

---

**Overview**

The focus of WellCare's Utilization Management (UM) Program is to provide members access to quality care and to monitor the appropriate utilization of services.

WellCare's UM Program has five principal functions:

1. Admission and continued stay review
2. Data gathering
3. Retrospective assessment
4. Case management
5. Discharge coordination

**Program Objectives**

- To ensure that WellCare members receive care in the most appropriate and cost-effective setting for the treatment of the individual's medical condition;
- To ensure that participating WellCare providers render appropriate, cost-effective quality services;
- To appropriately treat the member's medical condition through services determined to be medically necessary;
- To ensure that participating hospitals monitor patient care by establishing and administering effective Utilization Review Plans;
- To ensure that members receive necessary services that meet currently accepted professional quality standards of medical practices;
- To track a member's care to ensure he/she is not subject to over-utilization or under-utilization of medical services.

**Activities and Services Encompassed by the Program**

WellCare's UM Program includes, but is not limited to:

- Plan of treatment
- Discharge planning and coordination
- Oversight of hospital utilization review committee monitoring activities

- Certification of need for acute care
- Review of need for continued stay
- Post-payment review and assessment (including length of stay and ancillary service review)
- Data gathering
- Referral for educational services

**Review  
Functions for  
Authorized  
Hospitals**

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

- Certification and recertification of the need for acute care
- Treatment pursuant to a plan of care
- Operation of utilization review plans

At the time a WellCare member is admitted into a hospital for inpatient services, the admitting physician must certify that the inpatient services are medically necessary. The certification must be made at the time of admission. A comprehensive note in the medical record can meet this requirement at the time of admission.

The attending physician, or authorized representative, must recertify that inpatient services continue to be medically necessary and appropriate to the acute care setting. A comprehensive progress note in the medical record can meet this requirement at least every two days. WellCare requires that a written plan of care be completed for each member prior to authorization for payment, before admission to a hospital for elective admissions, and within 24 hours for emergency admissions. The plan should be multi-disciplinary and should include at least the attending physician and the nursing staff.

The plan must include:

- Diagnoses, symptoms/complaints indicating the need for admission
- A description of the functional level of the individual
- Medication or treatment orders
- Diet and activity level

- Plans for hospital course
- Plans for discharge.

**Services Which  
Require  
Prior  
Authorization**

In order to provide the best care possible for members, the Plan requires that all inpatient hospital admissions/observations be pre-certified and all outpatient procedures be prior approved.

**For services requiring prior authorization and for the telephone number of the Utilization Management department, refer to the Quick Reference Guide.**

Prior authorization is necessary for reimbursement, however, it does not guarantee reimbursement. The member must be eligible at the time the service is rendered. The goal is to ensure that covered medical and psychiatric services, and covered surgical procedures are medically necessary, and are provided in the most appropriate and cost-effective setting. The hospital medical record must substantiate the medical necessity including the appropriateness of the setting for the services provided and billed to WellCare.

All services regardless of certification are subject to review for medical necessity. In addition, emergency admissions must be certified within one business day after admission as a condition of reimbursement. For obstetrical care, inpatient hospital admissions for post-delivery services must be pre-certified when a delivery procedure cannot be coded on the hospital claim form (e.g., delivery at home, delivery en route to the hospital, etc.).

The Plan has up to 14 calendar days to determine whether a service requested is a medically appropriate and covered service. When possible, decisions on Prior authorization will be rendered by the Plan within three business days after adequate medical information has been received to determine medical necessity and appropriate level of care.

**FAILURE TO OBTAIN THE REQUIRED PRIOR AUTHORIZATION WILL RESULT IN DENIAL OF REIMBURSEMENT.**

---

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

The attending physician or hospital staff is responsible for obtaining pre-certification from WellCare and for providing the pre-certification number to each WellCare provider associated with the case (i.e., assistant physician, hospital, etc.). Failure to obtain the correct pre-certification number will result in denial of payment.

Requests for pre-certification should be submitted at least 10 business days prior to the planned admission or procedure. Once a procedure is approved, the approval is only valid for 60 days from the date of issuance. Recertification is required for hospital admissions that exceed the 60-day requirement. A request for recertification should be submitted to the Plan at least three days prior to the initial 60-day admission term. Pre-certification and recertification may be requested by contacting WellCare.

In cases when prior authorization has been obtained for an outpatient procedure, and during the procedure it is determined that the member requires an additional or different procedure, the procedure will be considered an urgent procedure.

The hospital's request for an update of the prior authorization will be considered timely if received within three business days of the date of the procedure.

When prior authorization has been obtained for an outpatient procedure, and after the procedure has been performed it is determined that the member requires inpatient services, the admission should be considered an emergency. The hospital's request for an update of the prior authorization should be considered timely if received within three business days of the beginning date of the episode of care.

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

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

**Procedures for  
Obtaining  
Prior  
Authorization for  
Dental Services  
Requiring  
Hospitalization**

Prior authorization is required for any dental service requiring inpatient or outpatient hospitalization. It is the responsibility of the attending dentist to obtain pre-certification and to provide the pre-certification number to the hospital. The failure of the attending dentist to obtain the correct pre-certification number will result in denial of payment.

**For prior authorization of dental services requiring hospitalization, contact the Plan's Utilization Management department at the telephone numbers listed on the Quick Reference Guide.**

**Procedures for  
Obtaining  
Prior  
Authorization for  
Transplants**

In order to receive prior authorization for a Medicaid-approved transplant, a written request with medical records must be received by WellCare for review.

WellCare must approve transplant procedures and related services prior to the transplant, regardless of the age of the member. Once a transplant procedure is approved, an authorization number will be assigned. The member must be eligible at the time services are provided and these services cannot be approved retroactively.

**For requests for approval of coverage of all transplant services, contact the Plan's Utilization Management department at the telephone numbers listed on the Quick Reference Guide.**

**Concurrent  
Review**

The Plan's concurrent review involves oversight of members admitted to hospitals, rehabilitation centers, skilled nursing facilities and other inpatient settings. The concurrent review nurse follows the clinical status of the member on an ongoing basis through telephone or on-site chart review and communication with the physicians and/or other health care professionals involved in the

member's care.

The concurrent review process incorporates the use of nationally recognized standards of medical practice, InterQual™ guidelines and when appropriate, determinations will also include consideration of relevant and appropriate psycho-social factors. Licensed nurses under the direction of the Plan's medical director perform reviews.

Integral to the concurrent review process is **notification** by the hospital of admissions; births and post stabilization care subsequent to emergency. Requests for post-stabilization care must be pre-authorized in order to ensure payment for post-stabilization services. Failure to make appropriate admission or post-stabilization **notification** will result in non-payment of a subsequent claim.

Based on nationally recognized standards of medical practice, WellCare will review all admissions to and services provided in an acute-care setting. All participating hospital reviews must be in compliance with procedures outlined in the hospital's utilization review plan. An entry must be made in the utilization review notes on the review date, indicate the name and title of the reviewer and be signed by the reviewer. This entry must also indicate the severity of illness/intensity of service (SI/IS) criteria that was met for medical necessity of the hospital stay. Failure to document the SI/IS criteria in the utilization review notes may result in the denial of reimbursement of your claim.

If the hospital utilizes an electronic entry system for utilization review, the entry must indicate a unique identifier with the name and title of the reviewer on file as well as the date the entry was made.

### **After-Hours Utilization Management**

The Plan provides authorization of inpatient admissions 24 hours a day, seven days a week. Physicians requesting after-hours authorization for inpatient admission should refer to their **Quick Reference Guide** for the telephone number to contact the 24-Hour Nurse Advisor Line. A

---

nurse will handle discharge planning needs that may occur after normal business hours.

**Plan Criteria for Utilization Management Decisions**

The Plan's UM department utilizes various criteria, which may include the following, when making coverage determinations:

- Medical necessity
- Member benefits
- Local and federal statutes and laws
- InterQual™
- Medicaid/Medicare guidelines
- Hayes Health Technology Assessment

**Admissions Requiring Review**

All admissions shall be screened through the WellCare Utilization Review program.

**Retrospective Reviews**

WellCare will review post-service requests for authorization of inpatient admissions or outpatient services occurring within three business days of the date of the admission or the date services were provided. 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 will take into account the member's needs at the time of service. All medical claims are subject to retrospective review by WellCare.

**Service Authorization Decisions**

The Plan has up to 14 calendar days after receipt of the request for service to determine whether a service requested is a medically-appropriate and covered service.

In some cases, a member has the right to a decision three business days after receipt of the request for service. Plan members can get a fast decision if waiting 14 days for a standard decision could seriously harm their health or ability to function. If the member asks for a fast decision, UM will decide whether to grant the request. If a fast decision is not granted, the request will be processed

within 14 calendar days. If any physician requests an expedited decision, it will be granted.

Members and providers may file a verbal or written request for an expedited authorization decision: To file a verbal or written request refer to the **Quick Reference Guide**. The Plan will document the verbal request in writing. Specifically state, "I want an expedited or 24-hour decision," or "I believe that my health/the health of my patient could be seriously harmed by waiting 14 days for a standard decision."

All pharmacy prior authorizations must be completed by no later than the end of the second working day or as expeditiously as the member's condition warrants.

**Extension for Service Authorization Decisions**

An extension of up to 14 calendar days is permitted, if the extension of time benefits the member. For example, if the member needs time to provide the Plan with additional information, or to complete additional diagnostic tests.

**Case Management**

The WellCare Case Management (CM) team facilitates collaborative relationships between the members, providers, member's support system, and the plan. The Case Management team advocates for member preferences and the members' unique health service needs. This is accomplished through assessment and planning, anticipating the members' future healthcare requirements to promote positive outcomes, prevention of complications, and eventual recovery. Case Management ensures continuity of care and a smooth transition for the member through the continuum of care, by coordinating care among physicians and other providers.

Case Managers coordinate services intended to achieve improved member care and health outcomes, reduction in utilization of emergent services and/ or inpatient hospitalizations and increase "community tenure" in terms of the time members spend in productive, rewarding activities. The CM team also provides member education and seeks to improve the efficiency and value of healthcare expenditures through efforts to assure access

---

to quality services which ultimately lower overall health related costs.

The Plan categorizes its case management programs to best meet the members' specific health care needs:

- All conditions that are mandated for case management by the Ohio Department of Job and Family Services
- Catastrophic, i.e., spinal cord injury, head trauma, etc.
- Transplant
- Complex, i.e., multiple co-morbidities, acute exacerbations of chronic states, ESRD, etc.
- Prenatal
  - High Risk Obstetrics
- Special Needs

### **Primary Care Providers (PCP)**

PCP's serve as an important partner; critical to the success of the Case Management Team. WellCare's CM Program is member centric; everything revolves around the members needs taking into account the individual culture, beliefs and expectations. The Plan's Case Management Team makes itself available to support the PCP and assist the PCP in coordinating care among multiple physicians, providers, services, facilities and disciplines. The PCP:

- Serve as an ongoing source of primary care for the member, including supervising, coordinating, and providing all primary care to the member.
- Are primarily responsible for coordinating other healthcare services furnished to the member, including:
  - Coordinating and initiating referrals to specialty care (both in and out-of-network)
  - Maintaining continuity of care
  - Maintaining the member's medical record
- The Case Management Team is comprised of specially-qualified nurses who assist the physician and/ or specialist (s) in achieving member optimum

wellness and autonomy through advocacy, communication, education and service facilitation.

The Plan has incorporated Case Management programs that manage members with specific healthcare needs, i.e. CHF, COPD, Asthma, Diabetes, multiple inpatient admissions, etc. The physician may call to request Case Management services for any Plan member.

**Prenatal Program**

The Prenatal Program promotes a healthy pregnancy and delivery for the member and baby. The member receives educational material, trimester and post-partum letters as well as access to the Case Management Team for questions, concerns, or if needed enrollment into the High Risk OB program.

**High-Risk OB Case Management**

The focused High-Risk OB Case Management Program provides assistance to members who are identified as potential high-risk pregnancies. If the physician notifies the Plan of a member's non-adherence, potential for the member's condition to worsen as the pregnancy progresses, or other concerns that may threaten the pregnancy, the High-Risk OB Case Management Program can support the physician with necessary interventions.

The High Risk OB Case Management Program provides assistance to members that are identified as potential high risk pregnancies.

**Transition of Members**

For members enrolling in the Plan, the Plan will honor written documentation of prior authorization of ongoing covered services. WellCare will cover pre-authorized services for 90 calendar days after the effective date of enrollment.

**Discharge Coordination**

Discharge coordination or planning is an essential part of the concurrent review process. It may include coordinating services required to assist in arranging for and implementing a member's transition to a more appropriate or lower level of care, as needed. The concurrent review

nurse coordinates services with the PCP, attending physician and/or the discharge planning personnel at the hospital.

If a member requires a transfer from an acute-care setting to a nursing care facility or home-care setting, the hospital will coordinate with WellCare to identify alternative services and to maintain continuity of care.