kentucky.wellcare.com](http://www.kentucky.wellcare.com), Provider tab, for more information. You may access the *No Auth Required CPT Codes List* under the Pharmacy tab on the Provider page, and access the *Injectable Infusion Form* in the Forms and Documents section on the Provider Resources page.

### **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;
- Non-prescriptive, over-the-counter (OTC drugs\*) with a few exceptions listed on the PDL;
- Drugs for the treatment of erectile dysfunction;
- DESI drugs or drugs that may have been determined to be identical, similar or related;
- Vitamin or mineral products other than prenatals or fluoride preparations (fluoride not covered over age sixteen (16));
- Investigational or experimental drugs; and
- Agents prescribed for any indication that is not medically accepted.

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

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

### **Step Therapy & Quantity Level Limits:**

Step therapy (ST) 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 drugs are recognized as safe, effective and economically sound treatments. The first-line drugs on our PDL have been evaluated through the use of clinical literature and are approved by our P&T Committee.

Quantity limits can be used to ensure that pharmaceuticals are supplied in a quantity consistent with Federal Drug Administration (FDA) approved dosing guidelines. Quantity limits can also be used to help prevent billing errors. Please refer to the PDL to view drugs requiring step therapy and those with quantity level limits.

### **Over-the-Counter (OTC) Medications**

Over-the-Counter (OTC) items listed on the PDL require a prescription. All other OTC items offered as an expanded benefit by WellCare do not require a prescription. Examples of OTC items listed on the PDL include:

- Multivitamins and multiple vitamins with iron for members less than sixteen (16) years of age (chewable or liquid drops);
- Iron;
- Non-sedation antihistamines;
- Enteric coated aspirin;



- Diphenhydramine;
- Insulin;
- Topical antifungals;
- Ibuprofen suspension;
- Permethrin;
- Meclizine;
- Insulin syringes;
- Urine test strips;
- H-2 receptor antagonists; and
- Proton Pump Inhibitors.

For a complete listing, please refer to the PDL which can be found on our website at [www.kentucky.wellcare.com](http://www.kentucky.wellcare.com).

### **Pharmacy Lock-In Program**

Members identified as over-utilizing 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 (Lock-in) status for a minimum of one (1) year. While in Lock-in, the member will be restricted to one (1) prescribing physician and one (1) pharmacy to obtain their medications. Claims submitted by other prescribers or other pharmacies will not be paid for the member. Members identified will also be referred to Case Management.

Members in the Lock-in program will be reviewed annually by the P&T Committee who shall determine the need for further lock-in according to established procedures and federal regulations regarding such action.

### **Member Co-Payments**

- \$2 for brand name drugs and diabetic/medical supplies
- \$1 for generic drugs and atypical anti-psychotic drugs if no generic equivalent for the atypical anti-psychotic drug exists
- \$0 for OTC medications listed on the PDL and birth control

### **Drug Evaluation Review Process**

The goal of the Drug Evaluation Review (DER) program (also known as prior authorization) is to ensure that medication regimens that are high-risk, have high potential for misuse or have narrow therapeutic indices are used appropriately and according to FDA-approved indications. The DER process is required for:

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

Providers may request an addition or exception to WellCare's PDL orally or in writing. For written requests, providers should complete a Drug Evaluation Review (DER) form, supplying pertinent member medical history and information. A DER form may be

accessed on WellCare's website at [www.kentucky.wellcare.com](http://www.kentucky.wellcare.com) under the Forms and Documents section.

To submit a request, orally or in writing, refer to the contact information listed on your Quick Reference Guide which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuide](http://www.wellcare.com/Provider/QuickReferenceGuide).

Upon receipt of the DER, a decision is completed within twenty-four (24) hours for all DER requests. If authorization cannot be approved or denied, and the drug is medically necessary, a seven (7) day emergency supply of the non-preferred drug shall be supplied to the member.

Prior Authorization (PA) 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.

### **Medication Appeals**

To request an appeal of a DER request decision, contact the Pharmacy Appeals department via fax, mail, in person or phone. Refer to the Quick Reference Guide which may be found on WellCare's website at [www.wellcare.com/Provider/QuickReferenceGuide](http://www.wellcare.com/Provider/QuickReferenceGuide).

### **Pharmacy Management - Network Improvement Program (NIP)**

The Pharmacy Network Improvement Program (NIP) is designed to provide physicians with quarterly utilization reports to identify over 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 twenty-four (24) hours a day.

For areas where there are no twenty-four (24) hour pharmacies, members may call Walgreen's Health Initiatives (WHI) for information on how to access pharmacy services.

### **WellCare's Specialty Pharmacy**

WellCare offers Specialty Pharmacy services to members who are taking medications to treat long-term, life-threatening or rare conditions. WellCare's Specialty Pharmacy team are experts in the special handling, storage and administration of these medications (i.e., injectables, infusables, orals) 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 twenty-four (24) to forty-eight (48) hours after contacting WellCare's Specialty Pharmacy.

To learn more about the conditions covered under WellCare's Specialty Pharmacy WellCare's website at [www.kentucky.wellcare.com](http://www.kentucky.wellcare.com). To contact the Specialty Pharmacy Department, refer to your Quick Reference Guide.

## **XII. WellCare Resources – Kentucky Medicaid**

### **Medicaid Forms and Documents**

[www.kentucky.wellcare.com/Provider/FormsandDocuments](http://www.kentucky.wellcare.com/Provider/FormsandDocuments)

### **Quick Reference Quick Reference Guides**

[www.kentucky.wellcare.com/Provider/QuickReferenceGuide](http://www.kentucky.wellcare.com/Provider/QuickReferenceGuide)

### **Clinical Practice Guidelines**

[www.kentucky.wellcare.com/Provider/CPGs](http://www.kentucky.wellcare.com/Provider/CPGs)

### **Clinical Coverage Guidelines**

[www.kentucky.wellcare.com/Provider/CCGs](http://www.kentucky.wellcare.com/Provider/CCGs)

### **Job Aids and Resource Guides**

[www.kentucky.wellcare.com/Provider/JobAidsandResourceGuides](http://www.kentucky.wellcare.com/Provider/JobAidsandResourceGuides)

### **XIII. WellCare Definitions – Kentucky Medicaid**

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

**“Abuse”** means Provider Abuse and Member Abuse, as defined in KRS 205.8451.

**“Action”** means, as defined in 42 CFR 438.400(b), the

- A. denial or limited authorization of a requested service, including the type or level of service;
- B. reduction, suspension, or termination of a service previously authorized by the Department, its agent or Contractor;
- C. denial, in whole or in part, of payment for a service;
- D. failure to provide services in a timely manner, as defined by Department;
- E. failure of an MCO or Prepaid Health Insurance Plan (PHIP) to act within the timeframes required by 42 CFR 438.408(b); or
- F. for a resident of a rural area with only one MCO, the denial of a Medicaid enrollee’s request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside a Contractor’s Region.

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

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

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

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

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

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

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

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

**“Covered Services”** means items and services covered under a Benefit Plan.

**“Department”** means the Department for Medicaid Services.

**“EPSDT”** means Early and Periodic Screening, Diagnosis and Treatment program that provides medically necessary health care, diagnostic services, preventive services, rehabilitative services, treatment and other measures described in 42 USC Section 1396d(a), to all members under the age of twenty-one (21).

**“EPSDT Special Services”** means medically necessary services which are not otherwise covered by the Kentucky Medicaid Program under EPSDT Covered Services.

**“Emergency Medical Condition”** means

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

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

B. 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 Medical Services”** or **“Emergency Care”** 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.

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

**“Ineligible Person”** means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care

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

**"Kentucky Contract"** means the Medicaid Managed Care Contract between the Commonwealth of Kentucky, Finance and Administration Cabinet and Wellcare of Kentucky, Inc., and any amendments, including, corrections or modifications thereto

**"LTAC"** means a Long-Term Acute Care hospital.

**"Member"** means an individual properly enrolled in a Benefit Plan and eligible to receive Covered Services at the time such services are rendered.

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

**"Members with Special Health Care Needs"** means members with special needs are defined as adults and children who face daily physical, mental or environmental challenges that place their health at risk and whose ability to fully function in society is limited.

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

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

**"PCP" or "Primary Care Provider"** means a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse, physician assistant, or health clinic, including an FQHC, primary care center, or RHC that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours a day, seven (7) days a week primary health care services to individuals, and for a Member who has a gynecological or obstetrical health care needs, disability or chronic illness, is a specialist who agrees to provide and arrange for all appropriate primary and preventive care. .

**"Prior Authorization"** means 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.

**“Provider”** means an individual or entity that has contracted to provide or arrange for the provision of Covered Services to Members under a Benefit Plan.

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

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

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

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

**“Zero Cost Share Dual Eligible Member”** means a Dual Eligible Member that is not responsible for paying any Part A or Part B cost sharing.

