



— 2019 KENTUCKY —
**MEDICAID
PROVIDER MANUAL**



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2019 WellCare of Kentucky Provider Manual Table of Revisions

Date	Section	Comments	Page	Change
7/12/2019	Section 1: Overview	Eligibility	10	Eligibility categories updated
		Core Benefits and Services, and Extra Benefits for Members	10-15	Benefits and services updated
		Services Not Covered by WellCare of Kentucky	16	New section added
7/12/2019	Section 2: Provider and Member Administrative Guidelines	Access Standards	24	Regular Dental appointments changed from 3 weeks to 30 days
		Responsibilities of Primary Care Providers	25	Responsibilities updated
		Termination of a Member	29	Added Member transfer information
		Hospital Admission Prior to the Member's Transition	36	New section added
		Outpatient Facility Services and Non-Facility Services	36	New section added
		Assignment of Primary Care Provider	38	Section updated
7/12/2019	Section 3: Quality Improvement	Medical Records	44	Section updated
7/12/2019	Section 4: UM, CM, DM	Prior Authorization	51	Required notification information added
		Procedures for Obtaining Prior Authorization for All Medical Services Except Dental Services and Transplants	52	Section updated
		Review and Functions for Authorized Hospitals	54	Updated timeframes for notification of

Date	Section	Comments	Page	Change
				acute inpatient admission and submission of clinical information
		Retrospective Review	55	Added Post Payment Review and Technical Denials
		Standard, Expedited and Extensions of Service Authorization Decisions	56	Retrospective or Post-Service Initial Decision Time Frame changed from 30 calendar days to 14 calendar days
		WellCare Adverse Benefit Determinations	57	Section updated
		Peer-to-Peer Discussion	58	Time frame changed from 3 business days to 7 business days
		Emergency/Urgent Care and Post-Stabilization Services	59	Section updated
		Continuity of Care	61	Prenatal care information updated
		Transition of Care	61	Added retroactive Medicaid coverage information
7/12/2019	Section 5: Claims	Tax Identification and National Provider Identifier Requirements	70	Section updated
		Claims Processing: Seventy-Two Hour Rule	73	Section updated
		Provider-Preventable Conditions	76	Criteria added
		Claim Payments Appeals	77	Section updated
		Overpayment Recovery	81	Section updated

Date	Section	Comments	Page	Change
7/12/2019	Section 6: Credentialing	Termination of Providers	87	Section updated
7/12/2019	Section 7: Appeals and Grievances	Provider Appeals Process	91	Time frame to file an appeal from the original UM or claim denial changed from 30 calendar days to 60 calendar days
		Independent External Third Party Review	92	New section added
		Appointment of Representative	94	Section updated
		State Fair Hearing for Members	96	Time frame changed from 45 calendar days to 120 calendar days from the final decision letter
		Continuation of Benefits while the Appeal and Medicaid Fair Hearing are Pending	97	Section updated
7/12/2019	Section 9: Delegated Entities	Overview	105	Section updated
		Delegation Oversight Process	105	New section added
7/12/2019	Section 10: Behavioral Health	Authorization Requests	107	New section added
		Prior Authorization	107	Section updated
		Responsibilities of Behavioral Health Providers	108	Access standards chart updated
		Discharge Planning	108	Section updated
		Readmission	109	Section updated
7/12/2019	Section 11: Pharmacy	Coverage Determination Review Process	113	Section updated
		Member Co-Payments	116	Section updated



Section 1: Overview

About WellCare

WellCare Health Plans, Inc., (WellCare) provides managed care services targeted to government-sponsored healthcare programs focused on Medicaid and Medicare, including prescription drug plans and health plans for families, and the aged, blind and disabled individuals. WellCare's corporate office is located in Tampa, Florida. WellCare serves approximately 5.5 million Members.

WellCare of Kentucky, Inc., contracted with the Kentucky Cabinet for Health and Family Services, Department for Medicaid Services (the Department) to provide Medicaid and Kentucky Children's Health Insurance Program (KCHIP) managed care services in seven of the state's eight regions beginning Nov. 1, 2011. On Jan. 1, 2013, WellCare began providing managed care services statewide. WellCare's experience and commitment to government-sponsored healthcare programs enables WellCare to serve its Members and Providers as well as manage its operations effectively and efficiently.

Mission and Vision

WellCare's vision is to be the leader in government-sponsored healthcare programs in partnership with the Members, Providers, governments and communities it serves.

WellCare will:

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

WellCare's values are:

- *Partnership* – Members are the reason WellCare is in business; Providers are WellCare's partners in serving its Members; and regulators are the stewards of the public's resources and trust. WellCare will deliver excellent service to its partners.
- *Integrity* – WellCare's actions must consistently demonstrate a high level of integrity that earns the trust of those it serves.
- *Accountability* – All associates must be responsible for the commitments they make and the results WellCare delivers.
- *One Team* – WellCare and its associates can expect and are expected to demonstrate a collaborative approach in the way they work.

Purpose of this Manual

This Provider Manual is intended for Medicaid Providers that are contracted with WellCare and provide healthcare 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 Contract between WellCare and healthcare Providers who include, without limitation: physicians, hospitals and ancillary Providers (collectively, Providers). **This Manual replaces and supersedes any previous versions prior to the Department's approval date of July 12, 2019, and is available on WellCare's website at**



www.wellcare.com/Kentucky/Providers/Medicaid. A paper copy may be obtained upon request, at no charge to the Provider, by contacting Provider Services or a Provider Relations representative.

In accordance with the Policies and Procedures clause of the Provider Contract, 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 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.

WellCare's Medicaid Managed Care Plans

WellCare provides Medicaid and CHIP managed care services in the Commonwealth of Kentucky (Commonwealth). These products are offered in select markets to allow flexibility and offer a distinct set of benefits to fit Member needs in each area. For product information, please refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

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:

- Families and children, including children enrolled in the Kentucky Children's Health Insurance Program (KCHIP);
- Aged, Blind or Disabled (ABD);
- Adults age 19 to 64 with income under 138% of the Federal Poverty Level; and
- Former Foster Care Children up to age 26.

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 65-years-old or older.

Certain Members who are eligible for Medicaid, including those eligible for both Medicaid and Medicare, children in foster care and children with disabilities, may be voluntarily enrolled into a Medicaid MCO, but may not be enrolled on a mandatory basis without a waiver from the Centers for Medicare & Medicaid Services (CMS).

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

Core Benefits and Services

Effective Jan. 1, 2019, the following Covered Services are provided as Medically Necessary to WellCare's Kentucky Medicaid Members:

WellCare of Kentucky, Inc.
Medicaid Provider Manual
Provider Services: **1-877-389-9457**

Benefit/Services	Co-pay Amount	Description/More Information
Allergy services	\$0	<ul style="list-style-type: none"> Covers both adult and children
Alternative birthing center	\$0	<ul style="list-style-type: none"> 2 visits within 6 weeks of delivery
Ambulatory surgical centers	\$4	<ul style="list-style-type: none"> Per visit Does not cover cosmetic surgery (except for post-mastectomy reconstructive surgery)
Behavioral health services	\$3	<ul style="list-style-type: none"> Mobile crisis Residential crisis stabilization Assertive community treatment (ACT) Peer support Parent training Wellness recovery support and crisis planning Crisis intervention outpatient
Cervical and vaginal cancer screening (Pap tests, pelvic exams)	\$0	<ul style="list-style-type: none"> Per screening 1 each year unless more are needed and as ordered by the Provider
Chiropractic care (restrictions may apply)	\$3	<ul style="list-style-type: none"> Per visit 26 visits per 12-month period
Dental services	\$3 \$0 co-pay for children preventive services	<ul style="list-style-type: none"> Per visit Preventive services Diagnostic services 1 oral exam each 12-month period 2 oral exams for Members younger than 21 if in conjunction with a cleaning 1 cleaning each 12-month period for Members 21 and older 2 cleanings each 12-month period for Members younger than 21 1 set of X-rays each 12-month period Extractions and fillings Oral surgery Orthodontic and prosthodontic services
Durable medical equipment	\$4	<ul style="list-style-type: none"> Per item
Dialysis End-Stage Renal Disease (ESRD)	\$0	<ul style="list-style-type: none"> Per visit Services and procedures that promote and maintain the functioning of the kidneys and related organs

Benefit/Services	Co-pay Amount	Description/More Information
Early & Periodic Screening, Diagnosis and Treatment (EPSDT) services – health checks for children under age 21	\$0	<ul style="list-style-type: none"> • 1 neonatal exam (right after the baby is born) • 1 exam at 1, 2, 4, 6, 9, 12, 15, 18 and 24 months • 1 exam each year for children ages 3 to 20
Emergency room	\$0 \$8 nonemergency	<ul style="list-style-type: none"> • Per emergency visit • Per nonemergency visit
Emergency ambulance and air transportation	\$0	<ul style="list-style-type: none"> • Per service • Basic life support (BLS) • Advanced life support (ALS) ambulance services
Family planning	\$0	<ul style="list-style-type: none"> • Per visit • Members of child-bearing age • Provided through routine physician visits or family planning clinics
Habilitation services	\$0	<ul style="list-style-type: none"> • Up to 20 visits per calendar year
Hearing services for children under 21	\$0	<ul style="list-style-type: none"> • 1 complete hearing evaluation per calendar year
HIV screening	\$0	<ul style="list-style-type: none"> • Per screening includes: <ul style="list-style-type: none"> - Pregnant women - Those who have an increased risk for the infection - Anyone who asks for the test
Home health care services	\$0	<ul style="list-style-type: none"> • Per visit • 20 limited visits per calendar year • Limits may be “exceeded” if medically necessary • Includes: <ul style="list-style-type: none"> - Skilled nursing - Home health aide - Physical, speech and occupational therapy - Please note: These services are covered for up to 20 visits per calendar year
Inpatient Hospital Services	\$50	<ul style="list-style-type: none"> • Per admission
Inpatient Mental Health / Substance Use Services	\$50	<ul style="list-style-type: none"> • Per admission
Immunizations	\$0	<ul style="list-style-type: none"> • Per immunization • Includes: <ul style="list-style-type: none"> - Adults and children - Flu - Pneumonia - Hepatitis B



Benefit/Services	Co-pay Amount	Description/More Information
Laboratory diagnostic and radiology services (by physician or lab)	\$3	<ul style="list-style-type: none"> Per visit
Maternity services	\$0	<ul style="list-style-type: none"> Per visit
Meals and lodging	\$0	<ul style="list-style-type: none"> For appropriate escorts who help you get covered medical services
Nonemergency ambulance stretcher services	\$0	<ul style="list-style-type: none"> When other means of transportation could endanger your health
Nursing facility services	\$0	<ul style="list-style-type: none"> Per visit Includes physician services
Nutritional counseling	\$0	<ul style="list-style-type: none"> Per session
OB ultrasounds	\$0	<ul style="list-style-type: none"> 2 each 9-month period unless more are ordered by the Provider (family planning)
Outpatient hospital services	\$4	<ul style="list-style-type: none"> Per visit Does not cover cosmetic surgery (except for post-mastectomy reconstructive surgery)
Outpatient mental health/substance use services	\$3	<ul style="list-style-type: none"> Per visit
Prescription drugs (for Members who do NOT have Medicare) (exceptions/restrictions may apply)**	\$4 Brand Name Drugs \$1 Generic Drugs \$1 Brand Name Drugs Preferred Over Generic	<ul style="list-style-type: none"> Unlimited prescriptions per month
Physician services (PCPs, specialists, physician assistants, nurse practitioners, nurse midwives)	\$3	<ul style="list-style-type: none"> Per visit Includes: <ul style="list-style-type: none"> Specialists Physician assistants Nurse practitioners Nurse midwives Office visits Medical/surgical care and consultation Diagnosis and treatment
Podiatry services	\$3	<ul style="list-style-type: none"> Per visit Routine foot care not covered except for certain conditions that require professional supervision
Preventive care	\$0	<ul style="list-style-type: none"> Wellness visits
Private duty nursing	\$0	<ul style="list-style-type: none"> Allows for 2,000 hours per year (outpatient only)
Prosthetic & orthotic devices	\$4	<ul style="list-style-type: none"> Per item



Benefit/Services	Co-pay Amount	Description/More Information
Psychiatric residential treatment facilities (PRTFs) (children ages 6 through 21)	\$0	<ul style="list-style-type: none"> Services are covered for residents ages 6 to 21 who need intensive care and a more highly structured setting than they can get in family and other community-based alternatives to hospitalization
Rural health clinic (RHC), federally qualified health center (FQHC) & primary care center (PCC)	\$3	<ul style="list-style-type: none"> Per visit
Second opinion	\$0	<ul style="list-style-type: none"> Per visit
Specialized children's services clinics	\$0	<ul style="list-style-type: none"> Per visit Sexual abuse medical exams are covered if medically necessary and Member is under age 18
Targeted case management services	\$0	<ul style="list-style-type: none"> Per service Behavioral health services that include a minimum of 4 sessions in 1 month including: <ul style="list-style-type: none"> - 1 face-to-face contact - 1 face-to-face contact with a parent, family Member, guardian or other person who has custody or supervision of the Member - 2 additional contacts that may be by telephone or face-to-face
Telehealth	\$0	<ul style="list-style-type: none"> Per service <ul style="list-style-type: none"> - Use of phones and other technology to access health services from a distance - Must use a Provider within the Kentucky Telehealth Network
Therapeutic group residential services	\$0	<ul style="list-style-type: none"> Per service Services in a therapeutic environment with 24-hour supervision and treatment in a group residential facility
Therapy – physical, speech, occupational	PT – \$3 per visit ST – \$3 per visit OT – \$3 per visit	<ul style="list-style-type: none"> Up to 20 visits per calendar year
Tobacco cessation	\$0	<ul style="list-style-type: none"> Per visit (doctor)
Transplant services	\$0	<ul style="list-style-type: none"> Per service



Benefit/Services	Co-pay Amount	Description/More Information
Urgent care center	\$3	<ul style="list-style-type: none"> Per visit Urgent or emergency treatment is covered if the PCP's office isn't open or can't be reached
Vision (adults 21 and over)	\$3	<ul style="list-style-type: none"> 1 exam per year 1 pair of eyeglasses per 24 months
Vision (children under 21)	\$0	<ul style="list-style-type: none"> 1 eye exam each calendar year Limit of 1 pair of eyeglasses per year, or a 2nd pair if 1st pair is broken or prescription changes

**Prescriptions in these classes are subject to exceptions or exemptions from the brand/generic rules:

- Certain antipsychotics: \$1
- Contraceptives for family planning: \$0
- Tobacco cessation: \$0
- Diabetes supplies:
 - Blood glucose meters: \$0
 - All other covered diabetic supplies: \$4 for 1st fill; \$0 for 2nd fill and beyond

For the most up-to-date information on Covered Services, please refer to Title 907 of the Kentucky Administrative Regulations available on the web at <http://www.lrc.ky.gov/kar/TITLE907.HTM>.

Extra Benefits for Members

WellCare offers extra benefits to Members at no cost. These include:

- Adult Vision, free pair of eyeglasses for Members age 21 and over every 24 months.
- Boy Scouts – FREE annual membership for Members ages 5-18 to join the Boy Scouts. Includes the fee for health and accident insurance.
- Girl Scouts – FREE annual membership for Member ages 5-18 to join the Girl Scouts.
- Steps2Success Program: WellCare wants to help Members take steps to be successful in reaching their employment, financial, and/or educational goals. WellCare will offer the following programs for Members:
 - Training: FREE job training and financial education classes.
 - Reading Scholarships: FREE reading scholarships for qualified Member who are in Pre-Kindergarten to 5th grade who want to improve their reading skills.
 - GED® exam – Members age 16 and older with no high school diploma can take the GED test for free.
- Free over-the-counter (OTC) items – \$120 per year (\$10/month) per family for OTC items sent to the Member's home, like diapers, pain relievers, reading glasses, vitamins, hand soap and almost 150 other items.
- FREE Meal Program for Members discharged from inpatient hospital, rehabilitation or skilled nursing facility.
- FREE Healthy Rewards Program – Members earn rewards for taking steps that help them live a healthy life (completing annual wellness visits including Well Child Visits). Rewards include:

- Prepaid debit card
- Gift Card to select retailers
- FREE sports physical – One (1) physical per year, provided by a PCP, for children age 6–18.
- Cell Phone – Members receive a FREE cell phone. Phone includes 1000 monthly minutes, 1GB of Data and unlimited text messaging for all Members.
- Healthy Moms Program--FREE diapers and gift cards through the Healthy Rewards Program. Up to \$50 FREE for attending all required doctor visits through the Healthy Rewards Program. Also includes Text4Baby—a free service offering health tips on pregnancy and baby’s first year
- FREE Community Assistance Line to connect you to community services such as utility assistance, food banks and transportation
- Free personal care and disease managers to offer Members support for conditions like diabetes and asthma, etc.
- 24-Hour Nurse Advice Line – WellCare’s Nurse Advice Line is available to Members at no cost. Members can call the line 24 hours a day, seven days a week.
- FREE 24-hour crisis line for help with drug and alcohol abuse and behavioral health concerns

Services Not Covered by WellCare of Kentucky

- Any lab 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 lab service)
- Cosmetic procedures or services performed only to improve appearance
- Hysterectomy procedures, if performed only to prevent pregnancy
- Medical or surgical treatment of infertility (for example, the reversal of sterilization, in vitro fertilization, etc.)
- Induced abortion and miscarriage services that go against 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 or experimental
- Sex change services
- Sterilization of a mentally incompetent or institutionalized Member
- Services provided outside of the United States, unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services
- Services or supplies greater than what’s allowed by federal or state laws, judicial opinions and the Kentucky Medicaid program
- Services for which a Member is not required to pay and for which no other person has a legal responsibility to pay

Provider Services

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



consists of Contract Operations, collection of credentialing and re-credentialing documents, and claims research and resolution.

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

Provider Relations representatives are available to assist in many requests for Providers. Providers may contact their local market offices for assistance. To request that a Provider Relations representative contact them, Providers may call the Provider Services number located on the *Quick Reference Guide*.

Interactive Voice Response (IVR) System

IVR system

- Technology to expedite Provider verification and authentication within the IVR
- Provider/Member account information is sent directly to the agent's desktop from the IVR validation process, so Providers do not have to re-enter information
- Full speech capability, allowing Providers to speak their information or use the touch-tone key-pad

Self-Service Features

- Ability to receive Member co-pay benefits
- Ability to receive Member eligibility information
- Ability to request authorization and/or status information
- Unlimited claims information on full or partial payments
- Receive status for multiple lines of claim denials
- Automatic routing to the PCS claims adjustment team to dispute a denied claim
- Rejected claims information is now available through self-service

Tips for using IVR

Providers should have the following information available with each call:

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

Benefits of using Self-Service

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

The Phone Access Guide is posted on www.wellcare.com/en/Kentucky/Providers/Medicaid under the Providers section, "Overview & Resources".



Providers may contact the appropriate departments at WellCare by referring to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

Website Resources

WellCare's website, www.wellcare.com/kentucky, offers a variety of tools to assist Providers and their staffs.

Available resources include:

- Provider Manual;
- *Quick Reference Guide*;
- *Clinical Practice Guidelines*;
- *Clinical Coverage Guidelines*;
- Forms and documents;
- Pharmacy and Provider lookup (directories);
- Authorization lookup tool;
- Training materials and job aids;
- Newsletters;
- Member rights and responsibilities; and
- Privacy statement and notice of privacy practices.

Secure Provider Portal: Key Features and Benefits of Registering

WellCare's secure online provider portal offers immediate access to what Providers need most. All participating Providers who create an account and are assigned the appropriate role/permissions can use the following features:

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

Provider Registration Advantage

The secure provider portal allows Providers to have one username and password, and be affiliated with multiple Providers/offices. Administrators can easily manage users and permissions. Once registered for WellCare's portal, Providers should retain their username and password information for future reference.

**How to Register**

To create an account, please refer to the *Provider Resource Guide* on WellCare's website at www.wellcare.com/en/Kentucky/Providers/Medicaid. For more information about WellCare's web capabilities, please call Provider Services or contact Provider Relations to schedule a website in-service.

Additional Resources

The *Provider Resource Guide* contains information about WellCare's secure online provider portal, Member eligibility, authorizations, filing paper and electronic claims, appeals and more. For direct access to WellCare's Provider Services team for day-to-day administrative tasks, please see the *WellCare Quick Access Guide to Provider Services*. Both documents can be found on WellCare's website at www.wellcare.com/en/Kentucky/Providers/Medicaid.

Another valuable resource is the *Quick Reference Guide*, which contains important addresses, phone/fax numbers and authorization requirements. Providers can find the *Quick Reference Guide* at www.wellcare.com/en/Kentucky/Providers/Medicaid.

Section 2: Provider and Member Administrative Guidelines

Provider Administrative Overview

This section is an overview of guidelines for which all participating WellCare Medicaid managed care Providers are accountable. Please refer to the Provider Contract or contact your WellCare 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 Department rules and regulations, and assist WellCare in complying with corrective action plans necessary for WellCare to comply with such rules and regulations;
- Retain all agreements, books, documents, papers and medical records related to the provision of services to WellCare Members as required by state and federal laws;
- Provide Covered Services in a manner consistent with professionally recognized standards of healthcare 42 C.F.R. § 422.504(a)(3)(iii);
- Use physician extenders appropriately. Physician assistants (PAs) and advanced practice registered nurses (APRNs) 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 APRNs whose scope of practice should not extend beyond statutory limitations;
- Clearly identify physician and extender titles (examples: M.D., D.O., APRN, PA) to Members and to other healthcare professionals;
- Honor at all times any Member's request to be seen by a physician rather than a physician extender;
- Administer, within the scope of practice, treatment for any Member in need of healthcare services;
- Cooperate with all quality improvement (QI) activities;
- Maintain the confidentiality of Member information and records;
- Allow WellCare to use Provider performance data for quality improvement activities;
- Respond promptly to WellCare's request(s) for medical records in order to comply with regulatory requirements and maintain the confidentiality of Member information and records;
- Ensure that:
 - All employed physicians and other healthcare practitioners and Providers comply with the terms and conditions of the Provider Contract between the Provider and WellCare;

- To the extent the physician maintains written agreements with employed physicians and other healthcare practitioners and Providers, such agreements contain similar provisions to the Provider Contract; and
- The physician maintains written agreements with all contracted physicians or other healthcare practitioners and Providers, which agreements contain similar provisions to the Provider Contract.
- 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;
- Ensure that the hours of operation offered to WellCare Members is not fewer than those offered to commercial 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:
 - Medical condition, including mental as well as physical illness;
 - Claims experience;
 - Receipt of healthcare;
 - Medical history;
 - Genetic information;
 - Evidence of insurability, including conditions arising out of acts of domestic violence; or
 - Disability.
- Freely communicate with and advise Members regarding the diagnosis of the Member's condition and advocate on the Member's behalf for the Member's health status, medical care and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services;
- Identify Members who are in need of services related to children's health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation or substance abuse. If indicated, Providers must refer Members to WellCare-sponsored or community-based programs; and
- 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 or other basis. Providers are required to determine eligibility for Covered Services prior to rendering services. In the event the service(s) is (are) excluded, Providers 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 <https://chfs.ky.gov/agencies/dms>.

School-based services provided by schools are excluded from coverage by WellCare and are paid by the Department through fee-for-service Medicaid. Any service provided under a child's Individualized Education Program (IEP) should not be duplicated. However, the Preventive Health Package pursuant to 907 KAR 1:360 is covered when supervised by appropriate medical personnel.

Responsibilities of All Providers

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

Provider Identifiers

All participating Providers are required to have a unique and active Kentucky Medicaid Provider number and a National Provider Identifier (NPI). For more information on NPI requirements, refer to *Section 5: Claims*. A current Medicaid Provider number is an important Medicaid program integrity control. WellCare verifies current Kentucky Medicaid Provider status by reference to data provided to it periodically by the Department. It is a Provider's responsibility to maintain a current Kentucky Medicaid Provider number with the Department. WellCare may deny reimbursement for claims for Covered Services if it determines that the Provider does not have an active Kentucky Medicaid Provider number at the time it adjudicates the claim.

Living Will and 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 lives. Living will and advance directive rights may differ between states. Kentucky Providers should follow the applicable KRS Section 311.621 - 311.643. Providers must comply with the advance directive requirements for hospitals, nursing facilities, Providers of home and healthcare hospices and health maintenance organizations (HMOs) specified in 42 CFR Part 49, subpart I, and 42 CFR Section 417.436(d).

Each WellCare Member (age 18 years or older and of sound mind), should receive information regarding living wills and advance directives. This allows Members to designate another person to make a decision should they become mentally or physically unable to do so.

Information regarding living wills and advance directives should be made available in Provider offices. Providers are also required to discuss living wills and advance directives with Members during their first primary care visit. Completed forms should be documented and filed in Members' medical records.

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

Provider Billing and Address Changes

Prior notice to a Provider Relations representative or WellCare's Provider Services team is required for any of the following changes:

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

Provider Termination

In addition to the Provider termination information included in the Provider Contract, the Provider must adhere to the following terms:

- Any contracted Provider must give at least 90 days prior written notice (180 days for a hospital) to WellCare before terminating his or her relationship with WellCare "without cause," unless otherwise agreed to in writing. This ensures that adequate notice may be given to WellCare Members regarding the Provider's participation status with WellCare. Please refer to the Provider Contract for details regarding the specific required days for providing termination notice as the Provider may be required by contract to give more notice than listed above; 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 6: Credentialing* of this Manual for specific guidelines regarding rights to appeal plan termination (if any).

WellCare will notify in writing all appropriate agencies and/or Members prior to the termination effective date of a participating Primary Care Provider (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:

- Intellectual disabilities 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 Supplemental Security Income (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;
- The 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 healthcare services furnished;
- Coordinate services with other third-party organizations to prevent duplication of services and share the results on identification and assessment of the Member's needs; and
- Ensure the Member's privacy is protected as appropriate during the coordination process.

For more information regarding utilization management for ISHCN, refer to *Section 4: Utilization Management, Care Management and Disease Management*.

Access Standards

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

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

Type of Appointment	Access Standard
PCP – Urgent	< 48 hours
PCP – Routine Care	< 30 days
Specialist – Routine	< 30 days
Specialist – Urgent	< 48 hours
Vision – Regular	< 30 days
Vision – Urgent	< 48 hours
Lab and X-ray – Regular	< 30 days
Lab and X-ray – Urgent	< 48 hours

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Type of Appointment	Access Standard
Dental – Regular	< 30 days
Dental – Urgent	< 48 hours

In-office waiting times for primary care visits, specialty and urgent care, optometry services and lab and X-ray services shall not exceed 30 minutes.

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

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

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

Responsibilities of Primary Care Providers

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

- See Members for an initial office visit and assessment within the first 90 days of enrollment in WellCare;
- Coordinate, monitor and supervise the delivery of medically necessary primary and preventive care services to each Member, including EPSDT services for Members under the age of 21;
- 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, Infants and Children (WIC) Program for nutritional assistance;
- Screen all newborn Members for those disorders specific in the Commonwealth's metabolic screen;
- 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® service;
- Submit encounters. For more information on encounters, refer to *Section 5: Claims*;
- Ensure Members utilize network Providers. If unable to locate a participating WellCare Provider for services required, contact Provider Services for assistance. Refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/en/Kentucky/Providers/Medicaid; and

- Comply with and participate in corrective action and performance improvement plan(s).
- Discuss Advance Medical Directives with all Members as appropriate
- Arranging and referring Members, when clinically appropriate, to behavioral health Providers
- Documenting all care rendered in a complete and accurate medical record for each Member and maintaining a current medical record for each Member, including documentation of all PCP and specialty care services
- PCP's must have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice.

Medical Records

PCPs shall 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:

- A. Member/patient identification information, on each page;
- B. 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;
- C. Date of data entry and date of encounter;
- D. Provider identification by name;
- E. Allergies, adverse reactions and any known allergies shall be noted in a prominent location;
- F. Past medical history, including serious accidents, operations, and illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e. documentation of chickenpox);
- G. Identification of current problems;
- H. The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering Provider's initials or other documentation indicating review;
- I. Documentation of immunizations pursuant to 902 KAR 2:060;
- J. Identification and history of nicotine, alcohol use or substance abuse;
- K. 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;
- L. Follow-up visits provided secondary to reports of emergency room care;
- M. Hospital discharge summaries;
- N. Advanced Medical Directives, for adults;
- O. All written denials of service and the reason for the denial; and
- P. 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:

- A. 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;
- B. Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits;
- C. Plan of treatment including:
 1. Medication history, medications prescribed, including the strength, amount, directions for use and refills;
 2. Therapies and other prescribed regimen; and
 3. Follow-up plans including consultation and referrals and directions, including time to return.

A Member's medical record shall include at a minimum for hospitals and mental hospitals:

- A. Identification of the beneficiary.
- B. Physician name.
- C. Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission; the plan of care (as required under 42 CFR 456.172 (mental hospitals) or 42 CFR 456.70 (hospitals). Initial and subsequent continued stay review dates (described under 42 CFR 456.233 and 42 CFR 465.234 (for mental hospitals) and 42 CFR 456.128 and 42 CFR 456.133 (for hospitals)
- D. Reasons and plan for continued stay if applicable.
- E. Other supporting material appropriate to include.
- F. For non-mental hospitals only:
 1. Date of operating room reservation.
 2. Justification of emergency admission if applicable.

Early and Periodic Screening, Diagnosis and Treatment

Any Provider, including physicians, nurse practitioners, registered nurses, physician assistants and medical residents who provide EPSDT screening services are responsible for:

- Providing all needed initial, periodic and interperiodic EPSDT health assessments, diagnosis and treatment to all eligible Members in accordance with Kentucky Medicaid administrative regulation 907 KAR 11:034 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 have the option to use vaccines available without charge under the Vaccines for Children (VFC) Program for Medicaid children 18-years-old and younger;
- Addressing unresolved problems, referrals and results from diagnostic tests, including results from previous EPSDT visits;
- Requesting a Prior Authorization for medically necessary EPSDT special services in the event other healthcare, 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 appointments.
- 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.

Except as otherwise noted by WellCare or in 907 KAR Chapter 1 or 3, an EPSDT diagnosis or treatment or an EPSDT special service which is not otherwise covered by the Kentucky Medicaid Program shall be covered subject to Prior Authorization if the requirements of subsections (1) and (2) of Section 9 of 907 KAR 11:034 are met. Requests for services will be reviewed to determine medical necessity without regard to whether the screen was performed by a Kentucky Medicaid Provider or a non-Medicaid Provider.

Providers will be sent a monthly membership list which specifies the health assessment-eligible children who have not had an encounter within 120 days of joining WellCare or who 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. Corrective action plans will be required for Providers who are below 80 percent compliance with all elements of the review.

For more information regarding the Kentucky Medicaid EPSDT periodicity schedule and/or the Kentucky Medicaid administrative regulation 907 KAR 11:034, refer to the Department's website at <https://chfs.ky.gov/agencies/dms>. For more information on the periodicity schedule based on the AAP guidelines, refer to the AAP website at www.aap.org/immunization/IZSchedule.html.

Primary Care Offices

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

- Support of the Provider Relations, Member Services, Health Services and Marketing and Sales Departments;
- The tools and resources available on WellCare's website at www.wellcare.com/en/Kentucky/Providers/Medicaid; and
- Information on WellCare network Providers for the purposes of referral management and discharge planning.

Closing of Provider Panel

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

- Submit the request in writing at least 60 days (or such other period of time provided in the Provider Contract) 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 reopening of the panel, including a specific effective date.

Covering Physicians/Providers

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

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

In non-emergency cases, should a Provider have a covering Physician/Provider who is not contracted and credentialed with WellCare, contact WellCare for approval. For contact information, refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/en/Kentucky/Providers/Medicaid.

Termination of a Member

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

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

A Provider shall not have the right to request a transfer from their practice for the following: a change in the Member's health status or need for treatment; a Member's utilization of medical services; a Member's diminished mental capacity; or, disruptive behavior that results from the Member's special healthcare needs unless the behavior impairs the ability of the Provider to furnish services to the Member or others. Transfer requests shall not be based on race, color, national origin, handicap, age or gender. WellCare shall have authority to approve all transfers.

The Provider should complete a *PCP Request for Transfer of Member* form, attach supporting documentation and fax the form to WellCare's Provider Services Department. A copy of the form is available on WellCare's website at www.wellcare.com/en/Kentucky/Providers/Medicaid/Forms. Request for Transfer of Members may also be submitted via WellCare's secure provider portal by users who have Administrator rights for their contract or sub-group. After logging in, Providers



should access the My Patients area, search for the Member, select Request Member Transfer from the Select Action menu, then complete and submit the form.

The initial PCP must serve until the new PCP begins serving the Member, barring ethical or legal issues. The Member has the right to file a grievance regarding such a transfer.

Domestic Violence and Substance Abuse Screening

PCPs should identify indicators of substance abuse or domestic violence. Sample screening tools for domestic violence and substance abuse are located at www.integration.samhsa.gov/clinical-practice/screening-tools and www.getdomesticviolencehelp.com/hits-screening-tool.html.

Smoking Cessation

PCPs should direct Members who wish to quit smoking to call WellCare's Customer Service and ask to speak to the Care Management Department. A Care Manager will educate the Member on national and community resources that offer assistance, as well as smoking cessation options available to the Member through WellCare.

Adult Health Screening

An adult health screening should be performed to assess the health status of all WellCare Medicaid Members, as applicable. The adult Member should receive an appropriate assessment and intervention as indicated or upon request.

Hospital/Facility Responsibilities

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

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

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

WellCare defines an inpatient as a patient who has been admitted to a participating hospital on the recommendation of a licensed doctor and is receiving room, board and professional services in the hospital on a continuous 24 hours-per-day basis. Transfers between units within the hospital are not considered new admissions, unless it is a

transfer from a medical unit to a psychiatric unit. Refer to *Section 4: Utilization Management, Care Management and Disease Management* for more information.

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

However, some patients may require 72 hours of outpatient observation services. Refer to *Section 4: Utilization Management, Care Management and Disease Management* for more information.

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

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

Level of care determinations will be based on InterQual™ criteria and Medical Director review.

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 ensure that the associates of WellCare value diversity within the organization and to see that Members in need of linguistic services receive adequate communication support. In addition, WellCare is committed to having its 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 may have cultural, linguistic or disability-related barriers for which alternative communication methods are needed;
- Utilize culturally sensitive and appropriate educational materials based on the Member's race, ethnicity, condition of disability and/or primary language spoken;
- Ensure that resources are available to overcome the language and communication barriers that exist in the Member population;
- Make certain that Providers care for and recognize the culturally diverse needs of the population;
- Teach staff to value the diversity of both their coworkers inside the organization and the population served, and to behave accordingly; and
- Provide cultural competency and disability training to all staff members and ensure training is provided both orally and in written format.

Cultural competence in healthcare describes a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enable effective work in cross-cultural situations. Healthcare services that are respectful of and

responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

Culturally and linguistically appropriate services (CLAS): The collective set of culturally and linguistically appropriate services (CLAS) mandates guidelines and recommendations intended to inform, guide and facilitate required and recommended practices related to culturally and linguistically appropriate health services. The U.S. Department of Health and Human Services, Office of Minority Health, has issued national CLAS standards. WellCare is committed to a continuous effort to perform according to those standards.

The components of WellCare's Cultural Competency Program include:

- WellCare analyzes data on the populations in each region it serves quarterly and as needed for the purpose of learning their cultural and linguistic needs as well as any health disparities they may suffer. Such analyses are performed at the time WellCare enters a new market and regularly thereafter, depending on the frequency with which new data become available. Data sources and analysis methods include the following:
 - State-supplied data for Medicaid and CHIP populations;
 - Demographic data available from the U.S. Census and any special studies done locally;
 - Claims and encounter data to identify the healthcare needs of the population by identifying the diagnostic categories that are the most prevalent;
 - Member requests for assistance, plus complaints and grievances, to identify areas of opportunity to improve service to Members from a cultural and linguistic angle; and
 - Data on race, ethnicity and language spoken for Members can be collected both electronically from the state data received and through voluntary self-identification by the Member during enrollment/intake or during encounters with network Providers.
- Community-Based Support – WellCare's success requires linking with other groups having the same goals.
 - WellCare reaches out to community-based organizations that support racial and ethnic minorities and disabled people to ensure that the community's existing resources for Members who have special needs are utilized to their full potential. The goal is to coordinate the deployment of both community and health plan resources, as well as to take full advantage of the bonds that may exist between the community-based entities and the covered population.
 - WellCare will develop and maintain grassroots sponsorships that will enhance WellCare's effort to reach low-income communities and provide opportunity for building meaningful relationships that benefit all Members of the communities. These sponsorships will be coordinated with Providers, community health fairs and public events.
- Management Accountability for Cultural Competency – The Quality Improvement Committee maintains ultimate responsibility for the activities carried out by the health plan related to cultural competency. The committee oversees the day-to-day operations of the quality program in the health plan including the Cultural Competency Program and improvement activities undertaken by the individual WellCare plans.



- WellCare’s Director of Quality Improvement is the principal executive in charge of the company’s efforts to meet its internal cultural competency objectives and any externally set rules and guidelines on the subject. The Director of Quality Improvement collaborates with the heads of all of WellCare’s functional units in making certain that the Cultural Competency Program plan is fully and properly executed.
- The Senior Management team, comprised of the unit leaders of all major functional departments of WellCare Health Plans and the heads of the state operations, is responsible for ensuring that culturally sensitive training occurs in their respective areas.
- Diversity and Language Abilities of WellCare – WellCare recruits diverse, talented staff Members to work in all levels of the organization. WellCare does not discriminate with regard to race, religion or ethnic background when hiring staff.
 - WellCare ensures that bilingual staff members are hired for functional units that have direct contact with Members to meet the needs identified. Today, one-third of WellCare’s Customer Service representatives are bilingual. Spanish is the most common translation required. Whenever possible, WellCare will also distinguish place of origin of its Spanish-speaking staff to ensure sensitivity to differences in cultural backgrounds, language idioms and accents. For example, in Georgia, approximately two-thirds of the Hispanic population is of Mexican origin. In Florida and New York City, the Puerto Rican population is predominant.
 - Where WellCare enrolls significant numbers of Members who speak languages other than English or Spanish, WellCare seeks to recruit staff who are bilingual in English plus one of those other languages. WellCare does this even if the particular population is not of a size that triggers state agency mandates.
- Diversity of Provider Network
 - 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.
 - Providers are recruited to ensure a diverse selection of Providers to care for the population served.
- Linguistic Services
 - Providers will identify Members who have potential linguistic barriers for which alternative communication methods are needed and will contact WellCare to arrange appropriate assistance.
 - Members may receive interpreter services at no cost when necessary to access Covered Services through a vendor, as arranged by the Customer Service Department.
 - Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency and sign language for the hearing-impaired. These services will be provided by vendors with such expertise and are coordinated by WellCare’s Customer Service Department.
 - 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 line for hearing-impaired services. WellCare’s Customer Service



Department is responsible for any necessary follow-up calls to the Member. The toll-free TTY number can be found on the Member identification card.

- Linkage to Community
 - WellCare is dedicated to partnering with community organizations to promote cultural understanding and to meet the needs of the diverse population. Wherever possible, WellCare will pursue linkages with national, state and local organizations dedicated to advancing both the broad interests and the health interests of groups having needs for culturally-based supports.
- Member/Patient Education
 - The multicultural basis of WellCare's patient education program is drawn from the Healthy People 2020 initiative. Healthy People 2020 is a "national health promotion and disease prevention initiative that brings together government agencies, nonprofit, voluntary, and professional organizations, businesses, communities and individuals to improve the health of all Americans, eliminate disparities in health, and improve years and quality of healthy life." (www.healthypeople.gov/2020/About-Healthy-People)
 - Given the nature of the population WellCare serves, from the 2020 list of conditions with disparate impacts on racial and ethnic minorities, WellCare has chosen **diabetes**, **asthma** and **cardiovascular disease** as the areas its Member health education will focus on.
 - Upon enrollment, Members receive a welcome packet that includes a Member Handbook, which outlines WellCare's Disease Management Program.
- Member Rights
 - WellCare adopts and acts on the basis of the Medicaid Member rights and responsibilities as approved by each state's Medicaid agency. All associates, including Customer Service representatives, are expected to treat Members in a manner that respects their rights and the expectations of their responsibilities.
- Provider Education
 - WellCare's Cultural Competency Program provides a Cultural Competency Checklist to assess the Provider office's Cultural Competency.
- Provider Performance Monitoring
 - In the event that Members file complaints or grievances with WellCare concerning a Provider that behaves in a manner inconsistent with standards for culturally and linguistically appropriate services, WellCare will investigate the matter with the same degree of concern applied to any other complaint or grievance. Offending Providers will be expected to take corrective measures, and WellCare will follow up to make certain that such action indeed was taken.
 - If WellCare observes patterns in complaint and grievance information that suggest there are systemic deficiencies in Providers' conformance to cultural competency aims, WellCare will investigate the root causes and define broad performance improvement projects to eliminate the weakness.
- Ongoing Self-Assessment



- WellCare will continually assess the cultural competency of the company, both nationally and at the level of each health plan unit, to ensure that WellCare is meeting the diverse needs of its Members, Providers and staff. A component of the self-assessment will be to utilize focus groups of Members, Providers and staff to explore the needs of all WellCare constituent groups and to listen to suggestions for improving its Cultural Competency Program.
- Annually, the Cultural Competency Program will be reviewed, revised and presented to the Quality Improvement Committee to ensure compliance with the program objectives.

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

For more information on the Cultural Competency Program, registered Provider Portal users may access the Cultural Competency training on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid/Training. A paper copy, at no charge, may be obtained upon request by contacting Provider Services or a Provider Relations representative.

Cultural Competency Survey

Providers may access the Cultural Competency Survey on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid/Training.

Member Administrative Guidelines

Overview

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

Member Handbook

All newly enrolled Members will be sent a Member Handbook within five business days of receiving the notice of enrollment from WellCare. The Member handbook may also be sent via email (upon consent from the Member) and is posted on WellCare's website at www.wellcare.com/Kentucky/Members/Medicaid-Plans/WellCare-of-Kentucky.

Enrollment

WellCare must obey laws that protect from discrimination or unfair treatment. WellCare does not discriminate based on a person's health status, need for health services, race, color, disability, religion, sex, sexual orientation, gender identity, 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 appeal procedures; and
- Brochures describing certain benefits not traditionally covered by Medicaid and other value-added items or services, if applicable.

Member Identification Cards

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

Eligibility Verification

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

Providers may do one of the following to verify eligibility:

- Access the WellCare website at www.wellcare.com/kentucky. Providers must be registered on WellCare's site and log in;
- Access WellCare's Interactive Voice Response (IVR) system. Providers will need their Provider ID number to access Member eligibility;
- Access the Commonwealth of Kentucky website at <https://chfs.ky.gov/agencies/dms>; and/or
- Contact the Provider Services Department.

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

Eligibility Requirements

In the event that a Member changes managed care organizations and the Provider delivers services to an individual who is no longer a Member of WellCare, but is a Member of another managed care organization, WellCare is entitled to recoup any payment made to the Provider.

Hospital Admission Prior to the Member's Transition

If the Member is an in-patient in any facility at the time of transition, the managed care organization responsible for the Member's care at the time of admission shall continue to provide coverage for the Member at that facility, including all Professional Services, until the recipient is discharged from the facility for the current admission. An inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a "current admission." The "same diagnosis" is defined as the first five digits of a diagnosis code.

Outpatient Facility Services and Non-Facility Services

Effective on the Member's Transition date, the new managed care plan will be responsible for outpatient services both facility and non-facility. Outpatient reimbursement includes outpatient hospital, ambulatory surgery centers, and renal dialysis centers.

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 get information about WellCare, its services and its doctors and Providers;
- To get information about their rights and responsibilities;
- To know the names and titles of doctors and other health Providers caring for them;
- To be treated with respect and dignity, confidentiality and nondiscrimination;
- To have their privacy protected;
- To have a reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;
- To agree to or refuse treatment and active participation in decision choices;
- To decide with their doctor what care they receive;
- To talk openly about care they need for their health, no matter the cost or benefit coverage, and the choices and risks involved. The information must be given in a way they understand;
- To timely access to care that does not have any communication or physical access barriers;
- To have the risks, benefits and side effects of medications and other treatments explained to them;
- To know about their healthcare needs after they get out of the hospital or leave the doctor's office;
- To refuse care, as long as they agree to be responsible for their decision;
- To refuse to take part in any medical research;
- To voice complaints or appeals about WellCare or the care it provides. Also, to know that if they do file a complaint or appeal, it will not change how they are treated;
- To not be responsible for WellCare's debts in the event of insolvency and to not be held liable for payments of Covered Services furnished under a contract, referral or other arrangement to the extent that those payments are in excess of the amount the Member would owe if the contractor provided the services directly;
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- To ask for and get a copy of their medical records from Providers in accordance with applicable federal and state laws. Also, to ask that the records be changed/corrected if needed. Requests must be received in writing from the Member or Member's representative. The records will be provided at no cost to the Member, and they will be sent within 14 days of receipt of the request;
- To timely referral and access to medically indicated specialty care;
- To have their records kept private;
- To make their healthcare wishes known through advance directives;
- To prepare advance medical directives pursuant to KRS 311.621 to KRS 311.643; 42 CFR Part 489, Subpart I and 42 CFR 422.128 and 42 CFR 438.10;
- To have a say in WellCare's Member rights and responsibilities policy;
- To voice grievances and receive access to the grievance process, receive assistance in filing an appeal, and receive a hearing from WellCare and/or the Department for Medicaid Services;
- To appeal medical or administrative decisions by using WellCare's appeal or the Commonwealth's State Fair Hearing process;

- To exercise these rights regardless of sex, sexual orientation, gender, gender identity, disability, age, race, ethnicity, income, education or religion;
- To have all WellCare staff observe their rights;
- To have all the above rights apply to the person legally able to make decisions about their healthcare;
- To be furnished services in accordance with 42 CFR 438.206 through 438.210, which includes accessibility, authorization standards, availability, coverage, coverage outside of network and the right to a second opinion; and
- To be responsible for cost sharing only as specified under Covered Services co-payments and to be responsible for cost sharing only as specified in the contract.
 - Any Indian enrolled with the Contractor eligible to receive services from a participating I/T/U Provider or a I/T/U primary care Provider shall be allowed to receive services from that Provider if part of Contractor's network.

WellCare Members have the responsibility:

- To become informed about Member rights;
- To give information that WellCare, its doctors and its Providers need to deliver care;
- To abide by WellCare's and the Department's Policies and Procedures;
- To become informed about service and treatment options;
- To actively participate in personal healthcare decisions and practice healthy lifestyles;
- To report suspected fraud and abuse;
- To follow plans and instructions for care that they have agreed to with their Provider;
- To understand their health problems;
- To help set treatment goals that they agree to with their Provider;
- To read the Member Handbook to understand how the plan works;
- To carry their Member ID cards at all times;
- To carry their Medicaid cards at all times;
- To show their ID cards to each Provider;
- To schedule appointments for all non-emergency care through their Provider;
- To get a referral from their Provider for specialty care;
- To cooperate with the people who provide their healthcare;
- To be on time for appointments;
- To tell the doctor's office if they need to cancel or change an appointment;
- To respect the rights of all Providers;
- To respect the property of all Providers;
- To respect the rights of other patients;
- To not be disruptive in the doctor's office;
- To know the medicines they take, what they are for and how to take them the right way;
- To make sure their Providers have copies of all previous medical records; and
- To let WellCare know within 48 hours, or as soon as possible, if they are admitted to the hospital or get emergency room care.

Assignment of Primary Care Provider

All Kentucky Medicaid Members enrolled in a WellCare Medicaid plan, except presumptively eligible, disabled children, and children in foster care, must choose a PCP



or they will be assigned to a PCP that is within WellCare's network within 24 hours. To ensure quality and continuity of care, the PCP is responsible for arranging all of the Member's healthcare needs from providing primary care services to coordinating referrals to specialists and Providers of ancillary or non-emergency hospital services.

If a Provider's name is not identified as the Primary Care Provider on the Member's card, the Member may see that Provider as long as the Provider is a participating Provider within WellCare's network.

A Member without SSI shall be offered an opportunity to: (1) choose a new PCP who is affiliated within WellCare's network or (2) stay with their current PCP as long as such PCP is affiliated with the plan's network. Each Member shall be allowed to choose his or her PCP from among all available in-network PCPs and specialists, as is reasonable and appropriate for Member.

A Member who has SSI but is not a dual eligible shall be offered an opportunity to: (1) choose a new PCP who is affiliated with the plan's network or (2) stay with their current PCP as long as such PCP is affiliated with the network. Each Member shall be allowed to choose his or her Primary Care Provider from among all available in-network Primary Care Providers and specialists as is reasonable and appropriate for Member.

Changing Primary Care Providers

Members may change their PCP selection at any time by calling Customer Service. Providers can also assist Members in changing their designated PCP while the Member is in the Provider's office by completing the *PCP Change Request Form* located on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid/Forms.

Women's Health Specialists

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

Hearing-Impaired, Interpreter and Sign Language Services

Hearing-impaired, interpreter and sign language services are available to WellCare Members through WellCare's Customer Service. PCPs should coordinate these services for WellCare Members and contact Customer Service if assistance is needed. Please refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid for the Customer Service telephone numbers.

Section 3: Quality Improvement

Overview

WellCare's Quality Improvement Program (QI Program) is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable medical and Behavioral 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 including:

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

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

The goals of the QI Program are to:

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

Provider Participation in the Quality Improvement Program

Network Providers are contractually required to cooperate with quality improvement activities, which include providing Member records for assessing quality of care. In addition, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule at 45 CFR 164.506 permits a covered entity (Provider) to use and disclose Protected Health Information (PHI) to health plans without Member authorization for treatment, payment and healthcare operations activities. Healthcare operations include, but are not limited to, the health plan conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing healthcare costs, care management and care coordination.

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

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

Member Satisfaction

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

Early and Periodic Screening, Diagnosis and Treatment Periodicity Schedule

The preventive pediatric healthcare guidelines for children are located on WellCare's corporate website at www.wellcare.com/Kentucky/Providers/Clinical-Guidelines/CPGs.

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

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

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

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

Each Provider office is required to have the following equipment to provide a complete health check:

- Weight scale for infants;
- Weight scale for children and adolescents;
- Measuring board or device for measuring length or height in the recumbent position for infants and children up to age 2;
- Measuring board or device for measuring height in the vertical position for children who are 2-years-old or older;
- Blood pressure apparatus with infant, child and adult cuffs;
- Screening audiometer;
- Centrifuge or other device for measuring hematocrit or hemoglobin;
- Eye charts appropriate to children by age;
- Developmental and behavioral screening tools; and
- Ophthalmoscope and otoscope.

Additional points of emphasis regarding EPSDT screens include the following:

- **Visit Requirements** – An interval health history, age-appropriate assessment of physical and mental health development, assessment of nutrition, complete/unclothed physical exam, age-appropriate health education/anticipatory guidance and growth chart are completed at each visit.
- **Immunizations** are administered at required age parameters and intervals with dates documented. If the immunizations are not up-to-date according to age and health history, the Provider should document why immunizations were not given at the time of the EPSDT screen. For the immunization schedule, refer to the preventive pediatric healthcare guidelines for children located on WellCare's corporate website at www.wellcare.com/Kentucky/Providers/Clinical-Guidelines/CPGs. Note that certain immunizations may not be covered in the context of covered benefits.
- **PCP Responsibilities** – A PCP is responsible to perform all required components of an EPSDT health screen, as per the AAP and ACIP periodicity schedules, and document appropriately in the Member's medical record. If a PCP chooses not to provide the immunization component of the screen, she or he has accountability to refer the Member to another network Provider (such as a health department entity) who can provide this service in a timely manner. WellCare will expect the PCP to follow up with the referred Provider to obtain documentation regarding the provision of the immunization(s) in order to maintain an accurate and complete medical record. WellCare will monitor for compliance to these requirements by reviewing immunization rates by the PCP. In the event the immunization rate of the PCP is less than the network average, WellCare will assess for practice access and availability by:
 - Conducting an audit to verify compliance with access and availability;
 - Requiring adoption of a corrective action plan (CAP) if access and availability standards are not met; and
 - Performing a focused medical record review. Based on negative findings, a CAP will be requested.
 - If compliance to the CAP is not demonstrated, WellCare will assess for a fee reduction; and
 - If lack of compliance continues, WellCare will petition for removal from network participation.

- **Lead Exposure Assessment** is done at the 6-month through 6-year age visits. Lead blood level for children with low-risk history is done at the 12-month and 2-year age visit. Lead blood levels in children with a high-risk history are done immediately. Any risk identified through lead risk assessment should be both documented in the medical record and addressed.
- **Annual Tuberculosis (TB) Skin Testing** is done if the Member is in a high-risk category. Only those children locally identified at high-risk for TB disease should be tested. Results of TB risk assessment and testing as needed should be documented in the child's medical record.
- **Developmental Delay** is to be assessed by use of a formalized tool at 9 months and 18 months and at 2 years and 3 years.
- **120-Day Non-Compliant Report** is a report that WellCare will send Providers. It includes a monthly membership list of EPSDT-eligible children who have not had a screen within 120 days of enrolling in WellCare or who are not in compliance with the EPSDT periodicity schedule. The PCP shall contact these Members' parents or guardians to schedule an appointment. WellCare will also send letters to the parents and guardians of EPSDT-eligible children to remind them of preventive services needed based on the child's age.
- **Establish and maintain a tracking system** to monitor acceptance and refusal of EPSDT service, whether eligible Members are receiving the recommended health assessments, and all necessary diagnosis and treatment, including EPSDT Special Services, when needed.

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. Providers are also measured annually for their compliance with *Clinical Practice Guidelines*. Areas identified for improvement are tracked and corrective actions are taken as indicated. The effectiveness of corrective actions is monitored until the problem is resolved. Approval of the *Clinical Practice Guidelines* occurs through the Quality Improvement Committee as well as through the Kentucky Department for Medicaid Services. *Clinical Practice Guidelines*, including preventive health guidelines, are on WellCare's website at www.wellcare.com/Kentucky/Providers/Clinical-Guidelines/CPGs.

Healthcare Effectiveness Data and Information Set

HEDIS® is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. The tool comprises 71 measures across eight 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 healthcare 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.

Medical Records

Medical records should be comprehensive and reflect all aspects of care for each Member. Records are to be maintained in a timely, legible, current, detailed and organized manner in order 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;
- Consultants' 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 by the Provider of service.

The Member's medical record is the property of the Provider who generates the record. However, each Member or her or his representative is entitled to one free copy of his or 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 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;
 - Emergency contact name and telephone numbers (if no phone, contact name and address);
 - Consent forms; and
 - Identification of language spoken and guardianship information.

- Date of data entry and date of encounter;
- Provider identification by name;
- Allergies and adverse reactions shall be noted in a prominent location;
- Past medical history, including serious accidents, operations and illnesses. For children, past medical history includes prenatal care and birth information, operations and childhood illnesses (i.e., documentation of chicken pox);
- Identification of current problems;
- Consultation, laboratory and radiology reports shall be filed in the medical record and must have documentation indicating review (ordering Provider's initials);
- Documentation of immunizations pursuant to 902 KAR 2:060;
- Identification and history of nicotine and 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 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;
 - Therapies and other prescribed regimen; and
 - Follow-up plans, including consultation and referrals and directions, including time to return.

A Member's medical record shall include at a minimum for hospitals and mental hospitals:

- A. Identification of the beneficiary.
- B. Physician name.
- C. Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission; the plan of care (as required under 42 CFR 456.172 (mental hospitals) or 42 CFR 456.70 (hospitals).
Initial and subsequent continued stay review dates (described under 42 CFR 456.233 and 42 CFR 465.234 (for mental hospitals) and 42 CFR 456.128 and 42 CFR 456.133 (for hospitals)
- D. Reasons and plan for continued stay if applicable.
- E. Other supporting material the committee believes appropriate to include.
- F. For non-mental hospitals only:

1. Date of operating room reservation.
2. Justification of emergency admission if applicable.

All Behavioral Health services shall be provided in conformance with the access standards established by the Department of Medicaid Services. When assessing Members for Behavioral Health services, the plan and its Providers shall use the most current version of DSM classification. The plan may require use of other diagnostic and assessment instrument/outcome measures in addition to the most current version of DSM. Providers shall document DSM diagnosis and assessment/outcome information in the Member's medical record.

PCPs and identified high-volume specialists are measured at least once every three years for their compliance with medical record documentation standards. Identified areas for improvement are tracked, and corrective actions are taken as indicated. Effectiveness of corrective actions is monitored until problem resolution occurs.

Confidentiality of Member information must be maintained at all times. Records are to be stored securely with access granted to authorized personnel only. Access to records should be granted to WellCare or its representatives without a fee to the extent permitted by state and federal laws. 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 8: Compliance*.

Patient Safety to Include Quality of Care and Quality of Service

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

Web Resources

WellCare periodically updates clinical, coverage and preventive guidelines as well as other resource documents posted on the WellCare website. Please check WellCare's website frequently for the latest news and updated documents at www.wellcare.com/Kentucky/Providers/Medicaid/Quality.

Section 4: Utilization Management (UM), Care Management (CM) and Disease Management (DM)

Utilization Management

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

The focus of the UM Program is on:

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

WellCare's UM Program includes components of Prior Authorization and prospective, concurrent and retrospective review activities. Each component is designed to provide for the evaluation of healthcare and services based on WellCare Members' coverage and the appropriateness of such care and services and to determine the extent of coverage and payment to Providers of care.

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

Medically Necessary Services

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

- Be based on an individualized assessment of the recipient's medical needs; and
- 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 healthcare 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 21 years of age; and
- Provided in accordance with 42 C.F.R. 440.230.

Criteria for Utilization Management Decisions

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

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

- InterQual™
- WellCare *Clinical Coverage Guidelines*;
- State Medicaid Contract;
- State Provider Handbooks, as appropriate;
- Federal and state statutes and regulations;
- Medicaid and Medicare guidelines; and
- Hayes Health Technology Assessment.
- Level of Care Utilization System (LOCUS);
- Child and Adolescent Service Intensity Instrument (CASII)
- Child and Adolescent Needs and Strengths Scale (CANS);
- Early Childhood Service Intensity Instrument (ECSII); and
- American Society of Addiction Medicine (ASAM).

The clinical 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 Providers upon request. Providers may request a copy of the criteria used for specific determination of Medical Necessity by calling the Provider Services Department listed on the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid. Providers may advise and comment on the development and adoption of clinical criteria through their Provider Relations representative who can provide contact information for the Chair of the Medical Policy Committee or another WellCare Medical Director.

Utilization Management Process

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

- Notifications;
- Referrals;
- Prior Authorizations;

- Concurrent review; and/or
- Retrospective review.

Decision and notification time frames are determined by National Committee for Quality Assurance (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.wellcare.com/Kentucky/Providers/Medicaid/Forms.

After-Hours Utilization Management

WellCare provides authorization of inpatient admissions 24 hours a day, seven days a week. Providers requesting after-hours authorization for inpatient admission should refer to the *Quick Reference Guide* on WellCare's website at

www.wellcare.com/Kentucky/Providers/Medicaid to contact an after-hours clinician.

Discharge planning needs that may occur after normal business hours will be handled by WellCare's after-hours clinicians.

Notification

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

- Prenatal Services – Notification of prenatal services enables WellCare to identify pregnant Members for inclusion into the Prenatal Program and/or WellCare's High-Risk Pregnancy Program. Obstetrical Providers are required to notify WellCare of pregnancies via fax using the *Prenatal Notification Form* within 30 days of the initial visit. This process will also expedite care management and claims reimbursement; and
- Inpatient Admission – Notification of a Member's admission to a hospital allows WellCare to log the hospital admission and follow-up with the facility on the following business day to receive clinical information. The notification should be received by fax or telephone and include Member demographics, facility name and admitting diagnosis.

Referrals

A referral is a request by a PCP for a Member to be evaluated and/or treated by a specialty Provider. WellCare does not require authorization as a condition of payment for specialist consultations provided by WellCare-contracted Providers. WellCare does not need to be notified when Members are referred in in-network Providers, including specialists. Please see the *Prior Authorization* section below if the Member is being referred to an out-of-network provider. Certain diagnostic tests and procedures considered by WellCare to be routinely part of an office visit may be conducted as part of the initial visit without an authorization. A searchable Authorization Lookup Tool is available online at www.wellcare.com/Kentucky/Providers/Medicaid.

WellCare does not require Providers to perform any treatment or procedure that is contrary to the Provider's conscience, religious beliefs or ethical principles in accordance with 42 CFR 438.102. If a Provider declines to perform a service because of ethical reasons, the Member should be referred to another Provider licensed, certified or accredited to provide care for the individual service, or be assigned to another PCP licensed, certified or accredited to provide care appropriate to the Member's medical condition. WellCare does not prohibit or restrict a Provider from advising a Member

about his or her health status, medical care or treatment, regardless of whether benefits for such care are Covered Services, if the Provider is acting within the lawful scope of practice.

Prior Authorization

Prior Authorization is the process of obtaining approval in advance of rendering a service. Prior Authorization may or may not require a medical record review. An authorization is granted for Covered Services and is provided only after WellCare agrees the treatment is medically necessary and a covered benefit. Prior Authorization allows for efficient use of covered healthcare services and ensures that Members receive the most appropriate level of care at the most appropriate setting. Prior Authorization may be obtained by the Member's PCP, treating specialist or facility. Prior Authorization is not a guarantee of payment, payment level or Member eligibility.

Reasons for requiring Prior Authorization may include:

- Review for medical necessity;
- Appropriateness of rendering Provider;
- Appropriateness of setting; and/or
- Care and disease management considerations.

Prior Authorization is **required** for elective or non-emergency services as designated by WellCare. Guidelines for Prior Authorization requirements by service type may be found on the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid. Providers can also use the searchable Authorization Lookup Tool at www.wellcare.com/Kentucky/Providers/Medicaid.

Some Prior Authorization guidelines to note are:

- The Prior Authorization request should include the diagnosis to be treated and the *Physician's Current Procedural Terminology*, (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, 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.

WellCare requires notification by the next business day when a Member is admitted to a facility. This includes all admissions and/or observation stays. Notification is necessary for WellCare to obtain clinical information to perform case management and ensure coordination of services. Failure to notify WellCare of admissions or observation stays may result in denial of the claim.

There is no limit on the number of days Medicaid allows for medically necessary inpatient hospital care. If a Member is readmitted to the hospital for the same or related problem within 14 days of discharge for the same diagnosis, it is considered the same admission. All admissions are subject to medical justification, and WellCare may request

documentation to substantiate medical necessity and appropriateness of setting. Documentation must be provided upon request in prepayment or postpayment review. Failure to show appropriate medical justification may be cause for denial, reduction or recoupment of reimbursement.

If a hospital determines that an outpatient hospital setting would have met the medical needs of a Member after the services were provided in an inpatient setting, the services may be billed to WellCare as outpatient if the claim is received within **365** days of the ending date of the service month. If the claim is received more than **365** days after the ending date, the services are not covered.

To substantiate the determination, a physician's order must document the Member's status at the time of admission and any changes in the Member's status.

Authorization Request Forms

WellCare requests that Providers use WellCare's standardized authorization request forms to ensure receipt of all pertinent information and enable a timely response to Provider requests, including:

- *Inpatient Authorization Request Form* is used to request authorization for services such as planned elective/non-urgent inpatient observation, inpatient skilled nursing facility and rehabilitation admissions.
- *Outpatient Authorization Request Form* is used to request authorization for services such as select outpatient hospital procedures, out-of-network services and transition of care services.
- *DME Services Authorization Request Form* is used to request authorization for items such as motorized wheelchairs, insulin pumps and Dynasplint® Systems.
- *Skilled Therapy Services Authorization Request Form* is used to request authorization for physical therapy (PT), occupational therapy (OT) and speech therapy (ST) services.
- *Home Health Authorization Request Form* is used to request authorization for services such as skilled nursing, home health aide and skilled therapy visits that are rendered in a home setting.

Providers may also submit authorization requests by using the Department for Medicaid Services's universal Prior Authorization form available on the WellCare website.

To ensure timely and appropriate authorization decisions, all forms must:

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

Incomplete information will result in calls and/or faxes to the ordering Provider for the missing information and could result in a delay of receipt of services to the Member. All forms are located on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid/Forms. All forms should be submitted via fax to the number listed on the form.

Procedures for Obtaining Prior Authorization for All Medical Services Except Dental Services and Transplants

The attending physician or hospital staff is responsible for obtaining Prior Authorization from WellCare and for providing the Prior Authorization number to each WellCare



Provider associated with the case; i.e., assistant physician and hospital, etc. Failure to obtain Prior Authorization will result in denial of payment.

Requests for Prior Authorization should be submitted at least 10 business days prior to the planned admission or procedure. Please remember to consult the authorization look-up tool within the Provider portal and obtain appropriate Prior Authorization. Failure to obtain Prior Authorization where required may result in denial of the claim.

Once a procedure is approved, the approval is valid for **60** days from the date of issuance.

For an authorization of a service, WellCare shall make a decision:

- (a) As expeditiously as the enrollee's health condition requires; and
- (b) Within two (2) business days following receipt of a request for service.

The timeframe for making an authorization decision may be extended by the:

1. Enrollee, or the Provider acting on behalf of and with consent of an enrollee, if the enrollee requests an extension; or
2. WellCare, if WellCare:
 - a. Justifies a need for additional information and how the extension is in the enrollee's interest;
 - b. Gives the enrollee written notice of the extension, including the reason for extending the authorization decision timeframe and the right of the enrollee to file a grievance if the enrollee disagrees with that decision; and
 - c. Makes and carries out the authorization decision as expeditiously as the enrollee's health condition requires and no later than the date the extension expires; and

Up to fourteen (14) additional calendar days. WellCare will complete the Medical Necessity review process within two (2) business days of receiving the request,

In cases when Prior Authorization has been obtained for an outpatient procedure, and during the procedure it is determined that the Member requires an additional or different procedure, the procedure will be considered an urgent procedure. The hospital's request for an update of the Prior Authorization will be considered timely if received within 7 calendar days of the date of the procedure.

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

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

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



Procedures for Obtaining Prior Authorization for Dental Services

Prior Authorization is required for any dental service requiring inpatient or outpatient hospitalization. It is the responsibility of the attending dentist to obtain Prior Authorization and to provide the Prior Authorization number to the hospital. Failure to do so will result in denial of payment.

For Prior Authorization of dental services requiring hospitalization, contact WellCare's UM Department at the telephone number listed on the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

Procedures for Obtaining Prior Authorization for Transplants

In order to receive Prior Authorization for a transplant, a written request with medical records must be received by WellCare for review. This pertains to liver, bone marrow, kidney and corneal transplants as well as medically necessary heart, lung and heart/lung transplants for Members. These records must include current medical history, pertinent laboratory findings, X-ray and scan reports, social history and test results that include serology and other relevant information.

Transplant procedures and related services must be approved by WellCare prior to the transplant, regardless of the age of the Member. Once a transplant procedure is approved, a Prior Authorization number will be assigned. The Member must be eligible at the time services are provided, and these services cannot be approved retroactively.

For requests for approval of coverage of all transplant services, contact WellCare's UM Department at the telephone number listed on the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

Review and Functions for Authorized Hospitals

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

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

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

Concurrent Review

Concurrent review activities involve the evaluation of a continued hospital, long-term acute care (LTAC) hospital, skilled nursing facility or acute rehabilitation stay for medical appropriateness utilizing the appropriate Medical Necessity criteria. The Inpatient Care Manager follows the clinical status of the Member through telephonic or on-site chart review and communication with the attending physician, hospital utilization manager, care 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 will be reviewed to:

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

The concurrent review process incorporates the use of InterQual™ criteria or WellCare *Clinical Coverage Guidelines* to assess quality and appropriate level of care for continued medical treatment. Reviews are performed by licensed clinicians under the direction of the WellCare Medical Director.

To ensure the review is completed timely, Providers must submit clinical information on the next business day after the admission, as well as upon request of the WellCare review clinician. Failure to submit necessary documentation for concurrent review may result in nonpayment.

Discharge Planning

Discharge planning begins upon admission and is designed for early identification of medical and/or psychosocial issues that will need post-hospital intervention. The Inpatient Care Manager works with the attending physician, hospital discharge planner, ancillary Providers and/or community resources to coordinate care and post-discharge services to facilitate a smooth transfer of the Member to the appropriate level of care. An Inpatient Care Manager may refer an inpatient Member with identified complex discharge needs to Short-Term Care Management for post-discharge follow-up.

Retrospective Review

A retrospective review 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.
- Post Payment Review and Technical Denials
 - WellCare (or its designee) conducts post-payment reviews of Provider's records related to services rendered to WellCare Members. During such reviews, the Provider should allow WellCare access to, or provide the medical record and billing documents requested that support the charges billed.
 - For post-payment reviews, medical records and/or related documentation will be reviewed as per the specific reason the records were requested. Upon completion of the medical record review, either the payment will stand or WellCare will issue a Recovery letter. The timeline for the requests of records is as follows:
 - Initial request: A letter will be mailed to the Provider asking that records be provided within 30 days from the date of the letter.



- Second reminder: If the requested records are not received within 30 days of the initial letter, a second letter may be mailed or outbound calls may be made to the Provider, allowing the Provider an additional 30 days to respond. If the records are not received by the 60th day after the initial request, WellCare will issue a technical denial with a request for repayment, and the recoupment process will begin directly following the 60-day period for the amount stated in the letter, or per state Medicaid rules as applicable.
- If the requested documentation is received after a technical denial has been issued, but within the dispute period outlined as per applicable contractual, State or Federal guidelines, the records will be reviewed. If the records submitted support payment of the original claim, the review will be closed. If the records submitted do not justify payment, a findings letter with a request for payment, with appeal rights, if applicable, will be issued to the Provider.

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

Standard, Expedited and Extensions of Service Authorization Decisions

Type of Authorization	Initial Decision Time Frame	Extension Length
Standard Pre-Service	2 business days	14 calendar days
Expedited Pre-Service	24 hours	48 hours
Concurrent	1 calendar day for initial request 24 hours for subsequent requests	14 calendar days 48 hours
Retrospective or Post-Service	14 calendar days	14 calendar days

Standard Service Authorization

WellCare is committed to processing Prior Authorization requests. WellCare will fax an authorization response to the Provider fax number(s) included on the authorization request form.

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 24 hours of the request.

Requests for expedited authorization decisions should be submitted by telephone, not fax, or WellCare's website. Please refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid for contact information.

Members and Providers may submit an oral request for an expedited 24-hour decision.

Observation

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

Such services are covered only when provided by the order of a physician or another individual authorized to admit patients to the hospital or to order outpatient tests. Observation services usually do not exceed 24 hours. However, some patients may require up to 72 hours of outpatient observation services.

If the patient is not stable after 72 hours, acute care criteria will be applied.

When a Member is placed under observation by a hospital, the patient is considered an outpatient until the patient is admitted as an inpatient. While under observation, the hospital may determine the patient needs further care as an inpatient admission or the patient may improve and be released. Observation is a covered revenue code on an inpatient claim.

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

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

Medical appropriateness and necessity, including that of the medical setting, must be clearly substantiated in the Member's medical record. If it is determined the outpatient observation is not covered, then all services provided in the observation setting are also not covered. Services provided for the convenience of the patient or physician and that are not reasonable or medically necessary for the diagnosis are not covered.

Observation services alone do not require authorization. However, if a procedure is performed during an observation stay that requires an authorization from WellCare, the facility or Provider must seek authorization approval for that procedure.

WellCare Adverse Benefit Determinations

An Adverse Benefit Determination is a denial or limited authorization of a requested service, including a determination based on the type or level of service, requirements for Medical Necessity, appropriateness, setting or effectiveness of a covered benefit. In the event of an Adverse Benefit Determination, WellCare will notify the Member in writing of the Adverse Benefit Determination. The notice will contain the following:

- The Adverse Benefit Determination that WellCare has made or intends to take;
- The reasons for the Adverse Benefit Determination;

- The right to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Member's Adverse Benefit Determination, including Medical Necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits
- The Member's right to appeal including information on exhausting the Contractor's one level of appeal as required by 42 CFR 438.402(b);
- The Member's right to request a State Fair Hearing after receiving notice that the Adverse Benefit Determination is upheld;
- Procedures for exercising Member's rights to appeal or file a grievance;
- Circumstances under which the appeal process can be expedited and how to request it;
- 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;
- Be available in the state-established prevalent non-English languages in its service area;
- Be available in alternative formats for persons with special needs; and
- Be easily understood in language and format.

Peer-to-Peer Discussion

In the event of an Adverse Benefit Determination following a medical necessity review, Peer-to-Peer Discussion is offered to the treating physician on the Adverse Benefit Determination communication. The treating physician is provided a toll-free number to the Medical Director Hotline to request a discussion with a WellCare Medical Director. Peer-to-Peer Discussion is offered within seven (7) business days following the receipt of the written determination by the Provider.

The review determination notification contains instructions on how to use the Peer-to-Peer Discussion 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
- Clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories and Provider offices under a Clinical Laboratory Improvement Amendment (CLIA) waiver do not require Prior Authorization. There are exceptions to this rule for specialty laboratory tests which require authorization regardless of place of service:
 - Reproductive laboratory tests;
 - Molecular laboratory tests; and
 - Cytogenetic laboratory tests.
- Certain tests described as CLIA-waived may be conducted in the Provider's office if the Provider is authorized through the appropriate CLIA certificate. A copy of the certificate must be submitted to WellCare.

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

All services performed without Prior Authorization are subject to retrospective review by WellCare.

Second Medical Opinion

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

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

Emergency/Urgent Care and Post-Stabilization Services

Emergency services are not subject to Prior Authorization requirements and are available to WellCare Members 24 hours a day, seven days a week. An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms.

An Emergency Medical Condition is:

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

WellCare provides payment for emergency services when furnished by a qualified Provider, regardless of whether that Provider is in the WellCare network. WellCare will pay for all emergency services that are medically necessary until the Member is stabilized. WellCare will also pay for any medical screening examination conducted to determine whether an emergency medical condition exists. The attending emergency room Provider, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge.

WellCare will consider the following criteria when reviewing claims for emergency healthcare services:

- The age of the patient;
- The time and day of the week the patient presented for services;

- The severity and nature of the presenting symptoms;
- The patient's initial and final diagnosis; and
- Any other criteria prescribed by the Department, including criteria specific to patients younger than 18 years of age.

WellCare reserves the right to review medical records for claims for a emergency services to validate the prudent layperson standard was met in accordance to KRS 304.17A-708. There is no single determining factor for determining the prudent layperson standard, but rather the evaluation of service shall be based on a variety of factors including, but not limited to, the list above.

Services that are determined to be non-emergent under the prudent layperson standard are not Covered Services in accordance with the Medicaid Managed Care Contract. Claims for emergency room visits that cannot be documented as true medical emergencies or potential medical emergencies may be retrospectively reviewed.

Upon request, providers must submit medical documentation for all retrospective emergency room review requests. Each claim submitted for review should contain the complete medical record which provides full insight on the Member's visit to the emergency room. All documentation will be reviewed and a letter of determination (indicating if the initial decision was upheld or overturned) will be sent for the claim.

In the event a claim payment decision is overturned based upon the review of the medical documentation, Providers are afforded the opportunity to appeal the decision through the formal appeal process. Providers may submit the claim for review under the formal appeals process. Providers have **60** days from the date of the decision to appeal.

Appeals for emergency room visits should be sent to WellCare's external reviewer as directed in Provider notification/EOP.

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

Once the Member's condition is stabilized, unplanned urgent admissions must be followed by notification to WellCare by calling the Provider Hotline and reporting the urgent or emergent admission within 24 hours of the admission. The caller should provide the following:

- Member's name;
- WellCare Member ID number;
- Name of admitting hospital;
- Referring Provider; and
- Diagnosis of Member.

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

1. In non-emergency situations where the Provider may be able to identify a chronic abuser of the emergency room, the Provider may exercise its right to advise the Member that they will not be accepted as a WellCare Member, and, in the event the Member elects to receive services, the Member will be responsible for all charges incurred. If a Member is not accepted for treatment as a WellCare Member, hospitals should offer the following alternatives to the Member:
 - Refer the Member to a specific alternate healthcare setting where he or she can obtain care the same day or next day; and
2. Instruct the Member as to the generally appropriate setting for treatment for such a condition in the future.

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

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

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

Continuity of Care

WellCare will allow Members in active treatment to continue care with a terminated treating Provider, when such care is medically necessary, through completion of treatment of a condition for which the Member was receiving care at the time of the termination, until the Member selects another treating Provider. None of the above may exceed six months after the termination of the Provider's contract.

WellCare will allow pregnant Members who have initiated a course of prenatal care, if the covered person is beyond the twenty-fourth week of pregnancy, the plan's obligation to pay for services extends through the delivery of the child, immediate postpartum care, and examination within the first six (6) weeks following delivery.

For continued care under this provision, WellCare and the terminated Provider shall continue to abide by the same terms and conditions as existed in the terminated contract.

Transition of Care

Authorization is not required for certain Members with previously approved services by another managed care plan. Retroactive Medicaid coverage is defined as a period of time up to three (3) months prior to the application month. WellCare shall cover all medically necessary services provided the Member during the retroactive coverage without a Prior Authorization. WellCare shall allow a Provider to submit a claim outside of the timely filing period when the Provider is notified after the end of WellCare's timely filing period of a retroactive change in MCO by receipt of a recoupment letter, and WellCare shall not deny the claim based on timely filing. WellCare will allow a Provider



to submit a claim outside of the timely filing period when the Provider is notified after the end of the Contractor's timely filing period of a retroactive change in MCO by receipt of a recoupment letter, and the Contractor shall not deny the claim based on timely filing.

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 ongoing care with a specialist or other Provider.

When WellCare becomes aware that a covered Member will be disenrolled from WellCare and will transition to a Medicaid fee-for-service program or another managed care plan, a WellCare Review Nurse/Care Manager who is familiar with that Member will provide a Transition of Care report to the receiving plan or appropriate contact person for the designated fee-for-service program.

If a Provider receives an adverse claim determination which he or she believes was a transition of care issue, the Provider should fax the adverse claim determination to the Appeals Department with documentation of approval for reconsideration. For contact information, please refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

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 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, in vitro 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;
- Postmortem services;
- Services that are investigational, mainly for research purposes, or experimental in nature. This includes, but is not limited to, drugs;
- Gender reassignment 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; and
- 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.

Limits to Abortion, Sterilization and Hysterectomy Coverage

For any Medicaid service provided by WellCare that requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be completed according to the appropriate Kentucky Administrative Regulation (KAR).

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. Elective abortions are not covered if used for family planning purposes.

An Abortion/Miscarriage Certification 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 Provider and can be found on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid/Forms.

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 ICD-10 codes to ensure that abortions are not being billed through the use of other procedure codes. A link to ICD-10 procedure codes can be found in the Compliance Section of this Manual.

Sterilizations

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

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

A copy of the required *Sterilization Consent Form* can be obtained through Health and Human Services Website: <https://www.hhs.gov/opa/sites/default/files/consent-for-sterilization-english-updated.pdf>

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 30 calendar days.



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

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

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

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

Hysterectomy

Prior Authorization is required for the administration of a hysterectomy to validate medical necessity. WellCare reimburses Providers for hysterectomy procedures only when the following requirements are met:

- The Provider ensured that the individual was informed, orally 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 and the attending physician must sign and date the *Hysterectomy Consent 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 *Hysterectomy Consent Form (MAP 251)* with the claim prior to submission to WellCare.

Forms are located on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid/Forms.

WellCare will deny payment on any claims submitted without the required documentation or with incomplete or inaccurate documentation. WellCare does not accept documentation meant to satisfy informed consent requirements that have 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.

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

Delegated Entities

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

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

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

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

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

Care Management Program

WellCare offers comprehensive integrated Care Management services to facilitate patient assessment, planning and advocacy in order 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 Care Management Programs.

WellCare's multidisciplinary Care Management teams are comprised of Care Managers who are specially trained clinicians who perform a comprehensive assessment of the Member's clinical status, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate outcomes for possible revisions of the care plan. The Care Managers work collaboratively with PCPs and specialists to coordinate care for the Member and expedite access to care and needed services.

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

The Care Management process begins with Member identification and follows the Member until discharge from the program. Members may be identified for Care Management by:

- Referral from a Member's Primary Care Provider or other specialist;
- Self-referral;

- Referral from a family member;
- Referral after a hospital discharge;
- After completing a Health Risk Assessment (HRA); and
- Data mining for high-risk Members.

WellCare's philosophy is that the Care Management Program is an integral management process to provide a continuum of care for WellCare Members. Key elements of the Care Management process include:

- **Clinical Assessment and Evaluation** – A comprehensive assessment of the Member is completed to determine where he or she is in the health continuum. This assessment gauges the Member's support systems and resources and seeks to align the Member with appropriate clinical needs.
- **Care Planning** – Collaboration with the Member and/or caregiver, the PCP and other Providers involved in the Member's care 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 (CMHC).
- **Member Advocacy** – advocating on behalf of the Member within the complex labyrinth of the healthcare system. Care Managers assist Members with seeking services to optimize their health. Care Management emphasizes continuity of care for Members through the coordination of care among physicians, CMHCs and other Providers.
- **Education**
- **Medication reconciliation**; and
- **Referrals to community-based services**

Members commonly identified for WellCare's Care Management Program include those with:

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

Individuals with Special Health Care Needs

ISHCN are persons who have or are at high risk for a 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 conditions. Individuals with these conditions include:

- Children in/or receiving foster care or adoption assistance;
- Blind/disabled children under age 19 and related populations eligible for SSI;
- Adults over the age of 65;
- Homelessness (upon identification);
- Individuals with chronic physical health illnesses;
- Individuals with chronic behavioral health illnesses; and
- Children receiving EPSDT Special Services.

For more information, please refer to *Section 2: Provider and Member Administrative Guidelines*.

Disease Management Program

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);
- COPD;
- Diabetes – adult and pediatric;
- 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 website at www.wellcare.com/Kentucky/Providers.

Candidates for Disease Management

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

Interventions for Members identified vary depending on their level of need and stratification level. Interventions are based on industry-recognized *Clinical Practice Guidelines*. Members identified at the highest stratification levels receive a comprehensive assessment by a Disease Management nurse, disease-specific



educational materials, identification of a care plan and goals and follow-up assessments to monitor adherence to the plan and attain goals.

Disease-specific *Clinical Practice Guidelines* adopted by WellCare may be found on WellCare's website at www.wellcare.com/Kentucky/Providers/Clinical-Guidelines/CPGs.

Access to Care and Disease Management Programs

If a Provider would like to refer a WellCare Member as a potential candidate to the Care Management Program or the Disease Management Program, or would like more information about one of the programs, he or she may call the WellCare Care Management Referral Line or complete and fax the request to the number on the *Quick Reference Guide*. Members may self-refer by calling the Care Management toll-free line or contacting the Nurse Advice Line after hours or on weekends (TTY available).

For more information on the Care Management Referral Line, refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

Section 5: Claims

Overview

The focus of WellCare's Claims Department is to process claims in a timely manner. WellCare has established toll-free telephone numbers for Providers to access a representative in WellCare's Provider Services Department. For more information, refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

Updated Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Process

WellCare (in partnership with PaySpan) has implemented an enhanced online Provider registration process for electronic funds transfer (EFT) and electronic remittance advice (ERA) services.

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

Multiple practices and accounts are supported. Providers can reuse enrollment information to connect with multiple payers. Different payers can be assigned to different bank accounts.

Providers will no longer receive paper Explanation of Payments (EOPs).

Effective October 1, 2015, EOPs can be viewed and/or downloaded and printed from PaySpan's website, once registration is completed.

Providers can register using PaySpan's enhanced Provider registration process at payspan.com. Providers can also view PaySpan's webinar anytime at: payspan.webex.com.

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

Timely Claims Submission

Unless otherwise stated in the Provider Contract, Providers must submit claims (initialed, corrected and voided) within 12 months (or six months from the Medicaid or primary insurance payment date, whichever is later) from the date of service for outpatient services or the date of discharge for inpatient services. For more information, please refer to the Department's website at <https://chfs.ky.gov/agencies/dms>. Unless prohibited by federal law or the Centers for Medicare & Medicaid Services (CMS), WellCare may deny payment for any claims that fail to meet WellCare's submission requirements for Clean Claims or that are received after the time limit in the Provider Contract for filing Clean Claims.

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

- A clearinghouse electronic acknowledgement indicating the claim was electronically accepted by WellCare; and



- A Provider's electronic submission sheet with all the following identifiers: patient name, Provider name, date of service to match Explanation of Benefit (EOB)/claim(s) in question, prior submission bill dates and WellCare product name or line of business.
- In cases of retro-eligibility assignment, another MCO's recoupment letter.

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 Identification and National Provider Identifier Requirements

To avoid claim delays or rejections, Providers will need to submit claims that contain the following information in alignment with the KY State DMS Roster Registration data:

- Billing NPI, Taxonomy, Billing Address (ZIP-5 or ZIP-9 which matches the roster)
- Rendering NPI, Taxonomy (if Rendering is different from Billing Provider)
- Atypical Providers are excluded but must be previously added on the WellCare atypical Provider list.
- Attending, Ordering, Referring NPI

Please compare the identification values on the claim to the information registered with KY DMS. If the State Roster is not accurate, please contact DMS to update the information before resubmission of claims. For any additional questions or concerns, please reach out to WellCare's EDI Ops team via email at EDI-Master@wellcare.com.

You will receive a claim rejection error if:

- A unique and effective Medicaid ID for the Billing Provider and/or Rendering Provider submitted on the claim cannot be found on the DMS State Roster.
- An Ordering, Referring, Prescribing and Attending Provider (OPR) is not enrolled in Kentucky Medicaid.

Providers of Kentucky Medicaid patients must be registered with the state Medicaid Program using their National Provider Identifier ("NPI"), Taxonomy Code and Billing address with the Kentucky Department for Medicaid Services (KY DMS).

WellCare will reject claims without the Tax ID and NPI, with the exception of Atypical Providers, defined as Providers who do not provide medical services (ex: non-emergency transportation, case management or environmental modifications). Atypical Providers must pre-register with DMS and WellCare before submitting claims to avoid NPI rejections. More information on NPI requirements, including HIPAA's NPI Final Rule Administrative Simplification, is available on the CMS website at <https://www.cms.gov/>

Taxonomy

Providers are required to submit claims with the correct taxonomy code consistent with Provider specialty and services being rendered in order to appropriately adjudicate the claim. WellCare may reject the claim or pay it at the lower reimbursement rate if the taxonomy code is incorrect or omitted. For additional details on taxonomy as it relates to KY roster edits see the above Tax Identification and National Provider Identifier Requirements section.

**Preauthorization Number**

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

National Drug Codes

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

Strategic National Implementation Process

All claims and encounter transactions submitted via paper, direct data entry (DDE) or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines. The SNIP validations used by WellCare to verify transaction integrity/syntax are available on WellCare's website at

www.wellcare.com/Kentucky/Providers/Medicaid/Claims.

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

Claims Submission Requirements

WellCare requires all participating hospitals to properly code all relevant diagnoses and surgical and obstetrical procedures on all inpatient and outpatient claims submitted. WellCare utilizes the ICD-10-CM or its successor mandated by CMS for all coding. In addition, the CPT-4 coding and/or Healthcare Common Procedure Coding System (HCPCS) is required for all outpatient surgical, obstetrical, injectable drugs, diagnostic laboratory and radiology procedures. When coding, the Provider must select the code(s) that most closely describe(s) the diagnosis(es) and procedure(s) performed. When a single code is available for reporting multiple tests or procedures, that code must be utilized rather than reporting the tests or procedures individually.

WellCare tracks billing codes and Providers who continue to apply incorrect coding rules. Providers will be educated on the proper use of codes as part of the retrospective review process. Should a Provider continue to repeat the inappropriate coding practice, the Provider will be subject to an adverse action.

Providers using electronic submission shall submit all claims to WellCare or its designee, as applicable, using the HIPAA-compliant 837 electronic format, or a CMS 1500 and/or UB-04, or their successors. Claims shall include the Provider's NPI, Tax ID and the valid taxonomy code that most accurately describes the services reported on the claim. The Provider acknowledges and agrees that no reimbursement is due for a Covered Service and/or no claim is complete for a Covered Service unless performance of that Covered Service is fully and accurately documented in the Member's medical record prior to the initial submission of any claim. The Provider also acknowledges and agrees that at no time shall Members be responsible for any payments to the Provider with the exception of Member expenses and/or non-covered services. For more information on paper submission of claims, refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

For more information on Covered Services under WellCare's Kentucky Medicaid plans, refer to WellCare's website at www.wellcare.com/Kentucky/Providers.

Electronic Claims Submissions

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

Because most clearinghouses can exchange data with one another, Providers should work with their existing clearinghouse, or a WellCare contracted clearinghouse, to establish EDI with WellCare. For a list of WellCare contracted clearinghouses, refer to the *WellCare Resource Guides*, on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

A unique WellCare Payer ID was included in the Provider welcome letter from WellCare. This WellCare Payer ID must be used to identify WellCare on electronic claims submissions. For more information on WellCare Payer IDs or to contact WellCare's EDI team, refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

HIPAA Electronic Transactions and Code Sets

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

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 regarding EDI implementation with WellCare, please refer to the *Wellcare Companion Guides* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid/Claims.

Paper Claims Submissions

For timelier processing of claims, Providers are encouraged to submit electronically. Claims not submitted electronically may be subject to penalties if specified in the Provider Contract. For assistance in creating an EDI process, contact WellCare's EDI team by referring to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

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

- Paper claims must only be submitted on an original (red ink on white paper) claim form.
- Any missing, illegible, incomplete or invalid information in any field will cause the claim to be rejected or processed incorrectly.
- Per CMS guidelines, the following process should be used for Clean Claims submission:
 - The information must be aligned within the data fields and must be:



- On an original red ink on white paper claim forms;
- Typed. Do not print, handwrite or stamp any extraneous data on the form.
- In black ink;
- In a large, dark font such as PICA or ARIAL, and 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.

CMS Fact Sheet about UB-04

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837I-FormCMS-1450-ICN006926.pdf

CMS Fact Sheet about CMS-1500

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837P-CMS-1500.pdf

Claims Processing

Seventy-Two Hour Rule

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

Disclosure of Coding Edits

WellCare utilizes clinical coding software to perform industry standard claim validity checks in accordance with all applicable rules and regulations which have been set forth by CMS (such as the National Correct Coding Initiative (NCCI) and the *National Physician Fee Schedule Manuals*), the American Medical Association (AMA) and Specialty Societies. WellCare uses the claim editing software to assist in determining proper coding for Provider claim reimbursement. The review process includes sending batched claim files to the vendor where the vendor compares the claim components (e.g., service codes, place of service) to the payment policies adopted by WellCare after which the vendor recommends that the incorrectly coded services receive the post payment adjustment or denial. The outbound Explanation of Payment (EOP) contains the description explaining the edit applied to the claim line. The claim editing software programs may result in either a postpayment adjustment or a claim denial which states the reason for the denial or requests submission of medical records that relate to the



claim for WellCare review. Providers may request reconsideration of any adjustment or denial by submitting a request for reconsideration to WellCare as long as it follows the dispute timely filing guidelines. A reduction in payment or a denial 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 the Provider Contract. 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. Coordination of Benefits (COB) information can be submitted to WellCare by an EDI transaction with the COB data completed in the appropriate COB elements. Only paper submitters need to send a copy of the EOB. WellCare may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services to the extent permitted by applicable laws. Providers shall follow WellCare Policies and Procedures regarding subrogation activity.

If Medicaid does not have a price for codes included on a crossover claim because it is covered by Medicare but not Medicaid, the Medicare coinsurance and deductible will be paid.

Encounters Data

Overview

This section is intended to provide delegated vendors, Providers and independent physician associations (IPAs) with the necessary information to allow them to submit encounter data to WellCare. If encounter data does not meet the service level agreements for timeliness of submission, completeness or accuracy, the 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 Provider Contract, vendors and Providers should submit complete and accurate encounter files to WellCare as follows:

- Encounters submission will be weekly;
- Capitated entities will submit within 10 calendar days of service date; and
- Non-capitated entities will submit within 10 calendar days of the paid date.

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

Accurate Encounters Submission

All encounter transactions submitted via Direct Data Entry (DDE) or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines as per the state requirements. SNIP Levels 1 through 5 shall be maintained. Once WellCare receives a delegated vendor's or Provider's encounters, the encounters are loaded into WellCare's Encounters System and processed. The encounters are subjected to a series of SNIP editing to ensure that the encounter has all the required information and that the information is accurate.

For more information on Workgroup for Electronic Data Interchange (WEDI) SNIP Edits, refer to their *Transaction Compliance and Certification* white paper at www.wedi.org/knowledge-center/comment-letters-testimony/resources/2010/03/10/transaction-compliance-and-certification-white-paper-version-4.0.

For more information regarding submitting encounters electronically, please refer to the *WellCare Companion Guides* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid/Claims.

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

Encounters Submission Methods

Delegated vendors and Providers may submit encounters electronically, through WellCare's contracted clearinghouse(s), via DDE or using WellCare's Secure File Transfer Protocol (SFTP) 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.wellcare.com/Kentucky/Providers/Medicaid/Claims.

Because most clearinghouses can exchange data with one another, Providers should work with their existing clearinghouse, or a WellCare contracted clearinghouse, to establish EDI with WellCare. For a list of WellCare contracted clearinghouses, refer to the *WellCare Provider Resource Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

A unique WellCare Payer ID was included in the Provider welcome letter. This WellCare Payer ID must be used to identify WellCare on electronic claims submissions. For more information on the WellCare Payer IDs or to contact WellCare's EDI team, refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

Submitting Encounters Using Direct Data Entry (DDE)

Delegated vendors and Providers may submit their encounter information directly to WellCare using WellCare's DDE portal. The DDE tool can be found on the Provider



Portal at www.wellcare.com/Kentucky/Providers. For more information on free DDE options, refer to the *Provider Resource Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

Encounters Data Types

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

- Dental – 837D format;
- Professional – 837P format;
- Institutional – 837I format; and
- 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, void or replacement 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.
- Void Encounter – A void encounter is an encounter that directs WellCare/KY Medicaid to reverse payment of a Paid claim.
- Replacement Encounter – A replacement encounter is an encounter that directs WellCare/KY Medicaid to replace the previously accepted version of a claim with a new version of the claim.

Balance Billing

Providers shall accept payment from WellCare for Covered Services provided to WellCare Members in accordance with the reimbursement terms outlined in the Provider Contract. Payment made to Providers constitutes payment in full by WellCare for covered benefits, with the exception of Member expenses. For Covered Services, Providers shall not balance bill Members any amount in excess of the contracted amount in the Provider Contract. 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.

A Provider may provide a service to a recipient on a non-Medicaid basis if the recipient agrees to receive the service on a non-Medicaid basis before the service begins and the service is not a Medicaid-covered service.

Provider-Preventable Conditions

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

WellCare will not pay a Provider for a provider-preventable condition that meets the following criteria:

- A. Is identified in the State Medicaid plan;
- B. Has been found by the Kentucky Department for Medicaid Services, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
- C. Has a negative consequence for the Member;
- D. Is auditable; and
- E. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

All Providers are to report provider-preventable conditions associated with claims for payment or Member treatments for which payment would otherwise be made.

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

- A different procedure altogether;
- The correct procedure but on the wrong body part; or
- The correct procedure on the wrong patient.

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

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

Hold Harmless Dual-Eligible Members

Those dual-eligible Members whose Medicare Part A and B Member expenses are identified and paid for at the amounts provided for 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.

Claim Payment Appeals

The claims appeal process is designed to address claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes and non-covered codes, etc. Claim payment appeals must be submitted to WellCare in writing within 24 months of the date of denial of the EOP.

Documentation consists of:

- Date(s) of service;
- Member name;
- Member WellCare ID number and/or date of birth;
- Provider name;
- Provider Tax ID;
- Total billed charges;



- The Provider's statement explaining the reason for the appeal; and
- Supporting documentation when necessary (e.g., proof of timely filing, medical records).

To initiate the process, please mail documentation to the address or fax it to the fax number listed in the *Quick Reference Guide* located on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

In accordance with 907 KAR 17:035, if you receive an adverse final decision of a denial, in whole or in part, of a health service or claim for reimbursement related to this service, you may request an external independent third-party review. You may only do so after first completing an internal appeal process with WellCare of Kentucky.

You must submit your request for external independent third-party review within 60 days from the date of receipt of the final adverse decision notice. Please note that all Providers **must** exhaust all internal WellCare appeal rights prior to requesting an external independent review.

You may submit your request to WellCare of Kentucky via one of the following methods:

- 1) Email: kyexternalreview@wellcare.com
- 2) Fax: **1-800-509-8203**
- 3) Mail: WellCare Health Plans
Attention: External Independent Third-Party Review
13551 Triton Park Blvd. Suite 1800
Louisville, KY 40223

WellCare will confirm receipt of your request for external third-party review within five business days of receiving your request.

As required by 907 KAR 17:035, if you request an external third-party review, WellCare will forward to the Department for Medicaid Services all documentation submitted by you during the appeal or dispute process within 15 business days of receiving your request. No additional documentation will be allowed for consideration by the external independent third-party review.

Additionally, if WellCare's decision is upheld by the external independent third-party review, you have the right to request an administrative hearing in accordance with 907 KAR 17:040 within 30 calendar days of the Department's written notice. You must submit your request for administrative hearing to:

Cabinet for Health and Family Services
Department for Medicaid Services
Division of Program Quality and Outcomes
275 East Main Street, 6C-C
Frankfort, KY 40621

Corrected or Voided Claims

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



How to submit a corrected or voided claim electronically:

- Loop 2300 Segment CLM composite element CLM05-3 should be '7' or '8'— indicating to replace '7' or void '8'
- Loop 2300 Segment REF element REF01 should be 'F8' indicating the following number is the control number assigned to the original bill (original claim reference number)
- Loop 2300 Segment REF element REF02 should be 'the original claim number' – the control number assigned to the original bill (original claim reference number for the claim you are intended to replace.)
- Example: REF *F8* Wellcare Claim number here~

These codes are not intended for use for original claim submission or rejected claims.

PLEASE NOTE: A corrected claim submission will void and replace the previously processed claim. A new claim number will be issued. Please be sure to bill all claim lines within the corrected claim that were billed in the original claim.

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”

3a PAT. CNTL #	4 TYPE OF BILL		
3b MED. REC. #	117		
5 FED. TAX NO.	6 STATEMENT FROM	COVERS PERIOD	7 THROUGH

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

64 DOCUMENT CONTROL NUMBER
298370064

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

Example:

22. RESUBMISSION CODE	ORIGINAL REF. NO.
7 or 8	123456456

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

Please Note: If the Provider handwrites, stamps or types “Corrected Claim” on the claim form without entering the appropriate Frequency Code “7” or “8” along with the Original Reference Number as indicated above, the claim will be considered a first-time claim submission.

The Correction or Void Process involves two transactions:

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

The Payment Reversal for this process may generate a negative amount, which will be seen on a later EOP than the EOP that is sent 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 CPT-4 codes based on the place of treatment (Provider 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 methodologies. When multiple surgeries are performed in a single session, reimbursement for facility services will be 100 percent of the surgical group rate for the primary procedure and 50 percent of the surgical group rate for the secondary and/or tertiary procedures. The percentages apply when eligible multiple surgical procedures are performed under one continuous medical service, or when multiple surgical procedures are performed on the same day and by the same surgeon.
 - According to the *Ambulatory Surgical Centers Manual*, Transmittal #6 page 5.2, when multiple surgeries are performed in a single session, reimbursement for facility services will be 100 percent of the surgical group rate for the primary procedure and 50 percent of the surgical group rate for the secondary procedure.

- **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 and methodologies.
- **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 or her distinct operative work by adding the appropriate modifier to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier '62' added.

Modifier

If there are no reimbursement guidelines specific to a modifier(s) on the 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 Professionals.

Overpayment Recovery

WellCare strives for one-hundred percent (100%) 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 inappropriate coding, duplication of payments, non-authorized services, erroneous contract or fee schedule reimbursement, non-covered benefit(s) and other reasons.

WellCare will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, WellCare will adhere to Kentucky Regulatory Statute KRS 304.17A-708 and limit its notice of retroactive denial to twenty-four (24) months from the payment receipt date. However, no such time limit shall apply to overpayment recovery efforts which are based on a reasonable belief of fraud or other intentional misconduct, or abusive billing, required by, or initiated at the request of, a self-insured plan, or required by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or Members

In all cases, WellCare or its designee will provide a written notice to the Provider 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 sixty (60) days for the Provider to send in the refund, request further information or dispute the retroactive denial.



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

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

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

For more information on contacting WellCare Customer Service, refer to the *Quick Reference Guide* on the WellCare website at:
www.wellcare.com/Kentucky/Providers/Medicaid.

Benefits During Disaster and Catastrophic Events
Refer to the Provider Contract.

Section 6: Credentialing

Overview

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

This evaluation includes (as applicable to practitioner type):

- Background;
- Education;
- Postgraduate training;
- Certification(s);
- Experience;
- Work history and demonstrated ability;
- Patient admitting capabilities;
- Licensure, regulatory compliance and health status which may affect a practitioner’s ability to provide healthcare; 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/healthcare 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 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, the agency shall be required to meet WellCare’s criteria to ensure that the



credentialing capabilities of the delegated entity clearly meet federal and state accreditation (as applicable) and WellCare requirements.

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

Practitioner Rights

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

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

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

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

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

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

Right to Correct Erroneous Information and Receive Notification of the Process and Time Frame

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

WellCare's written notification to the practitioner includes:

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

- WellCare's review process.

Baseline Criteria

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

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

Kentucky Medicaid Eligibility – All affiliated Providers delivering Covered Services for WellCare must currently be enrolled and active as providers in the Kentucky Medicaid Program.

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

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

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

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

Ability to Participate in Medicaid 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. In order to participate with WellCare of Kentucky, a Provider must complete a Provider Contract and submit all necessary credentialing information and his or her Kentucky Medicaid Provider Number. Providers are not eligible for participation if the Provider owes money to the Medicaid Program or if the Office of the Attorney General has an active fraud investigation involving the Provider. Existing Providers who are sanctioned and thereby restricted from participation in any government program are subject to immediate termination in accordance with WellCare Policies and Procedures.

New Providers and Providers Not Participating in Medicaid – If a potential Provider has not obtained a Kentucky Medicaid Provider Number, WellCare can facilitate a KYMAP-811 Kentucky Medicaid Enrollment Application to enroll within the network. 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 Who Opt Out of Medicare – A Provider who opts out of Medicare is not eligible to become a participating Provider. An existing Provider who opts out of Medicare is not eligible to remain as a participating Provider for WellCare.

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

Liability Insurance

WellCare Providers (all disciplines) are required to carry and continue to maintain professional liability insurance in the minimum limits of \$1,000,000/\$3,000,000 per Provider, unless otherwise agreed by WellCare in writing.

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

Site Inspection Evaluation

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

- Office-site criteria:
 - Physical accessibility;
 - Physical appearance; and
 - Adequacy of waiting room and examination room space.
- Medical/treatment record-keeping criteria.

SIEs are conducted for:

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

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

Covering Providers

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

Allied Health Professionals

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

Dependent AHPs include the following, and are required to provide collaborative practice information to WellCare:

- APRN;
- Certified Nurse Midwife (CNM);
- 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 Healthcare 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 and accreditation requirements and WellCare Policies and Procedures, re-credentialing is required every three years. A notice will be sent by mail that contains a preprinted re-credentialing application and instructions 180 days before a Provider's three-year re-credentialing due date. Notwithstanding KRS 304.17A-576(3), WellCare will not make any Provider Contract effective before the date of the completion of credentialing.

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 monthly basis, WellCare or its designee accesses the listings from the Office of Inspector General (OIG) Medicare/Medicaid Sanctions (exclusions and reinstatements) Report, for the most current available information. This information is cross-checked against 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.

Termination of Providers

WellCare must terminate any Provider who:

- Engages in an activity that violates any law or regulation and results in suspension, termination or exclusion from the Medicare or Medicaid program;
- Has a license, certification or accreditation terminated, revoked or suspended;
- Has medical staff privileges at any hospital terminated, revoked or suspended; or
- Engages in behavior that is a danger to the health, safety or welfare of Members.

In such instances, WellCare is required to notify the Department of the reason(s) for the termination.

WellCare will notify any Member of a Provider's involuntary termination provided such Member has received a service from the terminated Provider within the previous six



months. Such notice shall be mailed within fifteen (15) days of the action taken if it is a PCP and within thirty (30) days for any other Provider. .

If a Provider terminates participation with WellCare, WellCare will notify any Member of the Provider's termination provided such Member has received a service from the terminating Provider within the previous six months. Such notice shall be mailed the later of the following: (i) thirty (30) days prior to the effective date of the termination or (ii) within fifteen (15) days of receiving notice.

WellCare may terminate from participation any Provider who materially breaches the Provider Contract and fails to timely and adequately cure such breach in accordance with the terms of the Provider Contract.

WellCare will notify any Member of the Provider's termination provided such Member has received a service from the terminating Provider within the previous six months. Such notice shall be mailed the later of the following: (i) within fifteen (15) days of providing notice or (ii) thirty (30) days prior to the effective date of the termination.

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

On a monthly basis, WellCare or its designee contacts state licensure agencies to obtain the most current available information on sanctioned Providers. This information is cross-checked against the network of WellCare Providers. If a network Provider is identified as being currently under sanction, appropriate action is taken in accordance with WellCare Policies and Procedures. 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 levels. All disputes in connection with the actions listed below are referred to as a first level Peer Review Panel consisting of at least three qualified individuals of whom at least one is a participating Provider and a clinical peer of the practitioner that filed the dispute.



The practitioner also has the right to consideration by a second level Peer Review Panel consisting of at least three qualified individuals. At least one individual on the Panel will be a participating Provider and a clinical peer of the practitioner who filed the dispute. The second level panel is comprised of individuals who were not involved in earlier decisions.

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

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

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

The practitioner has a period of up to 30 days from the date WellCare receives the notification return receipt back in the mail to file a written request via recorded or certified return-receipt mail to access the Dispute Resolution Peer Review Panel Process.

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

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

The Dispute Resolution Peer Review Panel shall consider and decide the case objectively and in good faith. The Medical Director, within five business days after final adjournment of the Dispute Resolution Peer Review Panel hearing, shall notify the practitioner of the results of the first level Panel hearing. In the event the findings are positive for the practitioner, the second level review shall be waived.

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

Within 10 calendar days of the request for a second level Peer Review Panel hearing, the Medical Director or his or her designee shall notify the practitioner of the date, time and access number for the second level Peer Review Panel hearing.



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

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

Delegated Entities

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

Section 7: Appeals and Grievances

Appeals Process

Provider

Provider Appeals Process

A Provider may request an appeal regarding payment or contractual issues on his or her own behalf by mailing, by the secure provider portal online, or faxing a letter of appeal and/or an appeal form with supporting documentation such as medical records to WellCare.

Providers have 60 calendar days from the original utilization management or claim denial to file an appeal. Appeals submitted after that time will be denied for untimely filing. If the Provider feels she or he filed the appeal within the appropriate time frame, the Provider may submit documentation showing proof of timely filing. The only acceptable proof of timely filing is fax confirmation, a registered postal receipt signed by a representative of WellCare or similar receipt from other commercial delivery services.

Upon receipt of all required documentation, WellCare has 30 calendar days to review the appeal for medical necessity and conformity to WellCare guidelines and to render a decision to reverse or affirm. If the appeal is not resolved within 30 days, WellCare may request a 14-day extension from the Provider. If the Provider requests the extension, the extension shall be approved by WellCare.

Appeals received without the necessary documentation may be denied for lack of information. It is the responsibility of the Provider to submit the requested documentation within 60 calendar days of the denial to reopen the case. Records and documents received after that time frame will not be reviewed and the appeal will remain closed.

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

Reversal of Denial

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

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

Affirmation of Denial

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

Independent External Third Party Review

In accordance with 907 KAR 17:035, if a Provider receives an adverse final decision of a denial, in whole or in part, of a health service [including a denial, in whole or in part, involving emergency services] or claim for reimbursement related to this service, the Provider may request an external independent third-party review. A Provider may only do so after first completing an internal appeal process with WellCare. A request for independent external third party review must be submitted to WellCare within sixty (60) days of receiving the final decision letter from WellCare.

Requests for independent external third party reviews may be submitted to WellCare via one of the following methods:

- 1) Email: kyexternalreview@wellcare.com
- 2) Fax: **1-800-509-8203**
- 3) Mail: WellCare Health Plans
Attention: External Independent Third-Party Review
13551 Triton Park Blvd. Suite 1800
Louisville, KY 40223

WellCare will confirm receipt of your request for external third-party review within five (5) business days of receiving your request.

As required by 907 KAR 17:035, if you request an external third-party review, WellCare will forward to the Department for Medicaid Services all documentation submitted by you during the appeal process within fifteen (15) business days of receiving your request. No additional documentation will be allowed for consideration by the external independent third-party review.

Additionally, if WellCare's decision is upheld by the external independent third-party review, Providers have the right to request an administrative hearing in accordance with 907 KAR 17:040 within thirty (30) calendar days of the Department's written notice. You must submit your request for administrative hearing to:

Cabinet for Health and Family Services
Department for Medicaid Services
Division of Program Quality and Outcomes
275 East Main Street, 6C-C
Frankfort, KY 40621

If the administrative hearing officer upholds WellCare's decision, the Provider must reimburse the Department for Medicaid Services in the amount of \$600.00 (per hearing) within thirty (30) days of the issuance of the final order.

Member Appeals Process

Overview

A Member appeal is a formal request from a Member for a review of an Adverse Benefit Determination taken by WellCare. An appeal may also be filed on the Member's behalf by an authorized representative or a Provider with the Member's written consent. All appeal rights described in *Section 7: Appeals and Grievances* of this Provider Manual that apply to Members will also apply to the Member's authorized representative or a Provider acting on behalf of the Member with the Member's written consent. Appeals received from Providers that are on the Member's behalf for denied services with requisite consent of the Member are deemed Member appeals. To appeal, the Member, or his or her representative, may file an appeal request either orally via WellCare's Customer Service or in writing within 60 calendar days of the date of the Adverse Benefit 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 10 calendar days of the oral filing. For oral filings, the time frames for resolution begin on the date the oral filing was received by WellCare. Unless written confirmation of a standard oral appeal request is received, the case is closed as an invalid appeal and a decision is not made on the appeal. This requirement does not apply to requests for expedited appeal requests.

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

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting or effectiveness of a covered benefit;
- 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 Kentucky Department for Medicaid Services;
- The failure of WellCare to complete the authorization request in a timely manner as defined in 42 CFR 438.408;
- 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; and
- The denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

If the Member's request for appeal is submitted after 60 calendar days, then good cause must be shown in order for WellCare to accept the late request. Examples of good cause include, but are not limited to, the following:

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



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

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

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

Types of Appeals

A Member may file for a standard pre-service (utilization management denial), retrospective or an expedited appeal determination.

Standard pre-service appeals are requests for services that the Member has not received and WellCare has determined are not Covered Services, are not medically necessary, or are otherwise outside of the Member's benefit plan. Pre-service appeals are utilization management denial types and Providers must have the Member's written consent to assist the Member through this process.

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

Only pre-service appeals may be expedited. Expedited pre-service appeals are considered Member appeals and Providers must have the Member's written consent to assist the Member through this process.

Appointment of Representative

If the Member wishes to use a representative, then she or 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.wellcare.com/Kentucky/Providers/Medicaid/Forms.

In accordance with 907 KAR 17:010 Section 4; A Provider shall not be an authorized representative of an enrollee without the enrollee's written consent for the specific action that is being appealed or that is the subject of a state fair hearing.

For authorized representative purposes, written consent unique to an appeal or state fair hearing shall be required for the appeal or state fair hearing.

A single written consent shall not qualify as written consent for more than one (1):

- a. Hospital admission;
- b. Physician or other Provider visit; or
- c. Treatment plan.



Appeal Decision Time Frames

WellCare must make a determination from the receipt of the request on a Member appeal and notify the appropriate party within the following time frames:

- Acknowledgment of Appeal: 5 Business Days
- Standard Pre-Service Request: **30 calendar days**
- Retrospective Request: **30 calendar days**
- Expedited Request: **72 hours**

If WellCare fails to resolve an appeal within 30 calendar days, the Member is deemed to have exhausted WellCare's internal appeal process and may initiate a State Fair Hearing.

The standard pre-service, expedited and retrospective determination periods noted above may be extended by up to 14 calendar days if the Member requests an extension or if WellCare justifies a need for additional information and documents how the extension is in the interest of the Member. If an extension is not requested by the Member, WellCare will provide the Member with written notice of the reason for the delay within two business days of the decision to extend the time frame. The Member will also be informed of the right to request a grievance if they disagree with the plans request to extend the appeal file.

Standard Pre-Service and Retrospective Appeals Process

A Member may file a standard pre-service or retrospective appeal determination. A Member may also present his or her appeal in person.

Standard Pre-Service or Retrospective Appeal Decisions

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

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

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

Expedited Appeals Process

To request an expedited appeal, a Member or a Provider (regardless of whether the provider is affiliated with WellCare) must submit an oral or written request directly to WellCare. A request to expedite an appeal determination will be considered in situations where applying the standard procedure could seriously jeopardize the Member's life,



health or ability to regain maximum function, including cases in which WellCare makes a less than fully favorable decision.

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

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

WellCare will provide the Member with prompt oral notification within 24 hours regarding the denial of an expedited request and will follow up with written notification to the Member within two calendar days which:

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

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

If WellCare overturns its initial action and/or the denial, it will issue an authorization to cover the requested service, and notify the Member orally within 72 hours of receipt of the expedited appeal request followed with written notification of the appeal decision.

Denial of an Expedited Appeal Request

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

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

State Fair Hearing for Members

A Member or his or her authorized representative may request a State Fair Hearing if he or she is dissatisfied with an action that has been taken by WellCare. The hearing request must be post marked within 120 calendar days from the date of the plan's final decision letter.

If the Member wishes to use a representative, she or 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.wellcare.com/Kentucky/Providers/Medicaid/Forms.



Please note that Members **must** exhaust all internal WellCare appeal rights prior to requesting a State Fair Hearing.

State Fair Hearings are not the appropriate forum for billing or payment disputes. For process of appeal of a claims payment or grievance, please see *Section 5: Claims*.

All documents supporting WellCare's action must be received by the Department no later than five days from the date WellCare receives notice from the Department that a State Fair Hearing request has been filed. These records shall be made available to the Member upon request by either the Member or the Member's authorized representative. 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 Adverse Benefit Determination or the Member requests a State Fair Hearing within 120 days from the date on WellCare's Notice of Adverse Benefit Determination;
- 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;
- The enrollee fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after the notice of an adverse resolution to the enrollee's appeal
- 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 been met.

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

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 the appealed services promptly, as expeditiously as the Member's health condition requires, but not later than 72 hours from the date that WellCare receives notice reversing the determination, if the services were not furnished while the appeal was pending and the State Fair Hearing results in a decision to reverse WellCare's decision to deny, limit, or delay services.

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

Grievance Process

Provider

Providers have the right to file a grievance no later than 30 calendar days from the date the Provider becomes aware of the issue generating the grievance. Written resolution will be provided to the Provider within 30 calendar days from the date the grievance is received by WellCare. If additional time is needed, WellCare shall orally request a 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.

WellCare will provide all Providers written notice of the Provider grievance procedures at the time they enter into contract. A Provider grievance is considered to be any Provider who is dissatisfied with WellCare's policies, procedures, administrative functions or any aspect of the plan.

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

Member

A Member or a Member's representative, including the legal guardian of a minor Member or incapacitated adult or a Provider acting on behalf of the Member with written consent, has the right to file a grievance request either orally or in writing within 30 calendar days of the date of the incident or when the Member was made aware of the incident. WellCare will acknowledge the Member or Member's representative grievance in writing within five business days from the date the grievance is received by WellCare. The acknowledgement letter will include:

- Name and telephone number of the Grievance Coordinator;
- The expected date of the grievance resolution; and
- A request for any additional information needed to investigate the issue.

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 hour; and/or
- Handicap accessibility.

Upon receipt of the grievance, a written resolution will be mailed to the Member within 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 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.

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, she or 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.wellcare.com/Kentucky/Providers/Medicaid/Forms.

Grievance Submission

An oral grievance request shall be filed through the established toll-free number to 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 at:

WellCare of Kentucky
 Attention: Grievance Department
 P.O. Box 436000
 Louisville, KY 40253

For the submission address, telephone and fax number, please refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

Within five (5) working days of receipt of a grievance, WellCare will provide the enrollee with written notice that the grievance has been received and the expected date of its resolution.

Grievance Resolution

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



An extension may be requested up to 14 calendar days by the Member's or the Member's representative. WellCare may also initiate an extension if it can justify the need for additional information and it is in the Member's best interest. In all cases, extensions must be well-documented. WellCare will provide the Member or the Member's representative written notification regarding WellCare's decision to extend the time frame within two working days with the decision to extend the time frame of the grievance resolution.

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 10 years following the final decision by WellCare, 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.

Section 8: Compliance

WellCare's 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 subcontractors and their employees, are required to comply with WellCare Compliance Program requirements.

International Classification of Diseases (ICD)

ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). WellCare utilizes ICD for diagnosis code validation and follows all CMS mandates for any future ICD changes, which includes ICD-10 or its successor.

All Providers must submit HIPAA compliant diagnoses codes ICD-10-CM. Please refer to the CMS website for more information about ICD-10 codes at www.cms.gov, and the ICD-10 Lookup Tool at www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx for specific codes.

Information on ICD-10 transition and codes can also be found at www.wellcare.com/kentucky/Providers/ICD10-Compliance.

WellCare's compliance training requirements include, but are not limited to:

- Compliance Program Training
 - To ensure policies, procedures and related compliance concerns are clearly understood and followed.
 - To provide a mechanism to report suspected violations and disciplinary actions to address violations.
- HIPAA Privacy and Security Training
 - To encompass privacy and security requirements in accordance with the federal standards established pursuant to HIPAA.
 - Must include, but is not limited to:
 - Uses and disclosures of PHI;
 - Member rights; and
 - Administrative, physical and technical safeguards.
- Fraud, Waste and Abuse (FWA) Training
 - Must include, but is not limited to:
 - Laws and regulations related to fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback Statute, HIPAA, etc.);
 - Obligations of the Provider, including Provider employees and Provider subcontractors and their employees, to have appropriate policies and procedures to address fraud, waste and abuse;

- Process for reporting suspected fraud, waste and abuse;
- Protections from retaliation for employees and subcontractors who report suspected fraud, waste and abuse; and
- Types of fraud, waste and abuse that can occur.
- Cultural Competency Training
 - Programs to educate and identify the diverse cultural and linguistic needs of the Members that 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 subcontractors, 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 subcontractors, or by WellCare Members. Reports may be made anonymously through the WellCare fraud hotline at **1-866-678-8355**.

Details of the Corporate Ethics and Compliance Program may be found on WellCare's website at www.wellcare.com/Kentucky/Corporate/Compliance.

Code of Conduct and Business Ethics

Overview

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

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

Fraud, Waste and Abuse

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

Federal and state regulatory agencies, law enforcement and WellCare vigorously investigate incidents of suspected FWA. Providers are cautioned that unbundling,

fragmenting, up-coding and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD-CM), Physicians' Current Procedural Terminology (CPT) Health Care Common Procedure Coding System, (HCPCS) and/or *Universal Billing Revenue Coding Manual* as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

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

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

To report suspected fraud and abuse, please refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid or call WellCare's confidential and toll-free compliance hotline. Details of the Corporate Ethics and Compliance Program, and how to contact the WellCare fraud hotline, may be found on WellCare's website at www.wellcare.com/Kentucky/Corporate/Compliance.

Confidentiality of Member Information and Release of Records

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

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

Some examples of confidential information include:

- 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 AIDS or HIV testing that is protected under federal or state law.

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

Disclosure of WellCare Information to WellCare Members

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

For more information on how to request this information, Members may contact WellCare's Customer Service Department using the toll-free telephone number found on the Member's ID card. Providers may contact WellCare's Customer Service Department by referring to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

Provider Education and Outreach

Providers may:

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

Providers are prohibited from:

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

All subcontractors and Providers must submit any marketing or information materials which refer to WellCare by name to WellCare for approval prior to disseminating the materials.

Section 9: Delegated Entities

Overview

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

WellCare oversees the provision of services provided by the Delegated Entity and/or sub-delegate, and is accountable to federal and state agencies for the performance of all delegated functions. It is the 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.

Delegation Oversight Process

WellCare's Delegation Oversight Committee (DOC) was formed to be the governing body for the delegation oversight process, which provides oversight of subcontracted vendors where specific services are delegated. WellCare defines a "delegated entity" as a subcontractor which performs a core function under one of WellCare's government contracts. The Delegation Oversight Committee is chaired by the Sr. Director, Corporate Compliance Oversight. The committee members include appointed representatives from the following areas: Corporate Compliance, Legal, Shared Services Operations, Clinical Services Organization, and market representatives from each Regional Area. The Chief Compliance Officer has ultimate authority as to the composition of the Delegation Oversight Committee membership. The Delegation Oversight Committee will hold monthly meetings or more frequently as circumstances dictate.

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

WellCare monitors compliance through the delegation oversight process and the Delegation Oversight Committee by:

- Validating the eligibility of proposed and existing Delegated Entities for participation in the Medicaid and Medicare programs
- Conducting pre-delegation audits and reviewing the results to evaluate the prospective entity's ability to perform the delegated function
- Providing guidance on written agreement standards with Delegated Entities to clearly define and describe the delegated activities, responsibilities, and required regulatory reports to be provided by the entity
- Conducting ongoing monitoring activities to evaluate an entity's performance and compliance with regulatory requirements and accreditation standards
- Conducting annual audits to verify the entity's performance and processes support sustained compliance with regulatory requirements and accreditation standards.
- The development and implementation of Corrective Action Plans (CAPs) if the Delegated Entity's performance is substandard or terms of the agreement are violated



- Review and initiate recommendations to Senior Management and the Chief Compliance Officer for the revocation and/or termination of those entities not performing to the expectations of the current contractual agreement and regulatory requirements
- Track and trend compliance with oversight standards, entity performance, and outcomes

Section 10: Behavioral Health

Overview

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

Authorization Requests

Behavioral Health inpatient and residential services can be requested by calling our Pre-Certification Team. Providers requesting after-hours authorization for these admissions should refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid or call **1-855-620-1861** to contact an after-hours Care Manager.

Requests for other services can be requested using WellCare's standardized authorization request forms to ensure receipt of all pertinent information and enable a timely response to Provider requests. *Behavioral Health Request Forms* can be found on WellCare's Provider Website.

Providers may also submit authorization requests using the universal Prior Authorization form available on the WellCare website.

Prior Authorization

Services requiring Prior Authorization must be authorized prior to the service being rendered. Please remember to consult the authorization look-up tool on the Provider portal and obtain appropriate Prior Authorization. Failure to obtain Prior Authorization where required may result in denial of the claim.

Requests for Prior Authorization may be submitted up to 14 business days prior to the planned admission or procedure. Once a procedure is approved, the approval is valid for up to 90 days from the date of issuance.

After-Hours Utilization Management

WellCare Behavioral Health provides authorization of inpatient admissions 24 hours a day, seven days a week. Providers requesting after-hours authorization for inpatient admission should refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid or call **1-855-620-1861** to contact an after-hours Care Manager.

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 guidelines for assessing level of care criteria. In addition, WellCare utilizes Level of Care Utilization System (LOCUS); for children: Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children: Early Childhood Service Intensity Instrument (ECSII); and for substance use: American Society of Addiction Medicine (ASAM).

For complete information regarding benefits, exclusions and authorization requirements, or if a Provider needs to contact WellCare's Provider Services for a referral to a



behavioral health Provider, please refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

Responsibilities of Behavioral Health Providers

WellCare monitors Providers against the standards below to ensure Members can obtain needed health services within the acceptable appointments waiting times. The provisions below are applicable only to behavioral health Providers and do not replace the provisions set forth in *Section 2: Provider and Member Administrative Guidelines* for medical Providers. Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare.

Type of Appointment	Access Standard
Behavioral Health Provider – Non-Life-Threatening Emergency	< 6 hours
Behavioral Health Provider – Crisis Stabilization	< 24 hours
Behavioral Health Provider – Urgent	< 48 hours
Behavioral Health Provider – Post Inpatient Psychiatric Discharge	< 7 days
Behavioral Health Provider – Regular Appointments	< 30 days
Behavioral Health Provider – Other Referrals	< 30 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 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 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. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and forty-eight (48) hours for urgent care. Members also have access to a toll-free behavioral crisis hotline that is staffed 24 hours a day. The behavioral crisis phone number is printed on the Member's ID card and is available on WellCare's website.

Discharge Planning

Discharge planning begins upon admission and is designed for early identification of psychiatric, psychosocial and/or medical issues that will need post-hospital intervention. The Behavioral Health Care Manager works with the Provider's utilization reviewer to identify the Member's issues and needs, and makes appropriate referrals to Field Case Management, or Discharge Coordinators, as appropriate to coordinate care and post-discharge services and to facilitate a smooth transfer of the Member to the appropriate level of care.

Readmission

If a Member is readmitted to the hospital after being discharged from a psychiatric stay for the same or related problem within 24 hours of discharge for the same diagnosis, it is considered the same admission.

Medication

Behavioral Health service Providers must assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.

For information about WellCare's Care Management and Disease Management Programs, including how to refer a Member to these services, please see *Section 4: Utilization Management (UM), Care Management (CM) and Disease Management (DM)*.

All Behavioral Health services shall be provided in conformance with the access standards established by the Department of Medicaid Services. When assessing Members for Behavioral Health services, the plan and its Providers shall use the most current version of DSM classification. The plan may require use of other diagnostic and assessment instrument/outcome measures in addition to the most current version of DMS. Providers shall document DSM diagnosis and assessment/outcome information in the Member's medical record.

Continuity and Coordination of Care Between Medical and Behavioral Health Care

WellCare will work with PCPs to ensure appropriate screening and evaluation procedures for the detection and treatment of or referral for any known or suspected behavioral health problems. PCPs may provide any clinically appropriate Behavioral Health services within the scope of their practice. Conversely, behavioral health Providers may provide physical healthcare services if and when they are licensed to do so within the scope of their practice. However, if they are unable to treat the Member's physical health, behavioral health Providers should refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent.

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. This requirement shall be specified in all SBIRTs. Communication with the PCP should occur more frequently if clinically indicated. WellCare encourages behavioral health Providers to pay particular attention to communicating with PCPs at the time of discharge from an inpatient hospitalization (WellCare recommends faxing the discharge instruction sheet, or a letter summarizing the hospital stay, to the PCP). Please send this communication, with the properly signed consent, to the Member's identified PCP noting any changes in the treatment plan on the day of discharge.

WellCare strongly encourages 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 its 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. WellCare encourages its Providers to participate by providing feedback and input to the advisory council. Information regarding the advisory council will be made available on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid/Behavioral-Health.

Section 11: Pharmacy

Overview

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

- Preferred Drug List (PDL);
- Mandatory Generic Policy;
- Step Therapy;
- Quantity Limit;
- Age Limit;
- Pharmacy Lock-In Program;
- Coverage Determination Review Process;
- Network Improvement Program (NIP); and
- Exactus™ Pharmacy Solutions.

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

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

Pursuant to Section 1903(i) of the Social Security Act, all handwritten or computer generated/printed Medicaid prescriptions shall require one or more approved industry-recognized tamper-resistant features to prevent all three (3) of the following:

1. Copying of a completed or blank prescription form;
2. Erasure or modification of information written on the prescription pad by the prescriber; AND
3. Use of counterfeit prescription forms.

This requirement does not pertain to prescriptions received by fax, telephone, or electronically.

To contact WellCare's Pharmacy Department, please refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

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 selects drugs based on the drug's efficacy, safety, side effects, pharmacokinetics, clinical literature and cost-effectiveness profile. The P&T shall meet in Kentucky periodically throughout the calendar year as necessary and make recommendations to WellCare for changes to the PDL. 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 is on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid/Pharmacy and also available in hard copy upon request. Any changes to the list of pharmaceuticals and applicable pharmaceutical management procedures are communicated to Providers via the following:

- Quarterly updates in Provider and Member newsletters;
- Website updates; and/or
- Pharmacy and Provider communications that detail any major changes to a particular therapy or therapeutic class.

Additions to the Preferred Drug List

To request consideration for the addition of a drug to WellCare's PDL, Providers may write or fax WellCare, explaining the medical justification. For contact information, refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

For more information on requesting exceptions, refer to the *Coverage Determination Review Process* below.

Generic Medications

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

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

For more information on the Coverage Determination Review Process, including how to access the *Coverage Determination Request Form*, see Coverage Determination Review Process below.

Step Therapy

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

Step therapy programs are a safe and effective method of reducing the cost of treatment by ensuring that an adequate trial of a proven, safe and cost-effective therapy is attempted before progressing to a more costly option. First-line medications are recognized as safe, effective and economically sound treatments. The first-line

medications on WellCare's PDL have been evaluated through the use of clinical literature and are approved by WellCare's P&T Committee.

Medications requiring step therapy are identified on the PDL.

Quantity Limits

Quantity limits are used to ensure that pharmaceuticals are supplied in a quantity consistent with the Food and Drug Administration (FDA)-approved dosing guidelines. Quantity limits are also used to help prevent billing errors.

The PDL identifies medications with quantity limits.

Age Limits

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

The PDL identifies medications with age limits.

Pharmacy Lock-In Program

Members identified as overutilizing drugs in certain therapeutic classes, receiving duplicative therapy from multiple physicians or frequently visiting the Emergency Room seeking pain medication will be placed in Pharmacy Lock-in (Lock-in) status for a minimum of one year. While in Lock-in, the Member will be restricted to one prescribing physician and one 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 for Care Management. The Care Management team will work with the Member to create an individualized Care Plan. Care managers provide monitoring, education, communication and collaboration, and can assist with access to alternative treatments to improve a Member's health. For questions or concerns regarding the Lock-in program, Members or Providers may call **1-877-389-9457**, Monday–Friday, 7 a.m. to 7 p.m. EST. TTY/TDD users may call 711.

Coverage Determination Review Process

The goal of the Coverage Determination Review Program (also known as Prior Authorization) is to ensure that medication regimens that are high-risk, have high potential for misuse or have narrow therapeutic indices are used appropriately and according to FDA-approved indications. The program also ensures there is no undue disruption of a Member's access to care and prevents the penalization of the Provider or the Member, financially or otherwise, for Prior Authorization requests or approvals. The Coverage Determination Review Process is required for:

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

WellCare's Coverage Determination Review Program also ensures that:

- Clinical review criteria is aligned with FDA approved indications, best clinical practice standards, and/or other national standards
- A physician peer review shall be available upon a Provider's request for any denial
- Determinations including those from escalated reviews shall be made and communicated to the requesting Provider within twenty-four (24) hours from the initial request including weekends in compliance with the provisions of OBRA 1990 mandate, Section 1927 of the Social Security Act, and other federal regulations
- In the event a prescription is for a drug awaiting authorization and the pharmacy cannot reach the prescribing physician, and when the dispensing pharmacist using reasonable clinical judgment deems it necessary to avoid imminent harm or injury to the Member, a seventy-two (72) hour emergency supply shall be provided. If the physician prescribed an amount of drug that is less than a seventy-two (72) hour supply but is packaged so that it must be dispensed intact, the pharmacist may dispense the packaged drug and Contractor shall pay for this quantity even if it exceeds a calculated seventy-two (72) hour supply.

Providers may request an exception to WellCare's PDL orally or in writing. For written requests, Providers should complete a *Coverage Determination Request Form*, supplying pertinent Member medical history and information. A *Coverage Determination Request Form* may be accessed on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid/Forms.

To submit a request, orally or in writing, refer to the contact information listed on the Provider *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid. Upon receipt of the *Coverage Determination Request Form*, a decision is completed within 24 hours. If authorization cannot be approved or denied, and the drug is medically necessary, a seven day emergency supply of the non-preferred drug can be supplied to the Member.

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

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 Coverage Determination Request Review using the *Injectable Infusion Form*.

Approved self-injectable and infusion drugs are covered when supplied by retail pharmacies and infusion vendors contracted with WellCare. Please contact the Pharmacy Department regarding criteria related to specific drugs. The *Injectable Infusion Form* is on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid/Forms.

Medication Appeals

To request an appeal of a Coverage Determination Review decision, contact the Pharmacy Appeals Department via fax, mail, in person or by phone at **1-877-389-9457**. Refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

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

Coverage Limitations

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

- Agents used for anorexia, weight gain or weight loss;
- Agents used to promote fertility;
- Agents used for cosmetic purposes or hair growth;
- Drugs for the treatment of erectile dysfunction;
- DESI drugs or drugs that may have been determined to be identical, similar or related;
- Multivitamins with fluoride (with or without iron) for Members over age 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.

Over-the-Counter 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 (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 on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid/Pharmacy.



In addition to OTC products listed on the PDL, each household, on a monthly basis, is entitled to order \$10 worth of products from the over-the-counter catalog free of charge. Directions for ordering and catalog are available at:

www.wellcare.com/en/Kentucky/Members/Medicaid-Plans/WellCare-of-Kentucky/Benefits.

Member Co-Payments

- \$1 for generic drugs
- \$1 for brand name drugs that do not have generic versions
- \$4 for brand name drugs
- \$1 for brand name drug preferred over generic drug
- \$1 for pharmacy product class: certain antipsychotic drugs
- \$0 for pharmacy product class: contraceptives for family planning
- \$0 for pharmacy product class: tobacco cessation
- \$0 for pharmacy product class: diabetes supplies, blood glucose meters
- \$4 for first fill, \$0 for second fill and beyond, per day for pharmacy product class: diabetes supplies, all other covered diabetic supplies
- \$3 for specialty visits (Chiropractor, Dental, Vision, Podiatry)
- \$3 for therapy services (Physical therapy, Speech therapy, Occupational therapy)
- \$3 for office visits with a Physician
- \$3 for office visits with a Physician Assistant, APRN, Certified Pediatric and Family Nurse Practitioner, or Nurse Midwife
- \$3 for office visits for behavioral health care
- \$3 office to a Rural Health Clinic
- \$3 office visit to a Federally Qualified Health Center or a Federally Qualified Health Center look-alike
- \$3 office visits to a Primary Care Center
- \$3 for laboratory, diagnostic, or x-ray service
- \$4 for outpatient hospital service
- \$4 for durable medical equipment
- \$4 for outpatient surgery (ambulatory surgical center)
- \$8 for an emergency room visit for a non-emergency service
- \$50 for inpatient services (hospital admission or mental health/substance abuse admission)

Exemptions may apply, but are not limited, to foster children, a Medicaid or KCHIP beneficiary who is younger than 19 years of age, Members receiving hospice care, pregnant women, and beneficiaries who have reached their cost share limit for the quarter.

Pharmacy Management – Network Improvement Program

The Pharmacy Network Improvement Program (NIP) is designed to provide physicians with quarterly utilization reports to identify overutilization and underutilization of pharmaceutical products. The reports will also identify opportunities for optimizing best practices guidelines and cost-effective therapeutic options. These reports are delivered by the State Pharmacy Director and/or Clinical Pharmacy Manager to physicians identified for the program.

**Member Pharmacy Access**

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

For areas where there are no pharmacies open 24 hours a day, Members may call the PBM (Pharmacy Benefit Manager) for information on how to access pharmacy services. Contact information is also located on the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid.

Exactus™ Pharmacy Solutions

WellCare offers Specialty Pharmacy services to Members who are taking medications to treat long-term, life-threatening or rare conditions. The Exactus Pharmacy Solutions teams are experts in the special handling, storage and administration that injectables, infusibles, orals and other medications require. This team knows the insurance process and the Member's plan benefits. This means less chance of delays in a Member receiving their needed medication(s). Prescription orders generally ship directly to the Member's home, Provider's office or alternative address provided by the Member within 24 to 48 hours after contacting an Exactus Pharmacy Solutions representative. The actual ship date depends on whether or not Provider discussion is needed about the prescription.

To learn more about the conditions covered under Exactus Pharmacy Solutions, or how to contact them, refer to WellCare's website at www.wellcare.com/Kentucky/Providers/Medicaid/Pharmacy.

Section 12: Definitions and Abbreviations

Definitions

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

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

“Adverse Benefit Determination” means, as defined in 42 CFR 438.400(b), the

- A. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit;
- B. Reduction, suspension, or termination of a service previously authorized by the Department, its agent or WellCare;
- 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 WellCare or a Prepaid Health Insurance Plan (PHIP) to act within the time frames required by 42 CFR 438.408(b);
- 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 WellCare’s network; or
- G. Denial of an enrollee’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

“Appeal” means a request for review of an Adverse Benefit Determination or a decision by or on behalf of WellCare related to the Covered Services services provided, or the payment for the service.

“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 radiology, laboratory, dental, vision or hearing services.

“Centers for Medicare & Medicaid Services (CMS)” means the 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 payer liability, and ensure timely processing and payment by WellCare. A Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

"CLIA" 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 healthcare, diagnostic services, preventive services, rehabilitative services, treatment and other measures described in 42 USC Section 1396d(a) to all Members under the age of 21.

"EPSDT Special Services" means medically necessary health care, diagnostic services, treatment, and other measure described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses, and conditions identified by EPSDT screening services, whether or not such services are covered under the State Medicaid Plan.

"Emergency Medical Condition" means

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



“Emergency Services” or **“Emergency Care”** means covered inpatient and outpatient services that are as follows: (1) furnished by a Provider that is qualified to furnish these services; and (2) needed to evaluate or stabilize an emergency medical condition.

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

“Grievance” means the definition established in 42 C.F.R. 438.400.

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

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

“Members with Special Healthcare Needs” means Members with special needs 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 time frames for screenings within the Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) Program.

“PCP” or **“Primary Care Provider”** means a licensed or certified healthcare 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 24 hours a day, seven days a week primary



healthcare services to individuals, and for a Member who has a gynecological or obstetrical healthcare 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 any person (including physicians or other healthcare professionals), partnership, professional association, corporation, facility, hospital, or institution certified, licensed, or registered by the State of Kentucky to provide healthcare services that has contracted with WellCare to provide healthcare services to Members.

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

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

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

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

Abbreviations

AAP – American Academy of Pediatrics
 ABD – Aged, Blind or Disabled
 ACIP – Advisory Committee on Immunization Practices
 ACS – American College of Surgeons
 Agreement – Provider Contract
 AHP – Allied Health Professionals
 AIDS – Acquired Immune Deficiency Syndrome
 AMA – American Medical Association
 AOR – Appointment of Representative
 APRN – Advanced Practice Registered Nurse
 ASC – Ambulatory Surgical Centers
 CAD – Coronary Artery Disease
 CAP – Corrective Action Plan
 CHF – Congestive Heart Failure
 CHIP – Children’s Health Insurance Plan

CLAS – Culturally and Linguistically Appropriate Services
 CLIA – Clinical Laboratory Improvement Amendment
 CM – Case Management
 CMHC – Community Mental Health Center
 CMS – Centers for Medicare & Medicaid Services
 CNM – Certified Nurse Midwife
 COPD – Chronic Obstructive Pulmonary Disease
 CPT-4 – *Physician’s Current Procedural Terminology, 4th Edition*
 DDE – Direct Data Entry
 DEA – Drug Enforcement Administration
 Department – Kentucky Cabinet for Health and Family Services, Department for
 Medicaid Services
 DHHS – United States Department of Health and Human Services
 DM – Disease Management
 DME – Durable Medical Equipment
 DOC – Delegation Oversight Committee
 DSM– *Diagnostic and Statistical Manual of Mental Disorders*
 EDI – Electronic Data Interchange
 EOB – Explanation of Benefits
 EOP – Explanation of Payment
 EPSDT – Early and Periodic Screening, Diagnosis, and Treatment
 ER – Emergency Room
 ESRD – End Stage Renal Disease
 FDA – Food and Drug Administration
 FQHC– Federally Qualified Health Center
 FWA – Fraud, Waste and Abuse
 HCPCS – Healthcare Common Procedure Coding System
 HEDIS® – Healthcare Effectiveness Data and Information Set
 HIPAA – Health Insurance Portability and Accountability Act of 1996
 HIV – Human Immunodeficiency Virus
 HMO – Health Maintenance Organization
 HRA – Health Risk Assessment
 ICD-10-CM – *International Classification of Diseases, 10th Revision, Clinical Modification*
 ICD-10-PCS – *International Classification of Diseases, 10th Revision, Procedure Coding System*

IEP – Individualized Education Plan
IPAs – Independent Physician Associations
ISHCN – Individuals with Special Health Care Needs
IVR – Interactive Voice Response system
JNC – Joint National Committee
KCHIP – Kentucky Children’s Health Insurance Program
LTAC – Long-Term Acute Care
MCO – Managed Care Organization
NCCI – National Correct Coding Initiative
NCQA® – National Committee for Quality Assurance
NDC – National Drug Codes
NIH – National Institutes of Health
NIP – Network Improvement Program
NPI – National Provider Identifier
NPP – Notice of Privacy Practices
OA – Osteopathic Assistant
OB – Obstetrical/Obstetrician
OB-GYN – Obstetrician/Gynecologist
OIG – Office of Inspector General
OT – Occupational Therapy
OTC – Over-the-Counter
P&T Committee – Pharmaceutical and Therapeutics Committee
PA – Physician Assistant
PCC – Primary Care Clinic
PCP – Primary Care Provider
PDL – Preferred Drug List
PHI – Protected Health Information
PPC – Provider Preventable Condition
Provider ID – Provider Identification
PRTF – Psychiatric Residential Treatment Facility
PT – Physical Therapy
QI Program – Quality Improvement Program
RHC – Rural Health Clinic
SCM – Short-Term Case Management



SFTP – Secure File Transfer Protocol
SIE – Site Inspection Evaluations
SNF – Skilled Nursing Facility
SNIP – Strategic National Implementation Process
SSI – Supplemental Security Income
SSN – Social Security Number
ST – Speech Therapy
TB – Tuberculosis
TIN/Tax ID – Tax Identification Number
TTY – Telephone Typewriter
UM – Utilization Management
VFC – Vaccines for Children
WEDI – Workgroup for Electronic Data Interchange
WIC – Women, Infants and Children Program



Section 13: WellCare Resources

WellCare of Kentucky Homepage
<https://www.wellcare.com/kentucky>

Provider Manual and Other Provider Resources
www.wellcare.com/Kentucky/Providers/Medicaid

Forms and Documents
<https://www.wellcare.com/Kentucky/Providers/Medicaid/Forms>

Quick Reference Guide
www.wellcare.com/Kentucky/Providers/Medicaid

Clinical Practice Guidelines
www.wellcare.com/Kentucky/Providers/Clinical-Guidelines/CPGs

Clinical Coverage Guidelines
www.wellcare.com/Kentucky/Providers/Clinical-Guidelines/CCGs

Job Aids and Resource Guides
www.wellcare.com/Kentucky/Providers/Medicaid

Claims Updates
www.wellcare.com/Kentucky/Providers/Medicaid/Claims

Pharmacy
www.wellcare.com/Kentucky/Providers/Medicaid/Pharmacy

Quality
www.wellcare.com/Kentucky/Providers/Medicaid/Quality

Behavioral Health
www.wellcare.com/Kentucky/Providers/Medicaid/Behavioral-Health



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Quality care is a team effort.
Thank you for playing a starring role!

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