2016

HEALTH INSURANCE EXCHANGE PROVIDER MANUAL

KENTUCKY

WellCare® Health Plans

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Section 1: Welcome to WellCare

WellCare Health Plans, Inc. ("WellCare") provides managed care services focused on commercial Health Insurance Exchanges and government contracts such as Medicare Advantage, Medicaid and Children's Health Insurance Programs (CHIP), including prescription drug plans and health plans for families and individuals. WellCare's corporate office is located in Tampa, Florida. WellCare serves approximately 3.8 million Members as of September 30, 2015. WellCare's experience and commitment to these programs enable it 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 health care programs in partnership with the Members, Providers and communities it serves. WellCare will:

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

WellCare's core values include:

- *Partnership* –Members are the reason WellCare is in business; Providers are 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.
- *Teamwork* – With its fellow associates, WellCare can expect and is expected to demonstrate a collaborative approach in the way we work.

Purpose of this Manual

This Manual is designed for Providers who have contracted with WellCare to deliver quality health care services to its Members enrolled in a Kentucky Health Insurance Exchange Benefit Plan in the individual market.

This Manual serves as a guide to Providers and their staff to comply with the policies and procedures governing the administration of WellCare's Kentucky Health Insurance Exchange Benefit Plan and is an extension of, and supplements, the participating Provider agreement (the "Agreement") the Provider entered into with WellCare. This Provider Manual is available on WellCare's website at **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace**. A paper copy is available at no charge to Providers upon request.

In accordance with the Provider Agreement, participating Providers must abide by all applicable provisions of this Manual, and it may be modified from time to time. WellCare may change this Manual to reflect changes in its policies and procedures. All material changes shall become binding 30 days after WellCare's written notice to the Provider. If a change to the Provider Manual is to an existing prior authorization, precertification, notification, or Referral program, WellCare will provide the Provider with notice of the change at least 15 days in advance.

WellCare will notify the Provider of changes to this Manual in the form of Provider Bulletins or Manual updates, which shall be sent by mail, facsimile or other electronic means. WellCare may release Provider Bulletins that are state-specific and may override the policies and procedures in this Manual for Kentucky.

WellCare's Products

WellCare's products are designed to offer enhanced benefits to its Members as well as cost-sharing alternatives. WellCare's products are offered in selected markets to allow flexibility and offer a distinct set of benefits to fit Members' needs in each area. Providers may refer to the website at **www.wellcareplans.com** for more information.

In-Network Services

All services must be provided within the WellCare network, unless: (1) a Member needs emergency services, (2) a Member needs urgent care services out of WellCare's service area, or (3) such service is not available in network. Some services require prior authorization by WellCare or its designee.

Provider Services

Providers may contact the appropriate departments at WellCare by referring to the state-specific *Quick Reference Guide* on WellCare's website at **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace.** In addition, WellCare's Provider Relations representatives are available to assist Providers. Providers may contact their local market office for assistance.

Website Resources

WellCare's websites, **www.wellcare.com/Kentucky** and **www.wellcare.com**, offer a variety of tools to assist providers and their staffs. Available resources include:

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

Secure Provider Portal – Benefits of Registering

WellCare's secure online Provider Portal offers immediate access to an assortment of useful tools. Providers can create unlimited individual sub-accounts for staff Members allowing for separate billing and medical accounts.

All Providers who create a login and password using their Provider Identification (Provider ID) number have access to the following features:

- *Claims Submission Status and Inquiry*. Submit a new Claim, check the status of an existing Claim, and customize and download reports.
- *Member Eligibility and Cost-Sharing Information*. Verify Member eligibility and obtain specific cost-sharing information.
- *Prior Authorization Requests*. Submit prior authorization requests, attach clinical documentation and check authorization status. Providers can also print and/or save copies of authorization forms.
- *Pharmacy Services and Utilization*. View and download a copy of the Formulary, see drug recalls, access pharmacy utilization reports and obtain information about WellCare's pharmacy services.
- *Training*. Take required training courses and complete attestations online.
- *Reports*. Access reports such as active Members, authorization status, Claims status, eligibility status, pharmacy utilization and more.
- *Provider News*. View the latest important announcements and updates.
- *Personal Inbox*. Receive notices and key reports regarding the Provider's Claims, eligibility inquiries and prior authorization requests.

How to Register

To register, Providers should visit **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace**. For additional details, Providers may refer to the *Provider Resource Guide* found at **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace.** For more information about WellCare's Web capabilities, Providers may contact Provider Services or their Provider Relations representative.

Additional Resources

The *Resource Guide* contains information about WellCare's secure online Provider Portal, Member eligibility, prior authorizations, filing Claims, Appeals and more. For more specific instructions on how to complete day-to-day administrative tasks, Providers can find the *Resource Guide* on WellCare's website at **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace.**

Another valuable resource is the *Quick Reference Guide,* which contains important addresses, phone and fax numbers and prior authorization requirements. State-specific *Quick Reference Guides* can be found at **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace.**

Section 2: Provider and Member Administrative Guidelines

Provider Administrative Guidelines

Overview

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

- Meet the requirements of all applicable state and federal laws and regulations, including without limitation, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act and the Rehabilitation Act of 1973;
- 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;
- Maintain accurate medical Records and adhere to all WellCare policies governing the content and confidentiality of medical Records as outlined in *Section 3: Quality Improvement* and *Section 8: Compliance*;
- Provide Covered Services in a manner consistent with professionally recognized standards of health care;
- Use physician extenders appropriately.
    - Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNPs) should provide direct Member care within the scope of practice established by state rules and regulations and WellCare guidelines;
    - Assume full responsibility to the fullest extent permitted by law when supervising PAs and ARNPs, whose scope of practice should not extend beyond statutory limitations;
    - Honor, at all times, any Member request to be seen by a physician rather than a physician extender;
- Clearly identify their title (examples: M.D., D.O., ARNP, PA) to Members and to other health care professionals;
- Administer treatment for any Member in need of health care services they provide within the scope of the Provider's practice and subject to the Provider's professional judgment;
- Respond within the identified time frame to WellCare's requests for medical Records in order to comply with regulatory requirements;
- Allow WellCare to use Provider performance data for quality improvement activities;
- Ensure that:
    - All employed physicians and other health care practitioners and Providers comply with the terms and conditions of the Agreement;
    - Any written agreements with employed physicians and other health care practitioners and Providers contain provisions similar to the Agreement; and
    - The Provider maintains written agreements with all contracted physicians or other health care practitioners and Providers, which contain provisions similar to the Agreement;
- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene;
- Communicate timely clinical information between Providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical

information to WellCare, the Member or the requesting party at no charge, unless otherwise agreed;

- Preserve Member dignity and observe the rights of Members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimens;
- Not discriminate in any manner between WellCare Members and non-WellCare patients;
- Ensure that the hours of operation offered to WellCare Members are no less than those offered to other patients;
- Not deny, limit or condition the furnishing of treatment to any WellCare Member on the basis of any factor that is related to health status including, but not limited to, the following:
    - Medical condition, including mental and physical illness;
    - Claims experience;
    - Receipt of health care;
    - 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 domestic violence, smoking cessation or substance abuse. If indicated, Providers must refer Members to WellCare-sponsored or community-based programs; and
- Document the Referral to WellCare-sponsored or community-based programs in the Member's medical Record and provide the appropriate follow-up to ensure the Member accessed the services.

Responsibilities of All Providers

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

Member Cost Sharing

The Provider is responsible for collecting Member Cost Sharing. If a Provider collects Member Cost Sharing determined to exceed the Member's responsibility, the Provider must promptly reimburse the Member the excess amount. The Provider may determine an excess amount by referring to the Explanation of Payment (EOP). Member Cost Sharing is limited by a maximum out-of-pocket amount, as set forth below.

Maximum Out-of-Pocket

Member Cost Sharing is limited by an annual maximum out-of-pocket (MOOP) amount. If a Member has reached the MOOP amount for that particular Member's benefit plan, a Provider should not apply or deduct any Member Cost Sharing from that Provider's reimbursement.

Providers may obtain a Member's MOOP information via the Provider Portal or by contacting WellCare's Provider Services Department.

WellCare will notify the Provider of the amount in excess of the maximum out-of-pocket, and the Provider shall promptly reimburse the Member for any amount collected by the Provider in excess of the MOOP amount. If WellCare determines that the Provider did not reimburse the amount in excess of MOOP to the Member, WellCare may pay such amount due to the Member directly and recoup the amount from the Provider. If WellCare has deducted any Member Cost Sharing from the Provider's reimbursement in excess of the MOOP amount, WellCare will reimburse the Provider for the amount deducted to the extent that WellCare does not have to repay the Member such amount.

WellCare may audit the Provider's compliance with this section and may require the Provider to submit documentation to WellCare supporting that the Provider reimbursed Members for amounts in excess of the MOOP amounts.

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. Advance directives requirements may differ among states. These directives allow the Member to designate another person to make medical decisions on the Member's behalf if the Member becomes incapacitated.

Providers should provide each Member (age 18 years or older and of sound mind) with information regarding advance directives. Information regarding advance directives should be made available in Provider offices and discussed with each Member. Completed forms should be documented and filed in the Member's medical Records. Providers shall not, as a condition of treatment, require a Member to execute or waive an advance directive.

Provider Billing and Address Changes
Providers must provide prior notice to their Provider Relations representative or Provider Services 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; or
- Telephone and fax number.

Failure to notify WellCare prior to these changes may result in a delay in Claims processing and/or payment.

Members with Special Health Care Needs
Members with special health care needs have one or more of the following conditions:

- Mental retardation or related conditions;
- Serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders;
- Disabilities resulting from chronic illness, such as arthritis, emphysema or diabetes; or

- Children and adults with certain environmental risk factors such as homelessness or family problems that may lead to the need for placement in foster care.

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

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

Access Standards

All Providers must adhere to standards of timeliness for appointments and in-office waiting times. These standards take into consideration the immediacy of the Member's needs. WellCare shall monitor Providers against the standards below to ensure Members have timely access to Covered Services. Providers not in compliance with these standards will be required to implement corrective actions.

Type of Appointment	Access Standard
PCP – Urgent	< 24 hours
PCP – Routine	< 30 days

Please 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:

- Coordinate, monitor and supervise the delivery of primary care services to each Member;
- Assure Members are aware of the availability of public transportation where applicable;
- Provide access to WellCare or its designee to examine thoroughly the primary care offices, books, Records and operations of 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;
- Ensure Members utilize network Providers unless otherwise permitted by law or approved by WellCare. If unable to locate a WellCare-participating Provider for services

required, Providers may contact WellCare's Health Services Department for assistance. Refer to the state-specific *Quick Reference Guide* at: **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace**; and
- Comply with and participate in corrective action and performance improvement plan(s).

OB-GYN Services
A female Member may choose either a PCP or an OB-GYN for her routine and preventive women's health care services. A female Member may go to any qualified health care Provider who is a Participating Provider for routine and preventive women's health care services without a Referral or prior authorization. [KRS 304.17A-520] A female Member shall be covered for an annual Pap smear performed by an obstetrician or gynecologist without a Referral from a primary care Provider. [KRS 304.17A-647] The Provider may be required to obtain prior authorization for other Covered Services, follow a pre-approved treatment plan, or abide by procedures for making Referrals.

Resources for Primary Care Providers
Primary care Providers participating in WellCare's Provider network have access to the following WellCare resources:
- Support of WellCare's Provider Relations, Provider Services, Health Services and Marketing and Sales Departments;
- The tools and resources available on WellCare's websites at: **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace** and **www.wellcare.com**; and
- Information on WellCare network Providers for the purposes of Referral management and discharge planning.

Closing of Provider Panel
When requesting closure of a Provider's panel to new and/or transferring WellCare Members, PCPs must:
- Submit the request in writing at least 60 days prior to the effective date of closing the panel;
- Maintain the panel to all WellCare Members who were provided services before the closing of the panel; and
- Submit written notice of the re-opening of the panel, including a specific effective date.

Subject to applicable laws and Benefit Plan requirements regarding Provider-to-patient ratios, a Provider shall accept Members as patients as long as the Provider is accepting new patients. Providers shall give Health Plan 60 days' prior notice in advance of any circumstance where a Provider is not available to accept Members as patients.

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

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

In non-emergency cases, if a covering Provider is not contracted and credentialed with WellCare, contact WellCare for approval. For more information, refer to the state-specific *Quick Reference Guide* at **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace.**

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

WellCare maintains and monitors a panel of PCPs from which the Member may select a personal PCP. Except for Emergency Services or OB-GYN consultations, WellCare requires Members to obtain a Referral before receiving Specialist services. WellCare has a mechanism for assigning PCPs to Members who do not select one.

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

Termination of a Member by a Provider
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 the Member.

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

The Provider should complete a *PCP Request for Transfer of Member* form, attach supporting documentation and fax the form to WellCare's Provider Services Department. This form can be found on WellCare's website at **www.wellcare.com/Kentucky/Providers/Medicaid/Forms.**

Domestic Violence and Substance Abuse Screening

PCPs should identify indicators of substance abuse or domestic violence. Sample screening tools for domestic violence and substance abuse are located on WellCare's website at **www.wellcare.com/Kentucky/Providers/Clinical-Guidelines/CPGs.**

Smoking Cessation

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

Adult Health Screening

An adult health screening should be performed by a Provider to assess the health status of all WellCare Members. The adult Member should receive an appropriate assessment and intervention as indicated or upon request. Please refer to the adult preventive health guidelines and the Member physical screening tool, both located on WellCare's website at **www.wellcare.com/Kentucky/Providers/Clinical-Guidelines/CPGs.**

Cultural Competency Program and Plan

The purpose of the Cultural Competency Program is to ensure that WellCare meets the unique, diverse needs of its Members, values diversity within the organization, identifies Members in need of linguistic services and has adequate communication support for such Members. Providers shall recognize and make arrangements to care for the culturally diverse needs of WellCare Members they serve.

The objectives of the Cultural Competency Program are to:

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

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

The components of WellCare's Cultural Competency Program include:

- Data Analysis
    - Analysis of Claims and encounter data to identify the health care needs of the population;

- Collection of Member data on race, ethnicity and language spoken;
- Community-Based Support
  - Outreach to community-based organizations which support minorities and the disabled in ensuring that the existing resources for Members are being used to their full potential;
- Diversity
  - Non-Discriminating – WellCare may not discriminate with regard to race, religion or ethnic background when hiring associates;
  - Recruiting – WellCare recruits diverse talented associates in all levels of management;
  - Multilingual – WellCare recruits bilingual associates for areas that have direct contact with Members to meet the needs identified and encourages Providers to do the same;
- Diversity of Provider Network
  - 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.
- Provider Education
  - WellCare's Cultural Competency Program provides a Cultural Competency Checklist to assess the Provider office's Cultural Competency.

Registered Provider Portal users may access the Cultural Competency Program training on WellCare's website at **kentucky.wellcare.com/login/provider**. A paper copy may be requested by calling WellCare's Provider Services Department or contacting the Provider's Provider Relations representative.

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

Cultural Competency Survey
Providers may access the Cultural Competency Survey on WellCare's website at **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace.**

Member Administrative Guidelines
WellCare will make information available to Members on the role of the PCP, how to obtain care, what to do in an emergency or urgent medical situation, as well as their rights and responsibilities. WellCare will convey this information through various methods including a Member Policy (also called a "Member Contract").

Member Policy/Contract
All WellCare Members receive a Policy/Contract no later than 10 calendar days from the date of completed enrollment, including receipt of premium payment. Upon enrollment with WellCare, Members are provided the following in the Member policy:

- Terms and conditions of enrollment;
- Descriptions of the 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;
- Grievances, internal Appeal processes and external review processes; and
- Annual open enrollment periods, special enrollment periods and termination procedures.

Non-Discrimination
WellCare must obey laws that protect Members from discrimination or unfair treatment. WellCare does not discriminate based on a person's health status, source of payment, cost of treatment, participation in benefit plans, race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation or genetic information.

Member Identification Cards
Member identification cards (ID Card) are intended to identify WellCare Members and the type of Benefit Plan they have as well as facilitate their interactions with health care Providers. Information found on the Member ID 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 ID Card does not guarantee eligibility or coverage. Providers are responsible for ascertaining the current eligibility of the cardholder.

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

Providers may do one of the following to verify eligibility:

- Access the Provider Portal at **kentucky.wellcare.com/login/provider**;
- Access WellCare's Interactive Voice Response (IVR) system; or
- Contact WellCare's Provider Services Department.

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

Member Rights and Responsibilities

WellCare Members have specific rights and responsibilities when it comes to their care. The Member rights and responsibilities are provided to Members in the Member's policy and are outlined below.

Members have the right to:

- Request materials in other formats, such as large size print or audio, made available in a timely manner and in accordance with state laws.
- Choose a primary care Provider from a list of WellCare Participating Providers.
- Be treated with respect and recognition of dignity as a Member by everyone who works with WellCare.
- Privacy and to have their protected health information (PHI) protected.
- Get information about WellCare, its practitioners, its Providers and services, and Member rights and responsibilities.
- Help make decisions about their own health care.
- See their medical Records, get a copy of (and correct) their medical Records where legally allowed.
- Decide in advance how they want to be cared for in case of a life-threatening illness or injury.
- Make a complaint about WellCare or the care provided. A Member can call, fax, email or write to WellCare Customer Service.
- Appeal WellCare decisions with the right to have someone speak on their behalf during the Appeal process.
- Make recommendations about WellCare's Member rights and responsibilities policies.
- Be informed about their health. If a Member has an illness, they have the right to a candid discussion about all treatment options regardless of cost or benefit coverage.
- Terminate coverage from WellCare.
- Ask for a second opinion about their health condition.
- Request that someone outside of WellCare look into therapies that are Experimental or Investigational.
- Get interpreter services at no cost to the Member.
- Access Non-Participating Providers at the In-Network benefit level for Covered Services if an appropriate Provider is not available in WellCare's Provider Network.

Members also have certain responsibilities. These include the responsibility to:

- Show their WellCare Member ID Card when receiving care and not give their Member ID Card to others.
- Provide information to their Physician, Provider or WellCare that is needed for their care and follow the care plans agreed upon with their Physician.
- Learn to ask questions, follow plans and instructions for care and participate in their health care decisions and benefits if they have a question about their benefits. Build a relationship with Physicians. Cooperate with the Physician and staff by keeping

appointments and being on time. If the Member is going to be late or cannot keep an appointment, they should call the Physician's office.
- Inform WellCare of any fraud or wrongdoing.
- Understand their health problems and help develop mutually agreed-upon treatment goals.

Hearing-Impaired, Interpreter and Sign Language Services

Hearing-impaired, interpreter and sign language services are available to WellCare Members through Customer Service. PCPs should coordinate these services for Members and contact Customer Service if assistance is needed. Please refer to the state-specific *Quick Reference Guide* at **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace**.
for the Provider Services telephone numbers.

Section 3: Quality Improvement

Overview

WellCare's Quality Improvement Program (QI Program) is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable medical and behavioral 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 and focuses on key areas that include, but are not limited to:

- Quantitative and qualitative improvement in Member outcomes;
- Coordination and continuity of care with seamless transitions across health care settings/services;
- Cultural competency;
- Quality of care/service;
- Preventive health;
- Service utilization;
- Complaints/grievances;
- Network adequacy;
- Appropriate service utilization;
- Disease and Care Management;
- 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, Healthcare Effectiveness Data and Information Set (HEDIS®) measures and/or medical Record audits. The organization's Board of Directors has delegated authority to the Quality Improvement Committee to approve specific QI activities (including monitoring and evaluating outcomes, overall effectiveness of the QI Program and initiating corrective action plans when appropriate) when the results are less than desired or when areas needing improvement are identified.

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

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Quality Improvement Activities

The following are Quality Improvement activities performed by WellCare on an ongoing basis:

- Preventive health maintenance;
- Development and review of *Clinical Practice Guidelines*;

- Disease Management initiatives;
- HEDIS® studies;
- State and federal QI projects;
- Referrals for quality issues;
- Provider-specific issues identified through tracking and trending of complaints or Referrals;
- Medical Record content reviews – please review the *Medical Records* section below for specific documentation standards and requirements; and
- Chronic care improvement programs.

Provider Participation in the Quality Improvement Program

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

Member Satisfaction

WellCare periodically conducts a Member satisfaction survey of a representative sample of Members. Satisfaction with services, quality, and access is evaluated. The results are compared to performance goals and improvement action plans are developed to address any areas not meeting the standard.

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 health care delivery by all Providers, WellCare supports identification and implementation of a complete range of patient safety activities. These activities include medical Record legibility and documentation standards, communication and coordination of care across the health care network, medication allergy awareness/documentation, drug interactions, use 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, including:

- Regular checkups;
- Immunizations; and
- Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, tests for sexually transmitted diseases, Pap smears and mammograms.

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

to identify interventions, the support and activities of families, friends, Providers and the community have a significant impact on prevention.

Clinical Practice Guidelines

WellCare adopts validated evidence-based *Clinical Practice Guidelines* (CPGs) and uses the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other Provider may supersede CPGs, 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 CPGs are based on peer-reviewed medical evidence and are relevant to the population served. Approval of the CPGs occurs through the Quality Improvement Committee. *Clinical Practice Guidelines* are available on WellCare's website at **www.wellcare.com/Kentucky/Providers/Clinical-Guidelines/CPGs**.

Healthcare Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90% of America's managed care organizations to measure performance on important dimensions of care and service. The 2013 tool comprises 80 measures across five domains of care, including:

- Effectiveness of Care;
- Access and Availability of Care;
- Experience of Care;
- Health Plan Descriptive Information; and
- Utilization and Relative Resource Use.

HEDIS® is a 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 to capture 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 secured, timely, legible, current, detailed and organized manner which conforms to good professional medical practice. Records should be maintained in a manner that permits effective, professional medical review and medical audit processes and facilitates an adequate system for follow-up treatment.

Complete medical Records include, but are not limited to:

- Medical charts;
- Prescription files;
- Hospital Records;
- Provider Specialist reports;
- Consultant and other health care professionals' findings;
- Appointment Records; and

- Other documentation sufficient to disclose the quantity, quality, appropriateness and timeliness of the services provided.

WellCare conducts reviews of the medical Records of contracted Providers to determine compliance with established documentation standards, professional practice guidelines and preventive health guidelines. In accordance with requirements from federal and state regulatory agencies, WellCare may be required to periodically assess the medical Records of its Members to demonstrate WellCare's compliance with these requirements.

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

The general documentation requirements for medical Records are listed below. Documentation requirements for adult preventive care are on WellCare's website at **www.wellcare.com/Kentucky/Providers/Clinical-Guidelines/CPGs**.

All medical Records, including all entries in the medical Records, at a minimum must be:

- Neat, complete, clear and timely, and include all recommendations and essential findings in accordance with accepted professional practice;
- Signed and include the name and profession of the Provider;
- Legible to readers and reviewing parties; and
- Dated and Recorded in a timely manner.

Additionally, all medical Records must include:

- The Member's name (first and last name or identifier) on each page;
- The following personal and biographical data of the Member:
    - Name;
    - Member identifier;
    - Date of birth;
    - Gender;
    - Address;
    - Home and/or work telephone numbers;
    - Emergency contact name and telephone numbers, which may include next of kin or name of spouse;
    - Legal guardianship, if applicable;
    - Marital status; and
    - If not English, the primary language spoken by the Member and, if applicable, any translation or communication needs are addressed;
- Allergies and adverse reactions to medication prominently noted;
- HIPAA protected health information release;
- Current medication list;
- Current diagnoses/problem list;
- Summary of surgical procedures, if applicable;

- Age-appropriate lifestyle and risk counseling;
- Screening for tobacco, alcohol or drug abuse, with appropriate counseling and Referrals, if needed;
- Screening for domestic violence, with appropriate counseling and Referrals, if needed;
- The provision of written information regarding advance directives (for adults 18 years and older);
- An assessment of present health history and past medical history;
- Education and instructions – verbal, written or by telephone;
- If surgery is proposed, a discussion with the Member of the medical necessity of the procedure, the risks and alternative treatment options available;
- Evidence that results of ordered studies and tests have been reviewed;
- Consultant notes and Referral reports;
- Evidence of follow-up visits, if applicable; and
- Appropriate medically indicated follow-up after hospital discharge and emergency department visits.

Clinical encounters/office visits must minimally include:

- Chief complaint;
- History and physical examination for presenting complaint;
- Treatment Plan consistent with findings; and
- Disposition, recommendations and/or instructions provided.

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

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

Providers must follow state and federal laws regarding the retention of Records remaining under the care, custody and control of the physician or health care Provider.

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

Web Resources

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

Section 4: Utilization Management, Care Management and Disease Management

Utilization Management

Overview

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

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

WellCare does not reward its associates, practitioners, physicians or other individuals or entities performing Utilization Management activities for rendering denials of coverage, services or care determinations. WellCare does not provide for financial incentives, encourage or promote underutilization.

Prior Authorization

Prior authorization, also called precertification, allows for efficient use of Covered Services and ensures that Members receive the most appropriate level of care in the most appropriate setting. Prior authorization may be obtained by the Member's PCP, treating Specialist or a facility. WellCare provides a process in order to make a determination of medical necessity and benefits coverage for inpatient and outpatient services prior to services being rendered, unless prior authorization is prohibited by state or federal law.

Providers may submit requests for authorization by:

- Faxing a properly completed Authorization Request Form,
- Contacting WellCare via phone for inpatient services and urgent outpatient services; or
    - Submitting an online authorization request via WellCare's Web portal at **portal.wellcare.com/login/provider.**

The request for services must include the following:

- Member's name and identification number;
- The requesting Provider's demographics;
- Diagnosis code(s) and place of service;
- Services being requested and *Physician's Current Procedural Terminology, 4th Edition* (CPT-4) code(s);
- The treating Provider and facility demographics; and
- Medical history and any pertinent medical information related to the request, including current Plan of treatment and progress notes as to the necessity, effectiveness and goals.

For the appropriate contact information, refer to the state-specific *Quick Reference Guide* on WellCare's website at **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace.** All forms are located on WellCare's website at **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace/Forms.**

Prior Authorization may be required for the following categories of services:

- Air and land ambulance transportation for non-emergency and facility-to-facility transports;
    - Autism Spectrum Disorders (including Autistic Disorder, Asperger's Disorder and Pervasive Developmental Disorder, Not Otherwise Specified)
        - Medical Care
        - Habilitative or Rehabilitative Care
        - Pharmacy Care
        - Psychiatric Care
        - Psychological Care
        - Therapeutic Care
        - Applied Behavior Analysis
- Behavioral health services;
- Cancer clinical trials;
- Congenital defects and birth abnormalities;
- Dental services related to accident or injury;
- Diabetic equipment, education and supplies;
- Diagnostic laboratory testing (advanced);
- Certain diagnostic services;
- Advanced radiology, including but not limited to CAT, MRA, MRI, nuclear cardiology, nuclear medicine, PET and SPECT scans;
- Endometriosis and endometritis services;
- Home care services;
- Inpatient services, except emergency services;
- Maternity and newborn care;
- Medical supplies, durable medical equipment (DME) and appliances;
- Outpatient hospital/ambulatory surgery center procedures, except emergency services, and subject to exceptions;
- Physician home visits;
- Reconstructive services;
- Temporomandibular or craniomandibular joint disorder and craniomandibular jaw disorder;
- Therapy services;
- Transplant services;
- Vision services;
- Certain prescription drugs (please refer to the *Prescription Drug Formulary Reference Guide* for a list of drugs requiring prior authorization); and
- Any other services listed as requiring prior authorization in the Member policy.

Authorization Request Types	Time Frames for Authorization Decisions
Pre-Service Authorization	WellCare will send the Member of the Provider a decision within 14 days of receipt of the request for authorization of services. WellCare may extend the 14-day period for an additional 14 days because of matters beyond WellCare's control and the delay is in the Member's best interest. If this is necessary, WellCare will let the Provider know in writing within the first 14-day period. If the delay is because WellCare needs more information to make a decision, the Provider will have up to 45 days to provide the needed information.
Concurrent Services Authorization	WellCare will send the Provider a decision within 24 hours of receipt of the request for authorization of services involving continuation of concurrent services.
Post-Service Authorization	WellCare will send the Provider a decision within 30 days of receipt of the request for authorization of services. WellCare may extend the 30-day period for an additional 14 days due to matters beyond WellCare's control and when the delay is in the Member's best interest. If this is necessary, WellCare will let the Provider know in writing within the first 30-day period. If the delay is because WellCare needs more information to make a decision, the Provider will have up to 45 days to provide the needed information.
Expedited Authorization Request	WellCare will send the Provider a decision within 72 hours of receipt of the request.
Prescription Drugs Authorization Request	Please refer to the *Section 11 Pharmacy*.

Requests for medical conditions that may cause a serious threat to a Member's health are processed within 24 hours, but not later than 72 hours, measured from the time WellCare receives the request for urgent review or, if shorter, the period of time required under state or federal law. WellCare processes requests for urgent care services immediately by telephone.

If the Provider disagrees with WellCare's denial of service, the Provider may Appeal WellCare's decision. The process and instructions for Appeals is found in *Section 7: Internal Claims and Appeals, Grievances and External Review Processes.*

Standing Authorizations

If a Member has a condition or disease that calls for specialized medical care over a long period of time or the Member has a condition or disease that is life-threatening, worsening or disabling, the Member may need a standing authorization. With a standing authorization to a specialist, a

Member does not need a Referral or prior authorization every time the Member obtains services from that specialist. To request a standing authorization, a PCP may contact WellCare.

Second Opinions

Members have the right to a second surgical/medical opinion in any instance when the Member disagrees with his or her Provider's opinion of the reasonableness or necessity of surgical procedures or if there is potential for serious injury or illness. The second surgical/medical opinion, if requested, must be from a Provider chosen by the Member who may select:

- A Provider that is participating with WellCare; or
- A non-participating Provider.

If the Member chooses a non-participating Provider for a second opinion, WellCare will pay the amount of all charges which are usual, reasonable and customary in the community. Members must inform their PCP of their desire for a second surgical/medical opinion. If a participating WellCare Provider is selected, the PCP will issue a Referral to the Member for the visit. If a non-participating Provider is required, the PCP will contact WellCare for authorization.

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

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

Referrals

Referrals are requests by a PCP for a Member to be evaluated and/or treated by a participating specialty Provider. The PCP must document the reason for the Referral and the name of the Specialist in the Member's Record. The Specialist must document receipt of the request for a consultation. WellCare does not require a written Referral as a condition of payment.

Referral to a Non-Participating Provider

If WellCare determines that it does not have a participating Provider that has the training and experience to treat a Member's condition, it will approve a Referral to a non-participating Provider. Referrals to non-participating Providers will not be made for the convenience of the Member or another treating Provider. A participating Provider must ask for prior approval of the Referral to a specific non-participating Provider. If WellCare approves the Referral, all services done by the non- participating Provider are subject to a treatment Plan approved by WellCare in consultation with the PCP, the non-participating Provider and the Member. Covered Services from the non- participating Provider will be paid as if they were from a participating Provider. The Member will be responsible only for any applicable in-network Cost Sharing.

Emergency Services, Emergency Medical Conditions and Post-Stabilization Care

Emergency services are covered:

- Regardless of whether services are obtained in-network or out-of-network.

- Regardless of whether there is prior authorization for the services. A Member does not need prior authorization for emergency services, regardless of whether the services are provided in-network or out-of-network.
- In accordance with a prudent layperson's definition of "emergency medical condition," regardless of the final medical diagnosis.
- Whenever a WellCare Provider or other WellCare representative instructs a Member to seek Emergency Services either within or outside of the Member's WellCare Plan coverage.

Emergency Services or care for emergency medical conditions are available 24 hours per day, seven days per week for WellCare Members. If a Member thinks he or she has an emergency medical condition or needs Emergency Services, the Member should:

- Call 911 right away
- Go to the nearest hospital or emergency room

WellCare is not responsible for the care provided for an unrelated non-emergency problem during treatment for an emergency situation. For example, WellCare is not responsible for any costs, such as a biopsy associated with treatment of skin lesions performed by the attending Provider who is treating a fracture. Emergency Services are subject to coordination of benefits and Cost Sharing.

After-Hours Care or Urgent Care Services

Urgent care services are needed to prevent the serious decline of a Member's health from an unforeseen medical condition or injury and are available both inside and outside of the WellCare service area.

Away from the WellCare Service Area

If a Member is out of the WellCare service area and needs Emergency Services or care for an emergency medical condition, the Member should go to the nearest emergency room. When medically reasonable, the Provider should contact WellCare. When the Member is away from the WellCare service area, only urgent care services and Emergency Services are covered.

Members at School Outside of Their Service Area

If a Member needs urgent care services or Emergency Services while the Member is outside the WellCare service area while enrolled as a full-time student at a school or college, WellCare will provide benefits for covered urgent care or Emergency Services provided in a physician's office, clinic or hospital. The Member should seek Emergency Services as though the Member were inside the service area.

OB-GYN Services

A Member does not need prior authorization from WellCare or from any other person (including a PCP) to get OB-GYN care from a participating Provider who specializes in obstetrics or gynecology. The Provider, however, may be required to follow certain rules, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making Referrals.

Concurrent Review of Inpatient Services

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

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

The concurrent review process is conducted based on the Member's medical condition. Decisions will take into account the Member's medical condition and comorbidities. The review process is performed under the direction of the WellCare medical director.

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

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

Clinical information is requested to support the appropriateness of the admission, continued length of stay, level of care, treatment and discharge plans.

Discharge Planning

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

Some of the services involved in the discharge Plan include, but are not limited to:

- DME;
- Transfers to an appropriate level of care, such as an inpatient nursing rehabilitation (INR) facility, long-term acute care facility (LTAC) or SNF;
- Home health care;
- Medications; and
- Physical, occupational, or speech therapy (PT, OT, ST).

Retrospective Review

A retrospective review is any review of care or services that have already been provided. WellCare will accept for review within 5 days of patient discharge post-service requests for authorization of inpatient admissions or outpatient services. The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions and taking into account the Member's needs at the time of service. WellCare will also identify quality issues, utilization issues and the rationale behind failure to follow WellCare's prior authorization/pre-certification guidelines. For more information, see *Section 7: Internal Claims and Appeals, Grievances and External Review Processes.*

Requests for Reconsideration

WellCare provides an opportunity for the Provider to request a reconsideration of an adverse benefit determination. For more information, see *Section 7: Internal Claims and Appeals, Grievances and External Review Processes.*

Criteria for Utilization Management Determinations

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

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

- InterQual;
- Medical necessity;
- Member benefits;
- State and federal laws;
- *Clinical Coverage Guidelines*; and
- Hayes Health Technology Assessment.

The clinical reviewer and/or medical director apply medical necessity criteria in the context of the Member's individual circumstance and capacity of the local Provider delivery system. When the above criteria do not address the individual Member's needs or unique circumstance, the medical director will use clinical judgment in making the determination.

Members and Providers may request a copy of the criteria used for a specific determination of medical necessity by contacting Customer Service.

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

WellCare is responsible for:

- Requiring consistent application of review criteria for authorization decisions; and
- Consulting with the requesting Provider when appropriate.

One or more of the following criteria are used when services are requested that require utilization review:

Type of Criteria	Updated
Coverage and Referral Guidelines	Annually
InterQual	Annually
Hayes, Inc. Online™ (Medical Technology)	Ongoing
Medicare Carrier and Intermediary Coverage Decisions	Ongoing
Federal and State Laws Medicare National Coverage Decisions	Ongoing
Federal and State Laws	Ongoing

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

- Age;
- Comorbidities;
- Complications;
- Progress of treatment;
- Psychological situation; and
- Home environment, when applicable.

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

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

When WellCare's standard UM guidelines and criteria do not apply due to individual Member factors and the available resources of the local delivery system, the Health Services staff (Review Nurse, Care Manager) will consult with the Medical Director. The Medical Director may also utilize her or his clinical judgment in completing the service authorization request.

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

Continuity of Care

If the Agreement is terminated for any reason, other than a quality-of-care issue or fraud, the Provider shall continue to provide services, and WellCare shall continue to reimburse the Provider until the greater of (1) 90 days, (2) the Member or the Member's dependent is discharged from an inpatient facility, or the (3) active course of treatment is completed, and (4) in the case of a pregnant woman, services shall continue to be provided through the end of the postpartum period if the pregnant woman is in her fourth or later month of pregnancy at the time the Agreement is terminated, in accordance with the Agreement, NCQA and KRS 304.17A-527.

Participating Providers Who Become Non-Participating Providers
When a Provider terminates from the network, the Member may continue coverage and care with that physician when medically necessary until the Member is discharged from an inpatient facility or the hospital or until the Member finishes an active course of treatment, whichever is longer. If the Member is in the fourth month or later of pregnancy at the time the Provider leaves WellCare, the Member may continue to be treated by the physician until postpartum care is completed.

Care provided after termination shall continue under the same terms, conditions and payment arrangements as they existed in the terminated contract.

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

Continuity of Care for New Members
If a new Member has an existing relationship with a Provider who is not part of WellCare's Provider network, WellCare will permit the Member to continue an ongoing course of treatment by the non-participating Provider during a transitional period. WellCare will be responsible for continuing all medically necessary Covered Services until the Member's treatment Plan has been reviewed, which will occur no more than 90 calendar days after the Effective Date of the Member's enrollment.

For Members who are receiving prenatal care when they join WellCare, WellCare will make every effort to allow the Member to continue with the same prenatal care Provider for the length of the pregnancy and for postpartum care.

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

Special Circumstances for Continuity of Care
A Member with "special circumstances" is one who has a disability, a congenital condition, a life-threatening illness, or is past the 24th week of pregnancy where disruption of the Member's continuity of care could cause medical harm. If a Member with special circumstances is getting ongoing services from a non-participating Provider, unless the Provider was terminated for a reason related to quality, the Member will be permitted to continue treatment until such time as WellCare can reasonably transfer the Member to a participating Provider.

WellCare is not required to extend ongoing services from a non-participating Provider for persons with special circumstances:

- Beyond the 90th day after the termination or nonrenewal of the Provider;
- Beyond 9 months, in the case of a Member who at the time of the termination has been diagnosed with a terminal illness; or
- If the Member is beyond the 24th week of pregnancy, WellCare's duty to pay for services extends through the delivery of the child, immediate postpartum care and examination within the first 6 weeks following delivery.

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

Availability of Utilization Management Staff
WellCare's Health Services Department provides medical and support staff resources, including a Medical Director, to process requests and provide information for the routine or urgent authorization/pre-certification of services, Utilization Management functions and Provider questions, comments or inquiries. WellCare staff is available 24 hours per day, 7 days per week, including holidays.

For more information on contacting the Health Services Department via Provider Services, refer to the *Quick Reference Guide* on WellCare's website at **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace**.

Care Management Program

Overview
WellCare offers comprehensive Care Management services to facilitate patient assessment, planning and advocacy to improve health outcomes for patients. WellCare trusts Providers will help coordinate the placement and cost-effective treatment of patients who are eligible for WellCare's Care Management Programs.

WellCare's Care Management teams are led by specially trained Registered Nurses and Licensed Clinical Social Worker Care Managers who assess the Member's risk factors, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the 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 support capacity to the PCP and assist in actively linking the Member to Providers, medical services, residential, social and other support services, as needed. Providers may request Care Management services for any Member.

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

- A Referral from a Member's PCP;
- Self-Referral;
- Referral from a family Member;
- After completing a Health Risk Assessment; and
- Data mining for Members with high utilization.

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

- **Clinical Assessment and Evaluation** – A comprehensive assessment of the Member is completed to determine where she or he is in the health continuum. This assessment gauges the Member's support systems and resources and seeks to align them with appropriate clinical needs;
- **Care Planning** – Collaboration with the Member and/or caregiver, as well as the PCP, to identify the best ways to fill any identified gaps or barriers to improve access and adherence to the Provider's Plan of care;
- **Service Facilitation and Coordination** – Working with community resources to facilitate Member adherence with the Plan of care. Activities may be as simple as reviewing the Plan with the Member and/or caregiver or as complex as arranging services, transportation and follow-up; and
- **Member Advocacy** – Advocating on behalf of the Member within the complex labyrinth of the health care system. Care Managers assist Members with seeking the services to optimize their health. Care Management emphasizes continuity of care for Members through the coordination of care among physicians and other Providers.

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

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

Care Managers work closely with the Provider regarding when to discharge the Member from the Care Management Program. Reasons for discharge from the Care Management Program may include:

- The Member is meeting primary care Plan goals;
- The Member has declined additional Care Management services;
- The Member has disenrolled from WellCare; and/or
- The Member is unable to be contacted by WellCare.

Provider Access to Care Management

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

Disease Management Program

Chronic Care Management is a component of Care Management defined as a system of coordinated health care intervention and communication for populations with conditions in which patient self-efforts are significant.

Chronic Care Management supports the physician- or practitioner-patient relationship and Planof care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, evaluates clinical, human and economic outcomes on an ongoing basis with the goal of improving overall health.

Some examples of Chronic Care Management include, but are not limited to:

- Asthma – adult and pediatric;
- Coronary artery disease (CAD);
- Congestive heart failure (CHF);
- COPD;
- Diabetes – adult and pediatric;
- Stable depression; and
- Hypertension (HTN).

Additional programs available include obesity and smoking cessation.

Candidates for Disease Management

WellCare encourages Referrals from Providers, Members, hospital discharge planners, 24-hour nurse Referral line and others in the health care community. Interventions for Members identified are based on the Comprehensive DM Assessment followed by the industry-recognized *Clinical Practice Guidelines.* Following the comprehensive assessment, a Plan of care is formed including self-managing goals along with educational materials provided to the Member to offer support. With changes to the Member status, reassessments are completed and updates to the care Plan are implemented to identify goal and intervention modification for better outcomes. Disease-specific modules support the Planof care implemented for each Member.

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

Access to Care and Disease Management Programs

WellCare's Transition Needs Assessment (TNA) Program assists new Members in their transition from other health insurance coverage to WellCare. The program involves outreach to these Members prior to their effective date and within the first 30 days of their enrollment. During this outreach, Members are gauged for their health care needs including, but not limited to, their primary and Specialist Providers, current prescriptions, DME and home health. Members are also screened for eligibility for WellCare's Care Management and Disease Management Programs and any additional behavioral health care needs.

If Providers would like to refer an established WellCare Member as a potential candidate to WellCare's Care Management Programs or would like more information, Providers may call WellCare's Care Management Referral Line. 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/Health-Insurance-Marketplace.**

Section 5: Claims

Overview

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

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

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

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

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

Providers will no longer receive paper Explanation of Payments (EOPs). EOPs can be viewed and/or downloaded and printed from PaySpan's website, once registration is completed.

Providers can register using PaySpan's enhanced Provider registration process at payspan.com**.** Providers can also view PaySpan's webinar anytime at: payspan.webex.com. PaySpan Health Support can be reached via email at providersupport@payspanhealth.com, by phone at **1-877-331-7154** or on the Web at www.payspanhealth.com**.**

Timely Claims Submission

WellCare will process and pay Claims in accordance with KRS 304.17A-726. For institutional Providers, the Provider shall submit all Claims for reimbursement in an electronic form and format following for Clean Claims within 90 days of: (a) for inpatient services, the date of the Member's discharge; or (b) for outpatient services, the date the Covered Services were provided. For professional Providers, the Provider shall submit all Claims for reimbursement in an electronic form and format following for Clean Claims within 90 days of the date the Covered Services were provided.

WellCare requires all diagnosis coding to use ICD-10, or its successor, as mandated by CMS. *Refer to Compliance section for additional information.*

Unless prohibited by law or regulation, WellCare may deny payment of any Claim that fails to meet WellCare's submission requirements for Clean Claims or failure to timely submit a Clean Claim to WellCare.

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

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

- A clearinghouse electronic acknowledgement indicating Claim was electronically accepted by WellCare; and
- A Provider's electronic submission sheet that contains all the following identifiers:
  - Patient name;
  - Provider name;
  - Date of service to match Explanation of Benefits (EOB)/Claim(s) in question;
  - Prior submission bill dates; and
  - WellCare's product name or line of business.

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

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

Tax ID and National Provider Identifier Requirements

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

Taxonomy

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

Preauthorization Number

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

National Drug Codes

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

Strategic National Implementation Process

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

If a Claim is rejected for lack of compliance with WellCare's Claim submission requirements, the rejected Claim should be resubmitted within timely filing limits.

Claims Submission Requirements

Providers using electronic submission shall submit Clean Claims to WellCare or its designee, as applicable, using the HIPAA-compliant 837 electronic format or a CMS 1500/ UB-04 (or their successors), as applicable. Claims shall include the Provider's NPI, tax ID and the valid taxonomy code that most accurately describes the services reported on the Claim. The Provider acknowledges and agrees that no reimbursement or compensation is due for a covered service and no Claim is complete for a covered service unless performance of that covered service is fully and accurately documented in the Member's medical Record prior to the initial submission of any Claim. The Provider also acknowledges and agrees that at no time shall Members be responsible for any payments to the Provider with the exception of Member Cost Sharing 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/Health-Insurance-Marketplace**. For more information on WellCare's Covered Services, refer to WellCare's websites at **www.wellcare.com**.

Electronic Claims Submissions

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

Because most clearinghouses can exchange data with one another, Providers should work with their existing clearinghouse or the clearinghouses WellCare uses to establish EDI with WellCare. For a list of clearinghouses WellCare uses, for information on WellCare's unique payer identification numbers used to identify WellCare on electronic Claims submissions or to contact WellCare's EDI team, refer to the *Quick Reference Guide* on WellCare's website at **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace.**

HIPAA Electronic Transactions and Code Sets

HIPAA Electronic Transactions and Code Sets is a federal mandate that requires health care payers such as WellCare, as well as Providers engaging in one or more of the identified transactions, to have the capability to send and receive all standard electronic transactions using the HIPAA designated content and format. To promote consistency and efficiency for all Claims and encounter submissions to WellCare, it is WellCare's policy that these requirements apply to all paper and direct data entry (DDE) transactions.

Paper Claims Submissions

Providers must submit Claims to WellCare electronically. Claims not submitted electronically may be subject to penalties. 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/Health-Insurance-Marketplace.**

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

- Any missing, illegible, incomplete or invalid information in any field will cause the Claim to be rejected or processed incorrectly.
- The following process should be used for Clean Claims submission:
  - The information must be aligned within the data fields and must be:
    - On an original red-ink-on-white paper Claim form;
    - Typed. Do not print, hand-write or stamp any extraneous data on the form;
    - In black ink;
    - Large, dark font such as, PICA, ARIAL 10-, 11- or 12-point type; and
    - In capital letters.
  - The typed information must not have:
    - Broken characters;
    - Script, italics or stylized font;
    - Red ink;
    - Mini font; or
    - Dot matrix font.

Claims Submission

For inquiries related to Providers' electronic submissions to WellCare, please contact WellCare's EDI team at **EDI-Master@wellcare.com**.

Provider Services		**1-877-389-9457**
Preferred EDI Partner	EDI Payer ID	
RelayHealth (McKesson)	14163	**1-877-411-7271**

WellCare follows the CMS guidelines for paper Claims submissions. Since Oct. 28, 2010, WellCare accepts only the original "red Claim" form for Claim and encounter submissions. WellCare does not accept handwritten, faxed or replicated Claim forms. Claim forms and guidelines may be found on WellCare's website at: **www.wellcare.com/Kentucky/Providers/Medicaid/Claims.**

Mail paper Claim submissions to:

WellCare Health Plans, Inc.
Claims Department
P.O. Box 31372
Tampa, FL 33631-3372

Claims Processing

Readmission

WellCare may choose to review Claims if data analysis deems it appropriate. WellCare may review hospital admissions on a specific Member if it appears that two or more admissions are related based on the data analysis. Based upon the Claim review (including a review of medical Records if requested from the Provider). WellCare will make all necessary adjustments to the Claim, including recovery of payments which are not supported by the medical Record.

WellCare may recoup overpayments from Providers who do not submit the requested medical Records or who do not remit the overpayment amounts identified by WellCare.

Prompt Payment
WellCare will pay or deny a Clean Claim within 30 days of WellCare's receipt of the Clean Claim, except for Clean Claims involving organ transplants, which shall be paid, denied or contested within 60 days of receipt of the Clean Claim. The date of receipt of a Clean Claim shall be the date WellCare receives the Clean Claim electronically. The Provider shall submit all Claims electronically. The date of payment shall be the posting date of an electronic payment to a Provider account, the postmark date of a non-electronic payment mailed to a Provider or the documented date of non-mailed delivery of a non-electronic payment received by a Provider. WellCare will make all payments electronically. The Provider agrees to accept Claims details electronically and to provide WellCare with accurate electronic funds transfer or electronic remittance advice. WellCare may refuse to settle Claims on the basis that responsibility for payment should be assumed by other parties.

Coordination of Benefits (COB)
WellCare shall coordinate payment for Covered Services in accordance with the terms of a Member's Benefit Plan and state and federal laws. Providers shall bill primary insurers for items and services they provide to a Member before they submit Claims for the same items or services to WellCare. Any balance due after receipt of payment from the primary payer should be submitted to WellCare for consideration, and the Claim must include information verifying the payment amount received from the primary plan, as well as a copy of the EOB. WellCare will accept an EDI submission with COB information included in the transaction and does not require a paper EOB for COB Claims submitted by EDI. 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's policies and procedures regarding subrogation activity.

Members may be covered under more than one insurance policy at a time.

- If a Claim is submitted for payment consideration secondary to a primary insurance carrier, other primary insurance information, such as the primary carrier's EOB, must be provided with the Claim. WellCare has the capability to receive EOB information electronically. To submit other insurance information electronically, refer to the *WellCare Companion Guides* on WellCare's website at **www.wellcare.com/Kentucky/Providers/Medicaid/Claims**;
- If WellCare has information on file to suggest the Member has other insurance, WellCare may deny the Claim;
- If the primary insurance has terminated, the Provider is responsible for submitting the initial Claim with proof that coverage was terminated. In the event a Claim was denied for other coverage, the Provider must resubmit the Claim with proof that coverage was terminated; and/or
- If benefits are coordinated with another insurance carrier as primary and the payment amount is equal to or exceeds WellCare's liability, no additional payment will be made.

Provider-Preventable Conditions
WellCare follows CMS guidelines regarding Hospital Acquired Conditions, Never Events, and other Provider-Preventable Conditions (collectively, PPCs). Under Section 42 CFR 447.26

(implemented July 1, 2012), these PPCs are non-payable for Medicaid and Medicare. Additional PPCs may be added by individual states.

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

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

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

Corrected or Voided Claims

Corrected and/or voided Claims are subject to timely Claims submission guidelines.

How to submit a corrected or voided Claim electronically:

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

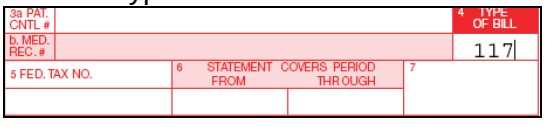
These codes are not intended for use for original Claim submission or rejected Claims.

To submit a corrected or voided Claim via paper:

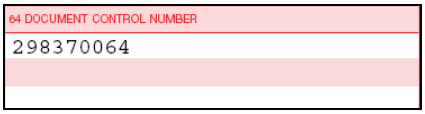
For institutional Claims, the Provider must include WellCare's original Claim number and bill the frequency code per industry standards.

Example:

Box 4 – Type of Bill: The third character represents the "Frequency Code."

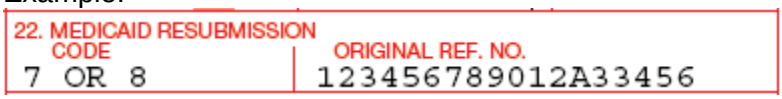


Box 64 – Place the Claim number of the prior Claim in Box 64.



For professional Claims, the Provider must include WellCare's original Claim number and bill Frequency Code per industry standards. When submitting a corrected or voided Claim, enter the appropriate bill frequency code left-justified in the left-hand side of Box 22.

Example:



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

Please note: If Providers stamp or type "corrected Claim" on the Claim form without entering the appropriate Frequency Code "7" or "8" along with the Original Reference Number as indicated above, the Claim will be considered an original first-time Claim submission.

The correction or void process involves two transactions:

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

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

Grace Periods

Grace Periods for Members Receiving the APTC

In accordance with 45 CFR 156.270(d) and 45 CFR 155.430, in the event that a Member receiving advance payment of the premium tax credit, as described in 45 CFR 156.270(d), fails to timely pay the Member's premiums (the "Member default"), WellCare will continue to provide the Member with coverage of services for three consecutive months following the Member default (the "grace period") if the Member has previously paid at least one full month's premium during the benefit year. During the grace period, WellCare will pay all appropriate Claims for services rendered to the Member in the first month of the grace period and may pend payment of Claims for services rendered to the Member in the second and third months of the grace period. WellCare will notify the Provider of the possibility for denied Claims when a Member is in the second and third months of the grace period as required by applicable laws.

Grace Periods for all Other Members

For all other Members (those who do not receive the APTC), WellCare will give the Member a 31-day grace period, starting on the date that the first premium payment was due but was not paid. If payment of all premiums due is not received from the Member by WellCare at the end of

the grace period, the Member policy will automatically terminate to the last date through which premium was paid. The Member shall be held liable for the cost of Covered Services received during the grace period, as well as any unpaid premium. In no event shall the grace period extend beyond the date the Member policy terminates.

Reimbursement

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

Surgical Payments

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

- **Incidental Surgeries/Complications** – A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for extra payment. Any complicated procedure that warrants consideration for extra payment should be identified with an operative report and the appropriate modifier. A determination will be made by WellCare's medical director regarding whether the proposed complication merits additional compensation above the usual allowable amount.
- **Admission Examination** – One charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.
- **Follow-up Surgery Charges** – Charges for follow-up surgery visits are considered to be included in the surgical service charge. Providers should not submit a Claim for such visits and Providers are not compensated separately. Follow-up days included in the global surgical period vary by procedure and are based on CMS policy.
- **Multiple Procedures** – Payment for multiple procedures is based on current CMS percentages methodologies. The percentages apply when eligible multiple surgical procedures are performed under one continuous medical service or when multiple surgical procedures are performed on the same day and by the same surgeon.
- **Assistant Surgeon** – Payment for an assistant surgeon and/or a non-physician practitioner for assistant surgery is based on current CMS percentages methodologies. WellCare uses the American College of Surgeons (ACS) as the primary source to determine which procedures allow an assistant surgeon. For procedures that the ACS lists as "sometimes," CMS is used as the secondary source.
- **Co-Surgeon** – Payment for a co-surgeon is based on current CMS percentages methodologies. In these cases, each surgeon should report his or her distinct operative work by adding the appropriate modifier to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier '62' added. "Co-Surgeon" means one of multiple surgeons who work together as primary surgeons performing distinct part(s) of a surgical procedure.

Modifiers
WellCare follows CMS guidelines regarding modifiers and only reimburses modifiers reimbursed by CMS.

Allied Health Providers
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 percentage of financial overpayments will occur while processing Claims. An overpayment can occur due to reasons such as retroactive Member termination, inappropriate coding, duplication of payments, non-authorized services, erroneous contract or fee schedule reimbursement and other reasons.

WellCare will proactively identify and attempt to correct inappropriate payments. In situations where the inappropriate payment caused an overpayment, WellCare will adhere to Kentucky Regulatory Statute 304.17A-708 and limit its notice of retroactive denial to 24 months from the payment receipt date. WellCare or its designee will provide a written notice to the Provider identifying the specific Claims, overpayment reason and amount, contact information and instructions on how to send the refund. If the retroactive denial of reimbursement results from coordination of benefits, the written notice will specify the name of the carrier and coverage period for the Member. The notice will also provide the carrier address WellCare has on file but recognizes that the Provider may use the carrier address it has on file. The standard request notification provides 60 days for the Provider to send in the refund, request further information, Appeal 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 the Provider independently identifies an overpayment, it can either (a) send a corrected Claim (refer to the *Corrected or Voided Claims* section of the manual), (b) contact WellCare Customer Service to arrange an offset against future payments, or (c) send a refund and explanation of 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/Health-Insurance-Marketplace.**

Section 6: Credentialing

Overview

Credentialing is the process by which the appropriate WellCare peer review bodies evaluate the credentials and qualifications of practitioners including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/health care delivery organizations. For purposes of *Section 6: Credentialing* in this Manual, all references to "practitioners" shall include Providers providing health or health-related services including the following: physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities, and other ancillary facilities/health care delivery organizations.

This review includes (as applicable to practitioner type):

- Background;
- Education;
- Postgraduate training;
- Certification(s);
- Experience;
- Work history and demonstrated ability;
- Patient admitting capabilities;
- Licensure, regulatory compliance and health status which may affect a practitioner's ability to provide health care; and
- Accreditation status, as applicable to non-individuals.

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

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

Please take note of the following credentialing process highlights:

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

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

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

Practitioner Rights

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

To Be Informed of Credentialing/Re-Credentialing Application Status

Written requests for information may be emailed to **credentialinginquiries@wellcare.com**. Upon receipt of a written request, WellCare will provide written information to the practitioner on the status of the credentialing/re-credentialing application, generally within 15 business days. The information provided will advise of any items pending verification or 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.

To Review Information Submitted in Support of Credentialing/Re-Credentialing Application

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

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

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 his or her application and has the right to correct the erroneous information. WellCare will provide written notification to the practitioner of the discrepant information.

WellCare's written notification to the practitioner will include:

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

- The addressee in the Credentialing Department to whom corrections must be sent;
- WellCare's documentation process for receiving the correction information from the Provider; and
- WellCare's review process.

Baseline Criteria

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

License to Practice – Practitioners must have a current, valid unrestricted license to practice in the state where services are provided.

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

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

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

Hospital-Admitting Privileges – Specialist practitioners shall have hospital-admitting privileges at a WellCare participating hospital (as applicable to specialty). 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 plan. Existing Providers who are sanctioned, and thereby restricted from participation in any government program, are subject to immediate termination in accordance with WellCare policy and procedure and the Agreement.

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

Liability Insurance

WellCare Providers (all disciplines) are required to carry and continue to maintain professional liability insurance, unless otherwise agreed to by WellCare in writing. The Provider shall maintain adequate commercial general liability and professional liability (malpractice) insurance or self-insurance coverage for Claims arising out of events occurring during the term of the

Agreement and any post non-renewal or termination activities under the Agreement, and such insurance coverage must be effective as of the effective date of the Agreement in amounts required to meet WellCare's credentialing criteria and workers' compensation insurance requirements under state laws. Upon WellCare's request, the Provider shall submit certificates of insurance or other evidence of coverage reflecting satisfaction of these requirements. Provider shall give WellCare at least 30 days' advance notice of any material modification, cancellation or termination of its insurance, unless a shorter time is required under state laws.

Site Inspection Evaluation

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

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

SIEs are conducted for:

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

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

Covering Physicians

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

Allied Health Professionals

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

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

- ARNPs;
- Certified nurse midwives (CNM);
- PAs; and
- Osteopathic assistants (OA).

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

- Licensed clinical social workers;

- Licensed mental health counselors;
- Licensed marriage and family therapists;
- Physical therapists;
- Occupational therapists;
- Audiologists; and
- Speech/language therapists/pathologists.

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

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

Updated Documentation
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 expiration.

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

Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials
On a monthly basis, WellCare, or its designee, contacts state licensure agencies to obtain the most current available information on sanctioned Providers. This information is cross-checked against the network of WellCare Providers. If a network Provider is identified as being currently under sanction, appropriate action is taken in accordance with WellCare policy and procedure. If the sanction imposed is revocation of license, the Provider is subject to immediate termination.

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 the Provider should be terminated.

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 sole opinion of WellCare's Medical Director, is engaged in behavior or practicing in a manner that appears to pose a significant risk to the health, welfare or safety of Members.

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

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

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

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

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

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

The practitioner has 30 days from the date of WellCare's notice to submit a written request to WellCare. This request must be sent by a nationally recognized overnight carrier or U.S. certified mail, postage pre-paid, with return-receipt requested, to invoke the Dispute Resolution Peer Review Panel process.

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

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

The Dispute Resolution Peer Review Panel shall consider and decide the case objectively and in good faith. WellCare's medical director, within five business days after final adjournment of the Dispute Resolution Peer Review Panel hearing, shall notify the practitioner of the results of

the first level panel hearing. In the event the findings are positive for the practitioner, the second level panel review shall be waived.

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

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

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

A practitioner who fails to request the Provider Dispute Resolution Peer Review process within the time, and in the manner specified, waives all rights to such review to which he or she might otherwise have been entitled. WellCare may terminate the practitioner and make the appropriate report to the National Practitioner Data Bank and state licensing agency as appropriate and if applicable.

Delegated Entities

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

Section 7: Internal Claims and Appeals, Grievances and External Review Processes

Definitions Specific to Grievances, Internal Appeals and External Reviews

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit based on:

- A determination of a participant's or beneficiary's eligibility to participate in a Plan and including, with respect to health benefit plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review;
- A determination that a benefit is experimental, investigational or not medically necessary or appropriate;
- A determination of an individual's eligibility to participate in a Plan or health insurance coverage;
- A determination that a benefit is not a covered benefit; or
- The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion or other limitation on otherwise covered benefits.

An Adverse Benefit Determination includes any rescission of coverage whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

Appeal means a request from a Member or authorized representative for WellCare to review an adverse benefit determination or coverage denial.

Authorized Representative means an individual authorized in writing by the Member or state law to act on the Member's behalf in requesting a health care service, obtaining Claim payment, or during the internal Appeal or external review process. A Provider may act on the Member's behalf without the Member's express consent when it involves urgent care.

Concurrent Review means utilization review conducted during a Member's course of treatment or hospital stay.

Coverage Denial means a determination by WellCare that a service, treatment, drug or device is specifically limited or excluded under the Member policy.

Expedited Internal Appeal means an Appeal deemed necessary when a Member is hospitalized or, in the opinion of the treating Provider, review under a standard time frame could, in the absence of immediate medical attention, result in any of the following:

- Placing the Member's health or, with respect to a pregnant woman, the health of the Member's unborn child in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of a bodily organ or part.

External Review means a review conducted by an independent review entity. A Member, an authorized representative or a Provider may request an external review of an adverse benefit determination.

Final Adverse Benefit Determination means an adverse benefit determination that is made during or by the end of the internal Appeal process. If the time period for the internal Appeal ends without a final adverse benefit determination by WellCare, then the internal Appeal will be deemed a final adverse benefit determination.

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

Independent Review Entity (IRE) means an individual organization certified by the Kentucky Department of Insurance to perform external reviews.

Internal Appeal means the process used by WellCare to address a request from a Member or authorized representative to review an adverse benefit determination or coverage denial.

Post-Service Appeal means an Appeal of an adverse benefit determination or coverage denial for a service that has already been provided.

Pre-Service Appeal means an Appeal of an adverse benefit determination or coverage denial for a service that has not been provided.

Prospective Review means utilization review that is conducted prior to a hospital admission or a course of treatment.

Retrospective Review means utilization review that is conducted after health services have been rendered to a Member. Retrospective review does not include the review of a Claim that is limited to an evaluation of reimbursement levels or adjudication of payment.

Urgent Care means health care or treatment with respect to which the application of time periods for making non-urgent determination:

- Could seriously jeopardize the life or health of a Member or the ability of a Member to regain maximum function; or
- In the opinion of a physician with knowledge of the Member's medical condition would subject the Member to severe pain that cannot adequately be managed with the care or treatment that is the subject of the utilization review.

Urgent care includes all requests for hospitalization and outpatient surgery. Additionally, a "Claim involving urgent care" includes any Claim that a physician with knowledge of the Member's medical condition determines is a Claim involving urgent care. Urgent care Appeals may also be referred to as an expedited Appeal.

Utilization Review means a review of the medical necessity and appropriateness of hospital resources and medical services given or proposed to be given to a Member. Areas of review include concurrent, prospective and retrospective review.

Provider Grievance Process

Providers may have the right to file a grievance no later than 30 days from the date that caused the dissatisfaction. Written resolution will be given 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 prior written consent.

WellCare will give all Providers written notice of the Provider grievance procedures at the time they enter into contract.

Member Grievance Process

The Member may file a grievance. A grievance may also be filed on the Member's behalf by an authorized representative. Alternatively, a Provider (with the Member's written consent) may file a grievance verbally or in writing within 30 calendar days. All grievance rights described in *Section 7* of this Manual that apply to Members will also apply to the Member's authorized representative or a Provider acting on behalf of the Member with the Member's written consent. WellCare will acknowledge the Member or Member's authorized representative grievance within five business days.

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

- Provider service including, but not limited to:
  - Rudeness by Provider or office staff;
  - Refusal to see Member (other than in the case of patient discharge from office); or
  - Office conditions.
- Services provided by WellCare including, but not limited to:
  - Hold time on telephone;
  - Rudeness of staff;
  - Involuntary disenrollment from WellCare; or
  - Unfulfilled requests.
- Access availability including, but not limited to:
  - Difficulty getting an appointment;
  - Wait time in excess of one hour; or
  - Handicap accessibility.

Grievance Submission

A Member or a Member's representative may file a standard grievance request either orally (via Customer Service or in person) or in writing within 60 calendar days of the date of the incident or when the Member was made aware of the incident. Contact information for the Grievance Department is in the state-specific *Quick Reference Guides* on WellCare's website at **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace**.

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 verbal or written grievance, consistent with applicable federal and state law. Unless an extension is elected, WellCare will send a closure letter upon completion of the Member's grievance.

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

WellCare will acknowledge the grievance in writing within five business days of receipt and provide a written resolution to the Member's concerns within 30 calendar days.
The Grievance Department will inform the Member of the determination of the grievance as follows:

- All grievances submitted, either verbally or in writing, will be responded to in writing; and
- The Member's grievance must be submitted to WellCare within 30 days of the event that caused dissatisfaction.

Provider Internal Appeals Process

A Provider may file an internal Appeal regarding Provider payment or contractual issues on his or her own behalf by mailing a letter of Appeal with supporting documentation, such as medical Records, to WellCare.

Providers have 90 calendar days from the original adverse benefit determination by Utilization Review or Claims to file a Provider internal Appeal. Decisions Appealed after that time will be denied for untimely filing. If the Provider feels she or he has filed the complaint within the appropriate time frame, the Provider may submit documentation showing proof of timely filing. Acceptable proof of timely filing is a registered postal receipt signed by a representative of WellCare or similar receipt from other commercial delivery services.

WellCare has 60 calendar days to review the case and issue a Final Adverse Benefit Determination for medical necessity and conformity to WellCare guidelines and Plan benefits and coverage.

Cases received without the necessary documentation may be denied for lack of information. It is the responsibility of the Provider to supply the necessary documentation within 60 calendar days of the notification to re-open the case. Records and documents received after that time frame will not be reviewed and the case will remain closed.

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

Reversal of Denial of Provider Internal Appeal

If all of the relevant information is received, WellCare will make a determination within 60 calendar days. If it is determined during the review that the Provider has complied with WellCare protocols, the services are a covered benefit and the services were medically necessary, the initial denial will be overturned. The Provider will be notified of this decision in writing.

The Provider may file a Claim for payment related to the Appeal if one has not already been submitted. If a Claim has been previously submitted and denied, it will be adjusted for payment if the Plan Appeal decision overturns the original adverse decision. WellCare will ensure that Claims are processed and comply with the federal and state requirements.

Affirmation of Denial of Provider Internal Appeal

If it is determined during the review that the services are not covered, the Provider did not comply with WellCare protocols and/or medical necessity was not established, the original 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 stated in the letter. The Provider may also request a copy of the clinical rationale used in making the Appeal decision by sending a written request to the address listed in the decision letter.

The Provider is only entitled to one level of Appeal. A Provider does not have the right to request an external Appeal on his/her own behalf.

Member Internal Appeals Process

In the event of an adverse benefit determination, utilization review or coverage denial, the Member and the Provider will receive written notice from WellCare. In addition to delivering specific information regarding the determination or denial to the Provider, WellCare will advise how the Provider may ask for a review of WellCare's decision and the process to initiate the review. The requested review is called an internal Appeal. The Provider's internal Appeal will be handled through WellCare's internal Appeals process.

The Member, the Member's authorized representative, or a Provider acting on behalf of the Member, may submit an internal Appeal (in writing or verbally) of an adverse benefit determination, utilization review or coverage denial. WellCare will supply the Provider with the forms to initiate an internal Appeal. In order for a Provider to act on the Member's behalf, the Provider must have express written consent from the Member, except in cases when it involves urgent care.

Providers may request these forms by contacting WellCare Customer Service. While Providers are not required to use WellCare's pre-printed form, WellCare encourages submitting an internal Appeal in writing to facilitate logging, identification, processing and tracking of the internal Appeal through the review process.

The Member, the Member's authorized representative, or the Provider on behalf of the Member must file an internal Appeal within 180 days, effective 1/1/2016, from the date of notice of an adverse benefit determination, utilization review or coverage denial.

Internal Appeal will be conducted by a licensed physician who did not participate in the initial review and denial. However, in the case of a review involving a medical or surgical specialty or subspecialty, WellCare will, upon request by a Member, authorized representative or Provider, have a board-eligible or certified physician in the appropriate specialty or subspecialty to conduct the internal Appeal.

WellCare will respond to internal Appeals wthin 30 days of receipt of the request for an internal Appeal.

Expedited Internal Appeals

The Member, the Member's authorized representative or the Provider acting on behalf of the Member may request an expedited internal Appeal when the Member is hospitalized or, in the opinion of the treating Provider, review under the standard time frame (i.e., 30 days) could, in the absence of immediate medical attention, result in any of the following:

1. Placing the Member's health or, if the Member is a pregnant woman, the health of the Member's unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of a bodily organ or part.

Time Frame for Responding to Member Internal Appeals

The time frame for WellCare's decision depends on the type of internal Appeal:

Request Type	Time Frame for Decision
Expedited Internal Appeal	Within 72 hours
Internal Appeal	Within 30 days

Pending the outcome of an internal Appeal, WellCare is required to provide continued coverage of the Appealed service or course of treatment. WellCare cannot reduce or terminate an ongoing course of treatment unless WellCare provides the Member with advance notice and an opportunity for advance review.

Concurrent Internal Appeals and External Review

Members in urgent care situations and/or receiving an ongoing course of treatment may be allowed to proceed with an expedited external review (see below) while the internal Appeals process is occuring. Additionally, Members requesting an internal Appeal of a determination that a recommended or requested service is experimental or investigational and that the Member's treating physician certifies in writing would be significantly less effective, if not promptly initiated, may simultaneously pursue expedited external and internal Appeals.

Exhaustion of Internal Appeal Process

As set forth above, it is no longer necessary under certain circumstances to exhaust the internal Appeals process before pursuing an external review. Additionally, a Member may pursue an external review before exhausting the internal Appeals process if WellCare fails to adhere to all the requirements of the internal Appeals process, unless WellCare demonstrates its violation was for good cause or due to matters beyond WellCare's control and occurred during an ongoing, good faith exchange of information between the Provider and WellCare. Absent these exceptions, the internal Appeals process must be exhausted before the Provider can use the

external review process, courts or any administrative proceeding to resolve matters regarding an adverse benefit determination or coverage denial.

External Review Process

A Member, authorized representative or Provider has the right to ask for an external review of the final adverse benefit determination. An external review is similar to an internal Appeal, except that the request is reviewed by an independent review entity. The Member, authorized representative or Provider may request an external review.

The Provider may file an external review request if:

1. WellCare sent the Provider a Notice of an Adverse Benefit Determination, Utilization Review or Coverage Denial;
2. The Provider has completed WellCare's internal Appeal process to the extent required, or WellCare failed to make a timely determination or notification of the Provider's internal Appeal pursuant to state law; and
3. The Member was enrolled under the Member policy on the date of service or, for prospective denials, the Member was enrolled and eligible to receive Covered Services under the Member policy on the date the proposed service was requested.

To request an external review:

- For expedited external reviews, the Provider may:
  - Call WellCare Customer Service and follow up with a brief written request, or
  - Send WellCare a written request for an expedited external review.
- For non-expedited external reviews, the Provider may:
  - Send WellCare a written request for an external review.

When a Provider submits an external review request, the Provider may contact WellCare for external review request forms. The Provider must also send WellCare a medical Records release form signed and completed by the Member authorizing the independent review entity to obtain all necessary medical Records from WellCare and any Provider utilized for review purposes regarding the decision to deny, limit, reduce or terminate coverage. The Member must also submit a written authorization if someone other than the Member will represent the Member during the external review.

WellCare may charge a $25 filing fee when a Provider files an external review request, not to exceed a $75 annual limit per person in a single Plan year. The fee may be waived in the event of hardship or refunded if the external review decision favors the Provider.

The cost of an external review by an independent review entity will be paid by WellCare as required by state law.

The Provider must submit his/her independent review entity request within four months of the date he/she receives the notice of a final adverse benefit determination.

The Provider's request will be sent by WellCare to the independent review entity with whom the State has contracted to perform external reviews. A copy of the request will also be sent to the state Department of Insurance.

The Member, authorized representative or Provider can submit additional written comments to WellCare and WellCare will forward them to the independent review entity.

If any additional information is submitted, it will be shared with WellCare in order to give WellCare a chance to reconsider the denial.

Complaint Process through the Kentucky Department of Insurance

If the Provider has any questions or concerns on his or her right to an external review or the action of an independent review entity, the Member, authorized representative or Provider can call the toll-free number, **1-800-595-6053**.

Request for Expedited External Review

In addition to the circumstances noted above, the Provider may request an expedited external review if the Member is:

1. Hospitalized, or
2. If, in the opinion of the treating Provider, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:
    a. Placing the Member's health or, if the Member is a pregnant woman, the Member's health or the unborn child's health in serious jeopardy;
    b. Serious impairment to bodily functions; or
    c. Serious dysfunction of a bodily organ or part.

Expedited external review requests can be started by calling the OPM toll-free number, **1-877-549-8152** or by calling Customer Service.

Time Frame for Responding to External Review Requests

WellCare will forward a request for an expedited external review to the Independent Review Entity (IRE) within 24 hours of its receipt of the request.

For expedited external reviews, the IRE will make a determination within 24 hours of the receipt of all information required from WellCare. An extension of up to 24 hours may be allowed if the Member and WellCare agree to the extension.

For all other requests for external review (i.e., non-expedited requests), the IRE will make a determination within 21 calendar days from the receipt of all information required from WellCare. An extension of up to 14 calendar days may be allowed if the Member and WellCare agree to the extension.

The time frame for the decision depends on the type of external review:

Type of Expedited Review	Time Frame for Decision by an Independent Review Entity
Expedited External Review	Within 24 hours of the IRE's receipt of all information required from WellCare, but no later than 72 hours from WellCare's receipt of the request for Expedited External Review from the Provider.

External Review	Within 21 calendar days of the IRE's receipt of all information required from WellCare, but no later than 45 days from WellCare's receipt of the request for External Review from the Provider.

WellCare will implement the decision of the independent review entity regardless of whether the Member has terminated his or her coverage or remains enrolled with WellCare. If coverage has been terminated with WellCare, WellCare will only provide the treatment, service, drug or device that was previously denied by WellCare and later approved by the independent review entity for a period not to exceed 30 days. Within 30 days of the decision in favor of the Member by the independent review entity, WellCare will provide written notification to the state Department of Insurance that the decision has been implemented in accordance with state law.

External review decisions are binding on the Member, the authorized representative, the Provider and WellCare, except to the extent there are remedies available under state or federal law.

Member Case File
At the Member's request, WellCare can send the Member a copy of the entire case file. This includes the actual benefit provision, the actual benefit, clinical guidelines and/or clinical criteria used to make the decision. WellCare will do this at no charge upon receipt of the Member's request. A request can be made by calling WellCare Customer Service.

Confidentiality – Medical Records and External Review Information
Medical Records and information relating to the external review are confidential.

General Rules and Information
General rules regarding WellCare's grievance, internal Appeal and external review processes include the following:

- The Member, authorized representative and Provider must cooperate with WellCare in its effort to promptly review and resolve a grievance, internal Appeal or external review. If the Member, authorized representative or Provider does not fully cooperate with WellCare, the Provider will be deemed to have waived his/her right to have the grievance or internal Appeal processed within the time frames set forth above.
- WellCare will offer to meet with the Provider by telephone. Arrangements will be made for a telephone conference to be held at WellCare's offices. WellCare will make these arrangements at no charge to the Provider.
- During the internal Appeal process, the services in question will be reviewed without regard to the decision reached when the adverse benefit determination was made.
- If WellCare finds new information that was not available when the adverse benefit determination was made, WellCare will share this with the Provider. WellCare must send the Provider any new medical information so the Provider has a chance to review the Claim file.

Grievances, Internal Appeals and External Reviews Contact Information

For Grievances:

WellCare Health Plans, Inc.
P.O. Box 31384
Tampa, FL 33631-3384
Fax: **1-866-388-1769**
Email address: **operationalgrievance@wellcare.com**

For Internal Appeals:

For Medical Internal Appeals:

WellCare Health Plans, Inc.
P.O. Box 31368
Tampa, FL 33631-3368
Fax: **1-866-201-0657**

For Pharmacy Internal Appeals:

WellCare Pharmacy Department
P.O. Box 31398
Tampa, FL 33631-3398
Fax **1-888-865-6531**

For External Reviews:

For Medical External Reviews:

WellCare Health Plans, Inc.
P.O. Box 31368
Tampa, FL 33631-3368
Fax: **1-866-201-0657**

For Pharmacy External Reviews:

WellCare Pharmacy Department
P.O. Box 31398
Tampa, FL 33631-3398
Fax **1-888-865-6531**

Kentucky Department of Insurance:

Kentucky Department of Insurance
P.O. Box 517
Frankfort, Kentucky 40602-0517
Email address: **doi.info@ky.gov**
1-502-564-3630
1-800-595-6053 (Toll free – Kentucky only)
TTY 1-800-648-6056
Web address: **insurance.ky.gov**

Section 8: Compliance

Compliance Program

WellCare's corporate ethics and compliance program, as may be amended from time to time, includes information regarding WellCare's policies and procedures related to fraud, waste and abuse and provides guidance and oversight as to the performance of work by WellCare, 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 abide by WellCare compliance program requirements. WellCare's compliance-related training requirements include, but are not limited to, the following initiatives:

- **Corporate Integrity Agreement (CIA) Training**
  - Effective April 26, 2011, WellCare's CIA with the OIG of the U.S. Department of Health and Human Services (HHS) requires that WellCare maintain and build upon its existing Compliance Program and corresponding training.
  - Under the CIA, the degree to which individuals must be trained depends on their role and function at WellCare.
- **HIPAA Privacy and Security Training**
  - Summarizes privacy and security requirements in accordance with the federal standards established pursuant to HIPAA and subsequent amendments to HIPAA;
  - Training includes, but is not limited to, discussion on:
    - Proper uses and disclosures of PHI;
    - Member rights; and
    - Physical and technical safeguards.
- **Fraud, Waste and Abuse (FWA) Training**
  - Must include, but is not limited to:
    - Laws and regulations related to FWA (i.e., False Claims Act, Anti-Kickback Statute, HIPAA, etc.);
    - Obligations of the Provider, including the Provider's employees and the Provider's subcontractors and their employees, to have appropriate policies and procedures to address fraud, waste and abuse;
    - Process for reporting suspected FWA;
    - Protections for employees and subcontractors who report suspected fraud, waste and abuse; and
    - Types of FWA that can occur.

Providers, including Provider employees and/or Provider subcontractors, must report to WellCare any suspected FWA, 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 Health Plans, Inc. FWA hotline at **1-866-678-8355**. Details of the corporate ethics and compliance program may be found on WellCare's website at **www.wellcare.com/en/Kentucky/Providers/Medicaid/Training**.

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 the ICD-10 transition and codes can also be found at **www.wellcare.com/Kentucky/Providers/ICD10-Compliance.**

Code of Conduct and Business Ethics

Overview

WellCare has established a Code of Conduct and Business Ethics that outlines ethical principles to ensure that all business is conducted in a manner that reflects an unwavering allegiance to ethics and compliance. WellCare's Code of Conduct and Business Ethics policy can be found at **www.wellcare.com/en/Kentucky/Providers/Medicaid/Training**.

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

Fraud, Waste and Abuse

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

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

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

In addition, Providers are reminded that medical Records and other documentation must be legible and support the level of care and service indicated on Claims. Providers engaged in fraud, waste 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.

To report suspected fraud, waste and abuse, please refer to the state-specific *Quick Reference Guides* on WellCare's website at **https://www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace** or call WellCare's confidential and toll-free compliance hotline at **1-866-364-1350**. Details of the corporate ethics and compliance program and how to contact WellCare FWA 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 must be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules and regulations. All consultations or discussions involving the Member, or his or her case, should be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the privacy and security rules and regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended. All Provider practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure there is a procedure or process in place for maintaining confidentiality of Member medical Records and other PHI as defined under HIPAA; and the practice is following those procedures and/or obtaining appropriate authorization from Members to release information or Records, where required by applicable state and federal law. Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

Every Provider practice is required to provide Members with information regarding its privacy practices and to the extent required by law, with its Notice of Privacy Practices (NPP). Employees who have access to Member Records and other confidential information are required to sign a Confidentiality Statement.

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

- Medical Records;
- Communication between a Member and a physician regarding the Member's medical care and treatment;
- All personal and/or PHI as defined under the federal HIPAA privacy regulations, and/or other state or federal laws;
- Any communication with other clinical persons involved in the Member's health, medical and 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.

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

Disclosure of Information

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

For more information on how to request this information, Members may contact Customer Service using the toll-free telephone number found on the Member's ID card. Providers may contact Provider Services by referring to the state-specific *Quick Reference Guides* on WellCare's website at **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace**.

Section 9: Delegated Entities/Subcontractors

Overview

WellCare may, by written contract, delegate certain functions. These functions include, but are not limited to, contracts for administration and management services, marketing, utilization management, quality assurance, care management, disease management, Claims processing, Claims payment, credentialing, network management, Provider Claim Appeals, customer service, enrollment, disenrollment, billing and sales, and Appeals and grievances (the "delegated services"). WellCare may delegate all or a portion of these activities to another entity/subcontractor (a "delegated entity").

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

Compliance

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

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

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

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

- Ensure that all delegated entities/subcontractors are eligible for participation in the State Health Insurance Exchanges, Medicaid and Medicare programs;
- Ensure that WellCare has written agreements with each delegated entity/subcontractor that specifies the responsibilities of the delegated entity/subcontractor and WellCare, reporting requirements and delegated activities in a clear and understandable manner;
- Ensure that the appropriate WellCare associates have properly evaluated the entity's/subcontractor's ability to perform the delegated activities prior to delegation;
- Provide formal, ongoing monitoring of the entity's/subcontractor's performance at least annually, including monitoring, to ensure quality of care and quality of service is not compromised by financial incentives; and
- Impose sanctions, up to and including the revocation and/or termination of delegation, if the delegated entity's/subcontractor's performance is inadequate.

Section 10: Behavioral Health

Overview

WellCare provides behavioral health Covered Services for its benefit plans. All higher levels of behavioral health care require prior authorization. Crisis Services, Assessment, Evaluation and medication services do require prior authorization but some outpatient services, such as psychological testing and therapy, do require prior authorization. Please refer to WellCare's BH prior authorization grid located on WellCare's website for a complete listing of services that do require authorization. If a Member is in need of a Referral to a behavioral health Provider, contact WellCare as referenced in the state-specific *Quick Reference Guides* on WellCare's website at **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace**.

Coordination of Care Between Medical and Behavioral Health Providers

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

Behavioral health Providers and medical Providers are expected to communicate with each other. With the Member's or the Member's legal guardian's consent, an initial and quarterly summary report of the Member's behavioral health status to the PCP should occur. Communication with the PCP should occur more frequently if clinically indicated. WellCare expects 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 believes in 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. WellCare staff is available to facilitate the lines of communication with any Providers should its assistance be needed.

To maintain continuity of care, patient safety and Member well-being, communication between behavioral health care Providers and medical care Providers is critical, especially for Members with comorbidities receiving pharmacological therapy. Fostering a culture of collaboration and cooperation will help sustain a seamless continuum of care between medical and behavioral health and impact Member outcomes.

Responsibilities of Behavioral Health Providers

WellCare monitors Providers against these standards to ensure Members can obtain needed health services within the acceptable appointment waiting times. The provisions below are

applicable only to behavioral health Providers and do not replace the provisions set forth in *Section 2: Provider and Member Administrative Guidelines* for medical Providers. Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare.

Type of Appointment	Access Standard
Behavioral Health Provider – Urgent	< 48 hours
Behavioral Health Provider – Post Inpatient Discharge	< 7 days
Behavioral Health Provider – Routine	< 10 days
Behavioral Health Provider – Non-Life-Threatening Emergency	< 6 hours
Behavioral Health Provider – Screening and Triage of Calls	< 30 seconds

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

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

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

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

Section 11: Pharmacy

Overview

WellCare's pharmaceutical management procedures are an integral part of the pharmacy program that promotes the utilization of the most clinically appropriate agents to improve the health and well-being of its Members. The Utilization Management tools that are used to optimize the pharmacy program include:

- Formulary;
- Prior authorization;
- Step therapy;
- Quantity limit; and
- Mail service.

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

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

To contact WellCare's Pharmacy Department, please refer to the state-specific *Quick Reference Guides* on WellCare's website at: **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace.**

For more information on WellCare's benefits, visit WellCare's website at **www.wellcare.com/Kentucky**.

Formulary

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

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

The Formulary is located on WellCare's website at **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace/Pharmacy-Tools**.

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

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

Additions and Exceptions to the Formulary

To request consideration for inclusion of a drug to WellCare's Formulary, Providers may write WellCare explaining the medical justification. For contact information, refer to the state-specific *Quick Reference Guides* at **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace**. For more information on requesting exceptions, refer to the *Coverage Determination* process below.

Coverage Limitations

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

- Agents when used for anorexia, weight loss or weight gain (even if used for a non-cosmetic purpose, such as morbid obesity);
- Agents when used to promote fertility;
- Agents when used for cosmetic purposes or hair growth;
- Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; and
- Agents when used for the treatment of sexual or erectile dysfunction.

Generic Medications

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

Step Therapy

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

Prior Authorization for Prescription Drugs

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

Quantity Limits

Quantity limits are used to encourage supplying pharmaceuticals in a quantity consistent with FDA-approved dosing guidelines. Quantity limits are also used to help prevent billing errors. Drugs that have quantity limits are designated by the letters "QL", and the quantity permitted, on WellCare's Formulary.

Mail Service

Drugs that are available through mail order are designated by the letters "MS" on WellCare's Formulary. A *Member Registration*, *Prescription Mail-Order Form* and a *Mail-Service Pharmacy Prescription Form* are located on WellCare's website at: **www.wellcare.com/Kentucky/Providers/Medicaid/Pharmacy**.

Injectable and Infusion Services

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

Over-the-Counter Medications

WellCare covers certain OTC medications and supplies recommended by the U.S. Preventive Services Task Force (USPSTF) at no cost when prescribed by a physician. Examples include:

- Aspirin to prevent cardiovascular disease (CVD) for men and women
- Iron supplements for children
- Chemoprevention of dental caries (cavities) – Fluoride supplementation for men, women and children
- Supplementation with folic acid for women planning, or capable of, pregnancy
- Counseling for tobacco use and smoking cessation drugs for adults
- Vitamin D supplementation to reduce fall injuries in community dwellings for at risk adults age 65 and older.

Certain age and gender limitations may apply. The list of recommended preventive services covered will be updated as new recommendations and guidelines are issued or as existing ones are revised or removed by the USPSTF.

Member Cost Sharing for Prescription Drugs

The Cost Sharing for prescription drugs is based on the drug's Formulary status, including tier location, and the Member's subsidy level. Refer to the Member's Summary of Benefits and Coverage for the exact Cost Sharing located on WellCare's website at: **www.wellcare.com/Kentucky/Members/Health-Care-Exchange/Health-Insurance-Marketplace-2016/Pharmacy-Services**.

Coverage Determination Request Process

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

The Coverage Determination request process is required for:

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

Obtaining a Coverage Determination Request

Complete a *Coverage Determination Request Form* and fax it to the Pharmacy Department. The form is on WellCare's website at: **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace/Forms**.

For the appropriate fax number, refer to the state-specific *Quick Reference Guides* on WellCare's website at: **www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace.**

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

If the coverage determination request meets the approved P&T Committee's protocols and guidelines, the Provider and/or pharmacy will be contacted with the coverage determination request approval. An approval letter is also sent to the Member and an attempt is made to inform them of the approval by telephone.

If the coverage determination request is not a candidate for approval based on approved P&T Committee protocols and guidelines, it is reviewed by a clinical pharmacist for final determination.

For those requests that are not approved, a follow-up letter is faxed to the Provider stating why the coverage determination request was not approved, including a list of the preferred drugs that are available as alternatives, if applicable. A denial letter is also sent to the Member and an attempt is made to inform them of the denial by telephone.

Medication Appeals

To request an Appeal of a coverage determination request decision, follow the internal Appeals and external review processes described in *Section 7: Grievances, Internal Appeals and External Reviews*.

Section 12: Definitions and Acronyms

Definitions

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

Accreditation Standards means the standards Health Plan is required to adhere to in order to acquire or maintain health Plan accreditation from the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC).

Advance Payments of the Premium Tax Credit (**APTC)** means payment of a tax credit specified under federal law that is provided on an advance basis to an eligible Member enrolled in a qualified health Planthrough the Kentucky Health Benefit Exchange in accordance with the Affordable Care Act.

Affordable Care Act (ACA) means the federal Patient Protection and Affordable Care Act, (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

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

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

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

Claim means a bill for services, a line item of service, or all services for one recipient within a bill on an industry standard form.

Clean Claim means a properly completed paper or electronic billing instrument, including the required health Claim attachments submitted in the following applicable form: (a) A Clean Claim from an institutional Provider shall consist of: (1) the UB-92 data set or its successor submitted on the designated paper or electronic format as adopted by the NUBC; (2) entries stated as mandatory by the NUBC; and (3) any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service. (b) A Clean Claim for dentists shall consist of the form and data set approved by the American Dental Association. (c) A Clean Claim for all other Providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee. (d) A Clean Claim for pharmacists shall consist of a universal Claim form and data set approved by the National Council on Prescription Drug Programs.

Coinsurance is a percentage of the charges for Covered Services the Member is required to pay when the Member receives Covered Services. The Coinsurance amount is calculated as a percentage of the rates that WellCare has negotiated with participating Providers. Coinsurance

amounts are listed in the Outline of Coverage. Coinsurance is not applicable to some Covered Services, but WellCare may apply a Deductible or Co-payment to those Covered Services. If required by law, the Member will not pay any Coinsurance nor will Cost Sharing apply to preventive services included in the essential health benefits.

Co-payment is a specific dollar amount the Member is required to pay when the Member receives Covered Services. Co-payments are listed in the Member's Outline of Coverage. Some Covered Services do not have a co-payment, but WellCare may apply a Deductible or Coinsurance to those Covered Services. If required by law, the Member will not pay any Co-payment nor will Cost Sharing apply to preventive services included in the essential health benefits.

Cost Sharing means any expenditure required by, or on behalf of, a Member and includes Deductibles, Coinsurance, co-payments or similar charges, but excludes premiums, balance billing amounts for non-network Providers and spending for non-Covered Services.

Covered Services means medically necessary services covered under a benefit plan, including essential health benefits and preventive health services. To qualify as a covered service, the item or service must be:

- Medically necessary or otherwise specifically included as a benefit under the Member's policy;
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under the Member's policy is in force;
- Not experimental or investigational or otherwise excluded or limited by the Member's policy or by any amendment or rider attached to the Member's policy;
- Authorized in advance by WellCare if prior authorization is required by the Member's policy; and
- Documented in the Provider's Records or the Member's medical Records.

Deductible is the amount the Member is required to pay in a calendar year for Covered Services before WellCare will cover or pay for those services at the applicable Co-payment or Coinsurance amounts. The Outline of Coverage states which Covered Services are subject to the Deductible. If the Outline of Coverage notes separate Deductible amounts for specified Covered Services, amounts paid toward one type of Deductible cannot be used to satisfy or fulfill a different type of Deductible. If required by law, the Member will not pay any Deductible, nor will Cost Sharing apply to preventive services included in the essential health benefits.

Emergency Medical Condition means (a) a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in: (1) 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; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part; or (b) with respect to a pregnant woman who is having contractions: (1) a situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or (2) a situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Services means, with respect to an emergency medical condition, (a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Essential Health Benefits (EHB) means the Covered Services and associated limits of a health insurance product offered by WellCare as defined by 42 USC 18022(b)(2) and shall include the minimum statutory standards required under applicable laws, including, where applicable: (a) ambulatory patient services; (b) emergency services; (c) hospitalization; (d) maternity and newborn care; (e) mental health and substance use disorder services, including behavioral health treatment; (f) prescription drugs; (g) rehabilitative and habilitative services and devices; (h) laboratory services; (i) preventive and wellness services and chronic disease management; and (j) pediatric services, including oral and vision care.

Exchange or **Health Insurance Exchange** means the state-based **Kentucky Health Benefit Exchange** (**KHBE**), conditionally approved by the U.S. Department of Health and Human Services pursuant to 45 CFR 155.105, and established pursuant to section 18031 of the Affordable Care Act to offer QHPs beginning Jan. 1, 2015.

Formulary means a list of prescription medications approved by the Federal Drug Administration (FDA) and chosen by WellCare in consultation with WellCare's Pharmacy and Therapeutics (P&T) Committee. The Formulary represents prescription therapies considered a needed part of a quality treatment program.

HIPAA means the federal Health Insurance Portability and Accountability Act of 1996, and rules and regulations pursuant thereto.

Individual Market means the market for health insurance coverage offered to individuals other than in connection with a group health plan. As used in this definition, **Group Health Plan** means an employee welfare Benefit Plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that such Plan provides medical care, and including any item or service paid for as medical care to an employee or the employee's dependent, as defined under the terms of the plan, directly or through insurance, reimbursement or otherwise, but not including excepted benefits.

Institutional Provider means a health care facility licensed under KRS Chapter 216B.

Maximum Out-of-Pocket (MOOP) is the sum of the Deductible, prescription drug Deductible (if applicable), Co-payment and Coinsurance as shown in the Member's Outline of Coverage. After the MOOP amount is met for an individual for a given benefit period, WellCare pays 100% of eligible Covered Services for the rest of that benefit period. The family MOOP amount is two times the individual MOOP amount. For the family MOOP, once the Member has met the individual MOOP amount, the remainder of the family MOOP amount can be met with the combination of any one or more Member's expenses that are Covered Services.

Medically Necessary or **Medical Necessity** are health care items and services that are (a) reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy; (b) appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice; (c) provided for medical reasons rather than primarily for the convenience of the Member, the Member's caregiver, or the health care Provider, or for cosmetic reasons; (d) 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; (e) needed, if used in reference to an emergency medical service, to exist using the prudent layperson standard; (f) provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in federal laws for individuals under 21 years of age; and (g) sufficient in amount, duration, and scope to reasonably achieve its purpose, subject to appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

Member means a Qualified Individual properly enrolled in a WellCare Exchange Benefit Plan and eligible to receive Covered Services at the time such services are rendered, and may include the Member's dependent.

National Uniform Billing Committee (NUBC) means the national committee of health care Providers, governmental payors, and commercial insurers that develop the national uniform billing requirements for institutional Providers as referenced in accordance with HIPAA.

Participating Provider means an individual or entity that has entered into an agreement with WellCare, or its contractor, to provide or arrange for the provision of Covered Services to Members.

Plan means WellCare Health Plans of Kentucky, Inc., which provides benefits to Members for the Covered Services described in the Member's policy.

Preventive Health Services shall be defined by 45 CFR 147.130, and WellCare may use reasonable medical management techniques to determine the frequency, method, treatment or setting of preventive health services to the extent not specified in the recommendations or guidelines specified in 45 CFR 147.130.

Primary Care Provider (PCP) means one of the following types of practitioners:

- Family or general practice (M.D. or D.O.)
- Internal medicine (M.D. or D.O.)
- An M.D. or D.O. specializing in pediatrics (pediatrician)
- An M.D. or D.O. specializing in obstetrics and gynecology (OB-GYN)

Provider means an individual or entity that has contracted, directly or indirectly, with WellCare to provide or arrange for the provision of Covered Services to Members under a benefit plan. Provider includes, but is not necessarily limited to, a hospital, physician or specialist, health care professional, podiatrist, psychologist, clinical social worker, occupational or physical therapist, physician's assistant or advanced registered nurse practitioner who is licensed, certified or otherwise legally permitted to provide Covered Services to Members under the Member's policy.

Qualified Health Plan (QHP) means an issuer that has in effect a certification that its benefit plans meet the criteria for certification described in 42 USC 18031(c).

Qualified Individual means an individual who has been determined eligible to enroll as a Member through the Exchange in a qualified health Plan in the individual market.

Record means any written, printed, or electronically Recorded material maintained by a Provider in the course of providing health services to a Member concerning the Member as a patient and the services provided. Record also includes the substance of any communication made by a Member to a Provider in confidence during or in connection with the provision of health services to the Member or information otherwise acquired by the Provider about a Member in confidence and in connection with the provision of health services to the Member.

Referral means the process by which the Member's Primary Care Provider directs the Member to seek and obtain Covered Services from other Providers.

Service Area means the geographic area in the Commonwealth of Kentucky in which WellCare has been authorized by the <state Department of Insurance> to offer a QHP. WellCare's service area includes these counties in Kentucky: Boone, Bullitt, Campbell, Fayette, Harlan, Jefferson, Jessamine, Kenton, Laurel, Leslie, Letcher, Perry and Warren counties.

Specialist means any licensed, board-certified or board-eligible physician who is not a PCP.

Stabilize or **Stabilization** means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman who is having contractions, to deliver (including the placenta).

Utilization Management means a system for reviewing the appropriate and efficient allocation of health care services under a Benefit Plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a Member should or will be reimbursed, covered, paid for or otherwise provided under the benefit plan. The system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.

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.

Acronyms

AIDS – Acquired Immune Deficiency Syndrome
ARNP – Advanced Registered Nurse Practitioner
CLAS – Culturally and Linguistically Appropriate Services
CMS – Centers for Medicare and Medicaid Services
COB – Coordination of Benefits
COPD – Chronic Obstructive Pulmonary Disease
CPT-4 – *Physician's Current Procedural Terminology, 4th Edition*
DEA – Drug Enforcement Agency
DME – Durable Medical Equipment
DSM-IV – *Diagnostic and Statistical Manual of Mental Disorders*
EDI – Electronic Data Interchange
EOB – Explanation of Benefits
EOP – Explanation of Payment
FDA – Food and Drug Administration
FWA – Fraud, Waste and Abuse
HEDIS® – Healthcare Effectiveness Data and Information Set
HHS – U.S. Department of Health and Human Services
HIPAA – Health Insurance Portability and Accountability Act of 1996
HIV – Human Immunodeficiency Virus
HMO – Health Maintenance Organization
ICD-10-CM – *International Classification of Diseases, 10th Revision, Clinical Modification*
ICD-10-PCS – International Classification of Diseases, 10th Revision, Procedure Coding System
IRE – Independent Review Entity
MOOP – Maximum Out-of-Pocket
NPI – National Provider Identifier
NPP – Notice of Privacy Practice
OB – Obstetric/Obstetrical/Obstetrician
OIG – Office of Inspector General
OT – Occupational Therapy
OTC – Over-the-Counter
P&T – Pharmacy and Therapeutics Committee
PA – Physician Assistant
PCP – Primary Care Provider
PHI – Protected Health Information
PT– Physical Therapy
QHP – Qualified Health Plan
QI Program – Quality Improvement Program
QIO – Quality Improvement Organization
RN – Registered Nurse
SIE – Site Inspection Evaluation
SNF – Skilled Nursing Facility
ST – Speech Therapy
UM – Utilization Management

Section 13: WellCare Resources

WellCare Marketplace Homepage
www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace

Secure Provider Portal
portal.wellcare.com/login/provider

Provider Homepage
www.wellcare.com/Kentucky/Providers

Quick Reference Guide
www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace

Provider Manual
www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace

Forms and Documents
www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace/Forms

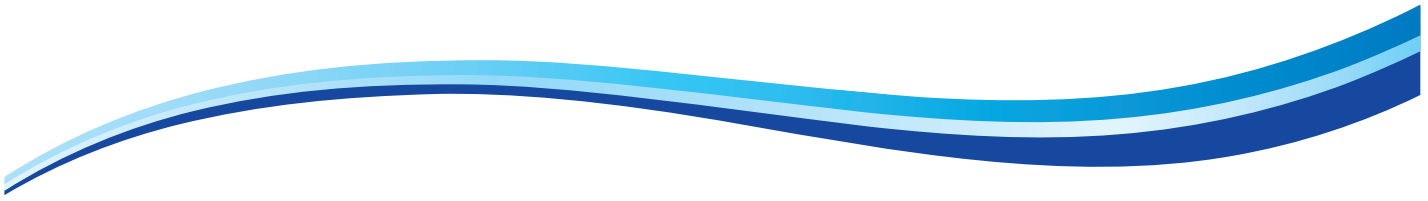
Pharmacy
www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace/Pharmacy-Tools

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

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

Quality
www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace/Quality

Other Resources
www.wellcare.com/Kentucky/Providers/Health-Insurance-Marketplace



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