



Dear Provider,

Welcome! Thank you for becoming a participating provider with WellCare Health Plans, Inc. (the Plan).

We recognize that, at times, the administrative requirements of managing your patients' health care can be complex. This Provider Manual is a source of answers to questions you may have about Plan coverage procedures, policies and other facts related to your provision of health care services to WellCare members.

As described in your contract with WellCare (the "Provider Agreement") this Provider Manual supplements and provides additional terms and conditions regarding your provision of covered services to WellCare members. In the event of a conflict between the Provider Agreement or any contract providing member coverage ("Coverage Document"), the Provider Agreement or Coverage Document will control over this Provider Manual.

The purpose of any medical policy that may be included in this Provider Manual is to provide guidelines to facilitate coverage decisions and is not intended to influence treatment decisions. While the Plan's medical policy assists in making appropriate coverage decisions that promote consistent, high quality, and cost-effective health care, providers are independent contractors and have an independent professional responsibility for the provision of health care to their patients in accordance with community standards regardless of any WellCare coverage decision. Nothing in this Provider Manual shall be construed as creating any relationship between you and the Plan other than that of independent entities that have contracted with each other solely for the purpose of providing the services described in the Provider Agreement.

WellCare makes no representations or warranties with respect to the content herein and specifically disclaims any implied warranties of merchantability of fitness for any particular purpose.

This Provider Manual is provided for the convenience of providers participating in any WellCare network. Nothing in this manual shall be interpreted as guaranteeing coverage of any service, treatment, drugs or supplies because coverage or non-coverage is always governed exclusively by the terms of the member's Coverage Document. Accordingly, in case of any question or doubt about coverage, you should always review the member's particular health benefit plan.

Updates to any part of this Provider Manual may be made by Plan at any time, so you should not assume that the Provider Manual remains current just because you have not received a replacement manual. As described in your Provider Agreement, the Plan may give notice of such updates in a variety of ways, depending on the nature of the update, including issuance of a new manual, a letter, a provider newsletter or other publication of the Plan, or by posting to the Plan's Web site.

Thank you for your participation with WellCare of Ohio. We look forward to helping you provide the highest quality of care to our Ohio members.



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This section is reserved for the Provider to insert additional information such as Plan notifications and correspondence that serve as updates to our policies and procedures. Examples are benefit changes, pharmacy updates, claim procedure updates and prior authorization changes, etc.



## ALL ABOUT WELLCARE

### Section 1

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#### Introduction

WellCare Health Plans, Inc. provides managed care services exclusively for government-sponsored health care programs, focusing on Medicaid and Medicare.

Headquartered in Tampa, Florida, WellCare offers a variety of health plans for families, children, the aged, blind and disabled and prescription drug plans, currently serving more than 2.5 million members nationwide.

#### Mission

WellCare will:

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

#### Core Values

##### Partnership

Members are the reason we are in business; providers are our partners in serving our members; and regulators are the stewards of the public's resources and trust. We will deliver excellent service to our partners.

##### Integrity

Our actions must consistently demonstrate a high level of integrity that earns the trust of those we serve.

##### Accountability

All associates must be responsible for the commitments we make and the results we deliver.

##### Teamwork

With our fellow associates, we can expect – and are expected to demonstrate – a collaborative approach in the way we work.



## ALL ABOUT WELLCARE

### Section 1

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#### **Accreditation**

WellCare's health plans are accredited by the Accreditation Association for Ambulatory Health Care (AAAHC), one of the leading quality standard-setting organizations in the nation. AAAHC evaluates the structure and function of medical and quality management systems in health care organizations. The Plan's compliance with these standards reflects its commitment to principals of quality and continuous improvement of the service provided.

#### Overview

This section of the Provider Manual addresses the respective responsibilities of participating physicians.

#### Primary Medical Offices

Primary Care Providers (PCPs) provide comprehensive primary medical services to Plan members. Primary Care offices participating in the Plan provider network receive the following benefits:

- Full support of the Provider Relations, Member Services, Claims and Health Services departments;
- Information on discharge planning; and
- Access to the medical resources of the participating network of providers, hospitals and ancillary services.

#### Primary Care Provider Responsibilities

Following is a summary of responsibilities specific to PCPs who render services to Plan members. Please also refer to the listing of responsibilities for “All Physicians.” Additional information can be found in the Provider Agreement.

- Coordinate, monitor and supervise the delivery of primary care services to each member.
- Assure the availability of physician services to members in accordance with “Appointment Scheduling” as outlined in this section.
- Arrange for on-call and after-hours coverage in accordance with “After-Hours Service” as outlined in this section.
- Provide access to the Plan or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity. A *related organization or entity* is defined as: Having influence, ownership or control and either a financial relationship or a relationship for rendering services to the primary care office.

- Submit an encounter for each visit where the provider sees the member or the member receives a HEDIS<sup>®</sup> (Healthcare Effectiveness Data and Information Set) service.
- Submit encounters on a CMS 1500 form or electronically via e-mail in the 837P file format.
- Ensure members utilize network providers. If unable to locate a participating provider for services required, contact Utilization Management for assistance.
- Allow members to go to non-participating Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) without a referral.
- Allow members access to contracted Certified Nurse Midwives (CNMs) and Certified Nurse Practitioners (CNP), if such services are available in the region. If there is not a contracted CNM or CNP in the region, the member should be allowed to receive such services outside of WellCare's network.
- Ensure sufficient supply and provide immunizations in accordance with the childhood immunization schedule as approved by the Advisory Committee on Immunization Practices (ACIP) of the U.S. Public Health Service and the American Academy of Pediatrics or when it is shown to be medically necessary for the child's health.

### **Domestic Violence and Substance Abuse Screening**

Physicians should identify indicators of substance abuse or domestic violence. Suggested screening tools for Domestic Violence and Substance Abuse are located in the **Provider and Member Education Materials** section of this manual.

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**Smoking  
Cessation**

PCPs should direct members who smoke or desire to quit smoking to call Member Services and ask to speak with the Care Management department. A care manager will educate the member on national and community resources that offer assistance, as well as the options available to the member by the Plan.

All members who call will receive educational material including “Just Quit,” a Tobacco Cessation Program Guide. Additionally, the Plan can assist OB providers when they identify pregnant members who are at risk as a result of smoking. Care managers can provide information and names of support groups available through the local health departments.

More information on smoking cessation is located in the **Provider and Member Education Materials** section of this manual.

**Adult Health  
Screening**

Wellness exams for adults should be performed by a PCP at the earliest opportunity upon enrollment into the Plan to assess the health status of a member age 21 or older.

The adult member should receive an appropriate adult health screening annually including assessment and interventions as indicated.

Please refer to the screening tools in the **Provider and Member Education Materials** section of this manual.

**Healthchek/EPSDT**

Healthchek, otherwise known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally-mandated comprehensive child health program for Medicaid recipients from birth through age 20. It is designed to maintain health by providing early intervention to discover and treat health problems. In Ohio, the EPSDT program is referred to as Healthchek.

Documentation for the Healthchek screen may be incorporated into the documentation routinely kept for well-child check-ups. However, when the patient

receives the Healthchek screen components or when the patient is referred elsewhere to receive components, it is imperative that the patient record reflects the components that were given and also the components, if any, that were referred elsewhere.

WellCare of Ohio has included a form in the Provider Manual for physicians to use to simplify documentation of Healthchek screenings.

### **Children with Special Health Care Needs**

Children with special health care needs (CSHCN) are defined as children age 17 and under who are pregnant, and members under 21 years of age with one or more of the following:

- Asthma;
- HIV/AIDS;
- A chronic physical, emotional or mental condition for which they need or are receiving treatment or counseling;
- Supplemental security income (SSI) for a health-related condition; and/or
- A current letter of approval from the Bureau of Children with Medical Handicaps (BCMh), Ohio Department of Health.

CSHCN children are identified through administrative review, PCP referrals or outreach.

Once members are identified, the Care Management department follows the Ohio Department of Job & Family Services (ODJFS) CSHCN program requirements.

### **Pre-certification**

Providers must refer members to participating providers for services not provided in the physician's office. Pre-certification must be obtained from WellCare's Utilization Management department for the certain medical services. Please refer to the **Quick**

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**Reference Guide** of this manual for contact information.

The following information is required when requesting pre-certification:

- Member's complete name;
- Member's date of birth;
- Member's WellCare ID number or Ohio Medicaid Number;
- The hospital name, if appropriate;
- Clear description of the member's medical condition, outpatient surgery or procedure(s) to be performed, type of home health services requested and proposed treatment plan;
- Diagnosis code(s) and proposed date(s) of service
- Treating physician's name, if other than the PCP; and
- Place of Service.

Requests for pre-certification are required at least 10 business days before the scheduled admission or service. Failure to coordinate medical care with or to obtain pre-certification from WellCare may result in denial of payment for these services.

### **Member Rights and Responsibilities**

Members have the following rights:

- To receive all services that the Managed Care Plan (MCP) is required to provide pursuant to the terms of their provider agreement with the ODJFS.
- To be treated with respect and with due consideration for their dignity and privacy.

- To be ensured of confidential handling of information concerning their diagnoses, treatments, prognoses and medical and social history.
- To be provided information about their health. Such information should also be made available to the individual legally authorized by the member to have such information or the person to be notified in the event of an emergency when concern for a member's health makes it inadvisable to give him/her such information.
- To be given the opportunity to participate in decisions involving their health care unless contraindicated.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- To be assured of auditory and visual privacy during all health care examinations or treatment visits.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To request and receive a copy of their medical records, and to be able to request that their medical records be amended or corrected.
- To be afforded the opportunity to approve or refuse the release of information except when release is required by law.
- To be afforded the opportunity to refuse treatment or therapy. Members who refuse treatment or therapy will be counseled relative to the consequences of their decision, and documentation will be entered into medical records accordingly.

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- To be afforded the opportunity to file grievances, appeals, or state hearings pursuant to the provisions of rules 5101:3-26-08.4 and 5101:3-26-08.5 of the Administrative Code.
  - To be assured that all written member information provided by the MCP is available:
    - At no cost to the member;
    - In the prevalent non-English languages of members in the MCP service area; and
    - In alternative formats and in an appropriate manner that takes into consideration the special needs of members including, but not limited to, visually-limited and LRP members.
  - To be assured that oral interpretation and oral translation services are available at no cost to members.
  - To be assured that the services of sign language assistance are available to hearing impaired members.
  - To be informed of specific student practitioner roles and the right to refuse student care.
  - To refuse to participate in experimental research.
  - To formulate advance directives and to file any complaints concerning noncompliance with advance directives with the Ohio Department of Health.
  - To change PCPs no less often than monthly. MCP's must mail written confirmation to the member of their new PCP selection prior to or on the effective date of the change.
  - To appeal to or file directly with the United States Department of Health and Human Services, Office of Civil Rights, any complaints of discrimination on the basis of race, color,

national origin, age or disability in the receipt of health services.

- To appeal to or file directly with the ODJFS Office of Civil Rights any complaints of discrimination on the basis of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services in the receipt of health services.
- To be free to exercise their rights and to be assured that exercising their rights does not adversely affect the way the MCP, the MCP's providers or ODJFS treats the member.
- To be assured that the MCP must comply with all applicable federal and state laws and other laws regarding privacy and confidentiality.
- To choose his or her health professional to the extent possible and appropriate.
- To be assured that female members have direct access to a woman's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated PCP if the PCP is not a woman's health specialist.
- To be provided a second opinion from a qualified health care professional within the MCP's panel. If such a qualified health care professional is not available within the MCP's panel, the MCP must arrange for a second opinion outside the network, at no cost to the member.
- To receive information on their MCP.

Members have the following responsibilities:

- To treat their health care providers and their office staff with courtesy and respect;

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- To fully inform their doctor about their medical problems;
  - To decide about having a medical treatment or procedure before it begins;
  - To help their PCP obtain their medical records;
  - To not seek care from a specialist without a referral from their PCP when a referral is required by WellCare;
  - To not seek care in an emergency room for non life-threatening conditions without contacting their PCP;
  - To keep all scheduled appointments and be on time; and
  - To follow the rules and regulations of WellCare.

**Note:** *This information is provided to each member.*

### **Member Grievances**

If the member is not satisfied with their physician or with WellCare (i.e. they think they have been treated badly, denied services or discriminated against in any way because of a handicap or source of payment), they have the right to complain to WellCare.

The member may submit their grievance on the telephone, in person or in writing. The member may call WellCare's Member Services department to express their grievance or write to the address listed on the **Quick Reference Guide**.

### **Living Will and Advance Directives**

Members have the right to control decisions relating to their medical care; including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life.

The law provides that each Plan member (age 18 years or older of sound mind), should receive information concerning this provision, and have the

opportunity to sign an Advance Directive Acknowledgement form to make their decisions known in advance. This allows them to designate another person to make a decision should they become mentally or physically unable to do so.

Forms should be available in provider offices and discussed with the member. The completed forms should be documented and filed in the member's medical record.

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

**Appointment Availability**

Providers must adhere to the following criteria to comply with the following appointment requirements:

- Services are to be available twenty-four (24) hours a day, seven (7) days a week, when medically necessary.

**Primary Care Providers**

- Members with emergency care needs must be triaged and treated immediately on presentation at the PCP site.
- Members with persistent symptoms must be treated no later than the end of the following working day after their initial contact with the PCP site.
- Members with requests for routine care must be seen within six (6) weeks.

**Specialty Care Providers**

- Members with emergency care needs must be triaged and treated immediately on presentation at the Specialist site.
- Members with persistent symptoms must be treated no later than thirty (30) days after their initial contact with the Specialist site.

- Members with requests for routine care (stable condition) must be seen within twelve (12) weeks.

**After-Hours Services**

The PCP must be available after regular office hours to offer advice and to assess any condition that may require immediate care. This includes referral to the nearest hospital emergency room in the event of a serious illness.

To assure accessibility and availability, PCPs shall be required to provide, or arrange for coverage of services, consultation or approval for referrals twenty-four (24) hours per day, seven (7) days per week. This coverage must consist of an answering machine, call forwarding, provider call coverage or other customary means. The chosen method of twenty-four (24) hour coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after hours coverage must be accessible using the medical office's daytime telephone number.

**Out-of-Area Member Transfers**

Participating physicians and providers should assist the Plan in arranging and accepting the transfer of members receiving care out of the service area, if the transfer is considered medically acceptable by the Plan physician and/or provider and the out-of-network attending physician.

**PCP Request for Transfer of a Member**

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

Membership acceptance must be without regard to color, gender, race, religious belief, national origin or handicap of applicant.

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Reasonable efforts should always be made to establish a satisfactory provider/member relationship in accordance with practice standards. The physician or provider should provide adequate documentation in the member's medical record to support his/her efforts to develop and maintain a satisfactory provider/member relationship.

If a satisfactory relationship cannot be established or maintained, the provider or physician shall continue to provide medical care for the Plan member. Care shall continue until such time that written notification is received from the Plan stating that the member has been transferred from the provider or physician's practice. Members will be allowed to stay with their current provider for up to 30 days or until the member is accepted with another provider.

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

The physician or provider should complete a PCP Request for Transfer of a Member form, attach supporting documentation and fax the form to Member Services. A copy of the form is available in the **Forms** section of this manual.

### **Responsibilities of All Physicians**

The remainder of this section is an overview of responsibilities for which all Plan providers are accountable.

Please refer to the Provider Agreement, or contact a Provider Relations representative for clarification on any of the following.

Physicians must, in accordance with generally accepted professional standards:

- Use physician extenders appropriately.

Physician assistants (PA) and advanced registered nurse practitioners (ARNP) should provide direct member care within the scope or practice established by the rules and regulations of the state of Ohio and Plan guidelines.

- The sponsoring physician will assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations.
- ARNPs and PAs should clearly identify their titles to members, as well as to other health care professionals.
- Any member request to be seen by a physician, rather than a physician extender, must be honored at all times.
- Accept treatment for any member in need of health care services they provide.
- Refer Plan members with problems outside of his/her normal scope of practice for consultation and/or care to appropriate specialists contracted with Plan.
- Identify members that have potential linguistic barriers for which alternative communication methods are needed and contact Member Services to arrange for appropriate assistance. Linguistic services such as oral translation/interpretation and sign language are provided by a Plan contracted vendor at no cost to members or providers.
- Refer members to participating physicians or providers, except when they are not available or in an emergency.
- Admit members only to participating hospitals, SNFs and other inpatient care facilities, except in an emergency.

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- Respond promptly to Plan requests for medical records in order to comply with regulatory requirements.
  - Inform Plan in writing within 24 hours of any revocation or suspension of their Bureau of Narcotics and Dangerous Drugs number, and/or suspension, limitation or revocation of their license, certification or other legal credential authorizing them to practice in the state of Ohio.
  - Inform Plan in writing immediately of changes in licensure status, tax identification numbers, telephone numbers, addresses, status at participating hospitals, loss of liability insurance, providers included in your practice, acceptance of new patients, standard office hours and any other change which would affect their status with Plan.
  - Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Plan member, subscriber or enrollee other than for co-insurance, deductibles or fees for non-covered services furnished on a “fee-for-service” basis. Non-covered services are services not covered in the member’s Plan contract.
  - Treat all member records and information confidentially, and not release such information without the written consent of the member, except as indicated herein, or as allowed or needed for compliance with state and federal law.
  - Maintain quality medical records and adhere to all Plan policies governing the content of medical records as outlined in the Plan’s Quality Improvement guidelines. All entries in the member record must identify the date and the provider.

- 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 clinical information between Plan providers timely. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to the Plan, the member or the requesting party, at no charge, unless otherwise agreed upon.
- Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen.
- Not discriminate in any manner between Plan members and non-Plan members.
- Providers are required to follow all applicable ODJFS guidelines related to marketing to members.
- Fully disclose to members their treatment options and allow them to be involved in treatment planning.
- Inform member of specific health care needs which require follow-up care and provide, as appropriate, training in self-care and other measures members may take to promote their own health.
- Identify members that are in need of services related to children's health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation or substance abuse. If indicated, providers must refer members to

plan-sponsored or community-based programs.

- The provider must document the referral to plan-sponsored or community-based programs in the member's medical record and provide the appropriate follow-up to ensure the member accessed the services.
- The provider will provide all of the following, where applicable, to members upon request:
  - Information related to the health care specialty, and board certification, if applicable;
  - The names of licensed facilities on the provider panel where the health care provider presently has privileges for the treatment, illness or procedure that is the subject of the request; and
  - Information regarding the health care provider's participation in continuing education programs and compliance with any licensure, certification or registration requirements, if applicable.
- A participating health care provider shall provide the following to WellCare upon request:
  - Medical records for utilization management and/or quality improvement activities; and
  - Provider's capitated by WellCare (excluding PCPs) shall submit financial information to WellCare, including, but not limited to Audited Annual Financial Statements. Financial Statements shall include Balance Sheet, Income Statement and Cash Flow Statement.

These documents are used in WellCare's evaluation of a provider's financial ability to perform and sustain services as defined in the Provider Agreement.

#### **Specialist Responsibilities**

Specialists are responsible for treating Plan members referred to them by the PCP and communicating back to the PCP for authorizations.

Specialists may not refer to another Plan specialist.

Specialists should also:

- Verify the PCP referred the member prior to rendering services through document confirmation (i.e. referral form), unless the provider has made other arrangements with WellCare or unless the specialist is one that a member may self-refer to;
- Provide only approved services as indicated by PCP on the referral document;
- Notify the member's PCP if another specialist or health care provider is needed to evaluate and treat member's condition; and
- Provide note of consultation to the member's PCP, in writing, of any recommended ongoing treatment program or elective inpatient admission.

Any inpatient or elective procedures are to be prior-authorized by Health Services. Please refer to the **Utilization Management** section of this manual for prior authorization instructions.

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

All consultations or discussions involving the member, or his/her case, should be conducted discreetly and professionally in accordance with all applicable state and federal laws including the HIPAA Privacy and Security regulations.

Any data or information pertaining to the diagnosis treatment, or health of any enrollee obtained from such person or from any provider by any HMO shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of these regulations; or upon the

express consent of the enrollee; or pursuant to statute or court order for the production of evidence or the discovery thereof or in the event of claim or litigation between such person and the HMO wherein privileges against such disclosure which the provider who furnished such information to the HMO is entitled to claim.

No health care provider may be penalized for considering, studying or discussing medically necessary or appropriate care with or on behalf of his or her patient.

All physician practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure that there is a: (i) privacy officer on staff; (ii) a policy and procedure in place for confidentiality of members' protected health information (PHI); and (iii) that the practice is following those procedures and/or obtaining appropriate authorization from members to release PHI where required by applicable state and federal law.

Policies and procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information to include PHI.

All members have a right to confidentiality, and any health care professional or individual person who deals directly or indirectly with the member or his/her medical record must honor this right. Every practice is required to provide to members their Notice of Privacy Practice. Employees who have access to member records and other confidential information are required to sign a "Confidentiality Statement."

Some examples of confidential information includes:

- Any communication between a member and a physician;
- All protected health information as defined under the federal HIPAA Privacy regulations;
- Any communication with other clinical persons

involved in the member's health, medical and mental care (i.e., diagnosis, treatment and any identifying information such as name, address Social Security number (SSN, etc.);

- Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem; and
- Any communicable disease (such as Acquired Immune Deficiency Syndrome (AIDS) or human immunodeficiency virus (HIV) testing that is protected under federal or state law.

When an individual enrolls in the Plan, federal law permits the health care provider permission to release his/her medical records to the Plan, members of the provider network, or agencies conducting regulatory or accreditation reviews, and business associates.

The Notice of Privacy Practice (NPP) informs the patient or member of their member rights under HIPAA and how the provider and/or health plan may use or disclose the members' PHI. HIPAA regulations require each provider and health plan to provide a NPP to each new patient or member accordingly.

## **Fraud and Abuse**

### **What is Peer Profiling?**

The WellCare Special Investigations Unit (SIU) performs a multitude of pre-pay and post-pay functions. One of those specifically being Peer Profiling.

*Peer profiling* is primarily a post-pay function conducted using a myriad of analytical engines and driven by established norms within a specialty. For example, every pediatrician that provides services within the demographic for WellCare is pooled into one data set. The SIU is careful to remove pediatricians with sub-specialties so as not to include a pediatric cardiologist in with a straight pediatrician. We group each pediatric sub-specialty and perform that function separately.

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From that data set our Data Analytics team is able to determine the bell curve and define the distribution for any range of codes. One of the most commonly profiled ranges of the SIU screen would be CPT codes 99211, 99212, 99213, 99214 and 99215.

Once established we focus our initial concern on the providers that have billing patterns two to three deviations from the norm, or also known as 'skewed right' of the bell curve. This normally triggers an audit or further investigation related to determining if the documentation supports the billing.

### **Special Investigations Unit**

A corporate Special Investigations Unit (SIU) has been established according to federal and state statutory, regulatory and contractual requirements and includes management, investigators, analysts, medical coding auditors and claim review specialists. SIU capabilities include pre-payment and retrospective reviews, provider profiling models, performance metrics, data mining, analysis and reporting and specialized business partner arrangements to augment in-house resources.

The mission of the SIU is outlined below:

- Comply with applicable federal and state statutory, regulatory and contractual requirements regarding fraud, waste and abuse;
- Effectively detect, investigate and report suspected fraud, waste and abuse;
- Identify and recover overpayments caused by error, fraud, waste or abuse;
- Assist in the development of anti-fraud plans, policies and procedures, and fraud and abuse awareness, education and training materials;
- Assist in conducting education and training for associates, providers, members, first-tier,

delegated and related entities on fraud and abuse awareness and other related topics according to established training schedules; and

- Assist in conducting vulnerability assessments, auditing and monitoring activities of first-tier, delegated and related entities.

**Second Opinions**

Members may request a second medical opinion concerning surgical procedures or serious injury or illness. The member may choose a qualified physician that is participating with the Plan. If such qualified physician is not available within the Plan, the PCP must obtain prior authorization for the member to obtain a second medical opinion outside the network, at no cost to the member.

It is the responsibility of the PCP to coordinate tests ordered as a result of a second opinion with participating providers and develop a treatment plan for the member after review of the second medical opinion.

**Covering Physicians**

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

In non-emergency cases, should you have a covering physician who is not contracted and credentialed with the Plan, contact the Plan for approval. The physician should be credentialed by the Plan, must sign an agreement accepting the negotiated rate and agree not to balance bill Plan members.

For additional information, please contact the Provider Relations department.

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#### **Provider Billing and Address Changes**

Prior notice to the Plan is required for any of the following changes:

- 1099 mailing address
- Tax Identification Number (TIN) or Entity Affiliation (W-9 required)
- Group name or affiliation
- Physical or billing address
- Telephone and/or fax number
- Providers included in your practice
- Acceptance of new patients
- Standard office hours

#### **Provider Termination**

In addition to the provider termination information included in your Provider Agreement with the Plan, the provider must adhere to the following terms:

- Any contracted providers must adhere to the without cause termination provisions of your Provider Agreement. Please refer to your contract for the details regarding the specific required days for providing termination notice.
- Unless otherwise provided in the termination notice, terminations occur on the last day of the month.
- Providers who receive a termination notice from the Plan may submit an appeal. Please refer to the **Appeals and Grievances** section of this manual for specific guidelines.

The Plan, due to regulatory requirements, must notify in writing all appropriate agencies and/or members upon a provider termination as required by regulations and statutes.

#### **Disclosure of Information**

Periodically members may inquire as to the operational and financial nature of their health plan. In accordance with federal and state disclosure requirements, the Plan must provide that information

to the member upon request. Members may contact Member Services to request this information.

**Delegated  
Entities**

All participating providers or entities delegated for Network Management and Network Development should meet all applicable standards and are held to the same standards as defined in this section. Reviews are performed and compliance is monitored on a regular basis.

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**Overview** The Plan will ensure that members are aware of the role of their Primary Care Providers (PCPs), how to obtain care, what to do in an emergency or urgent medical situation, as well as their rights and responsibilities as a WellCare of Ohio member. The Plan will convey this information through various methods including a Member Handbook.

**Member Handbook** All newly enrolled members will receive a Member Handbook on or before their initial effective date of coverage.

**Enrollment** Membership enrollment in WellCare's Medicaid health plans is voluntary as members may select from participating MCPs or by state-mandated assignment. Eligible Medicaid beneficiaries must enroll in one of the MCPs.

The Plan accepts members without consideration of the applicant's health condition, gender, race, religious belief, national origin or handicap.

Upon enrollment in the plan, members are provided with the following:

- Terms and conditions of enrollment;
- Description of covered services;
- Information about PCPs; such as location, telephone number and office hours;
- Information regarding "Out-of-Plan" emergency services;
- Grievance and disenrollment procedures;
- "Over-the-counter" brochure, if applicable.

**Member Identification Cards** Member identification cards are intended to identify Plan members and facilitate their interactions with physicians and other health care providers. Information found on the

member identification card may include the member's name, identification number, plan type, PCP name and telephone number, health plan contact information and claims filing address. Possession of the member identification card does not guarantee eligibility or coverage. The physician or provider is responsible for ascertaining the current eligibility of the cardholder.

**Eligibility  
Verification**

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

You may do one of the following to verify eligibility:

- Access the WellCare Web site at **ohio.wellcare.com** (contact your Provider Relations representative to schedule a Web site in-service);
- Access WellCare's Interactive Voice Response (IVR) system. You will need your Provider ID number to access member eligibility; or
- Contact the Provider Hotline at (800) 951-7719.

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

**Member Rights  
and  
Responsibilities**

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

WellCare members have the right:

- To receive all services that the Managed Care Plan (MCP) is required to provide pursuant to the terms of their Provider Agreement with the Ohio

Department of Job & Family Services (ODJFS).

- To be treated with respect and with due consideration for their dignity and privacy.
- To be ensured of confidential handling of information concerning their diagnoses, treatments, prognoses and medical and social history.
- To be provided information about their health. Such information should also be made available to the individual legally authorized by the member to have such information or the person to be notified in the event of an emergency when concern for a member's health makes it inadvisable to give him/her such information.
- To be given the opportunity to participate in decisions involving their health care unless contraindicated.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- To be assured of auditory and visual privacy during all health care examinations or treatment visits.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To request and receive a copy of their medical records, and to be able to request that their medical records be amended or corrected.
- To be afforded the opportunity to approve or refuse the release of information except when release is required by law.
- To be afforded the opportunity to refuse treatment or therapy. Members who refuse treatment or therapy will be counseled relative to the consequences of their decision, and documentation

will be entered into the medical record accordingly.

- To be afforded the opportunity to file grievances, appeals, or state hearings pursuant to the provisions of rules 5101:3-26-08.4 and 5101:3-26-08.5 of the Administrative Code.
- To be assured that all written member information provided by the MCP is available:
  - (a) At no cost to the member;
  - (b) In the prevalent non-English languages of members in the MCP service area; and
  - (c) In alternative formats and in an appropriate manner that takes into consideration the special needs of members including but not limited to visually-limited and LRP members.
- To be assured that verbal interpretation and verbal translation services are available at no cost to members.
- To be assured that the services of sign language assistance are available to hearing impaired members.
- To be informed of specific student practitioner roles and the right to refuse student care.
- To refuse to participate in experimental research.
- To formulate advance directives and to file any complaints concerning noncompliance with advance directives with the Ohio Department of Health.
- To change PCPs no less often than monthly. MCPs must mail written confirmation to the member of their new PCP selection prior to or on the effective date of the change.
- To appeal to or file directly with the United States Department of Health & Human Services – Office of Civil Rights – any complaints of discrimination on the basis of race, color, national origin, age or

disability in the receipt of health services.

- To appeal to or file directly with the ODJFS Bureau of Civil Rights (BCR) any complaints of discrimination on the basis of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services in the receipt of health services.
- To be free to exercise their rights and to be assured that exercising their rights does not adversely affect the way the MCP, the MCPs providers or ODJFS treats the member.
- To be assured that the MCP complies with all applicable federal and state laws and other laws regarding privacy and confidentiality.
- To choose their health professional to the extent possible and appropriate.
- To be assured that female members have direct access to a woman's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated PCP if the PCP is not a woman's health specialist.
- To be provided a second opinion from a qualified health care professional within the MCPs panel. If such a qualified health care professional is not available within the MCPs panel, the MCP must arrange for a second opinion outside the network, at no cost to the member.
- To receive information on their MCP.

Members also have certain responsibilities. These include the responsibility:

- To treat their health care providers and their office staff with courtesy and respect;

- To fully inform their doctor about their medical problems;
- To decide about having a medical treatment or procedure before it begins;
- To help their PCP obtain their medical records;
- To not seek care from a specialist without a referral from their PCP when a referral is required by WellCare;
- To not seek care in an emergency room for non life threatening conditions without contacting their PCP;
- To keep all scheduled appointments and be on time; and
- To follow the rules and regulations of WellCare.

**Note:** This information is provided to each member.

### **Medical Necessity**

Members will be informed that medically necessary services are:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition;
- Compatible with the standards of acceptable medical practice in the community;
- Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for the convenience of the member or the convenience of the health care provider or hospital; and
- Not primarily custodial care unless custodial care is a covered service or benefit under the members evidence of coverage.

**Emergency/  
Urgent/Post  
Stabilization  
Care**

Emergency Services are available to members 24 hours a day, seven days a week to treat an emergency medical condition.

Emergency and Post Stabilization services and care do not require prior authorization. Members are instructed, in case of an emergency, to call **911** or proceed to the nearest hospital emergency room. Members should notify their PCP as soon as possible following emergency treatment in order to receive appropriate follow-up care.

WellCare has an Emergency Department diversion program that is described in the **Care Management** section of this Provider Manual.

Once the member's condition is stabilized, the Plan may require pre-certification for hospital admission or prior authorization for follow-up care.

**Assignment of  
Primary Care  
Provider**

All Plan members must choose their PCP or they will be assigned to a PCP within the Plan's network. To ensure quality and continuity of care, the PCP is responsible for arranging all of the member's health care needs from providing primary care services to coordinating referrals to specialists and providers of ancillary or hospital services. However, a PCP referral is not required for Behavioral Health visits.

Behavioral Health specialists are responsible for communicating treatment, admissions, discharges and prescribing practices to the member's PCP.

**Changing  
Primary Care  
Providers**

Members may change their PCP selection at any time by calling Member Services.

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**Overview**

WellCare's Utilization Management (UM) Program is designed to meet contractual requirements with the Ohio Department of Job & Family Services (ODJFS) and provide members access to high-quality, cost-effective and medically-necessary care while ensuring prompt and accurate payment to providers.

The focus of the UM Program is on:

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

*Medically necessary or medical necessity* means health care services that a health care provider, exercising prudent clinical judgment, would provide to a patient and are necessary for the diagnosis or treatment of disease, illness

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or injury, without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part or significant pain and discomfort.

A medically-necessary service must:

- Meet generally accepted standards of medical practice;
- Be appropriate to the illness or injury for which it is performed as to type of service and expected outcome;
- Be appropriate to the intensity of service and level of setting;
- Provide unique, essential and appropriate information when used for diagnostic purposes;
- Be the lowest cost alternative that effectively addresses and treats the medical problem; and
- Meet general principles regarding reimbursement for Medicaid covered services found in rule 5101:3-1-02 of Ohio Administrative Code.

Mental Health services shall be provided in accordance with:

- A process of mental health assessment that accurately determines the clinical condition of the member;
- The acceptable standard of practice for such clinical conditions; and
- The inclusion of distinct criteria for children and adults.

Preventive health care, though not customarily thought of as a medically-necessary service, is available through the Early Periodic Screening, Diagnosis and Treatment (EPSDT), also known as the Healthchek program.

#### **Plan Criteria for UM Decisions**

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

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

#### **Prior Authorization, Pre-certification and Referral Procedures**

The Plan shall:

- Not require prior authorization or pre-certification for emergency services, or post-stabilization services, as referenced in the **Quick Reference Guide**;
- Require prior authorization and/or pre-certification for all non-emergency inpatient and outpatient admissions except for normal newborn deliveries as referenced within the **Quick Reference Guide**;
- Require prior authorization and/or pre-certification for all non-emergent, out-of-network services, as referenced in the **Quick Reference Guide**;
- Conduct prior authorization and pre-certification reviews by a currently licensed, registered or certified health care professional who is appropriately trained in the principles, procedures and standards of utilization review;
- Notify the provider of prior authorization determinations in accordance with predetermined time frames;
- Require that members obtain a referral from their PCP prior to accessing non-emergency specialized services or as identified within specific provider contracts except for specialists to which members may self-refer.

#### **Service Authorization Forms**

The Inpatient, Outpatient or Ancillary Services Authorization Request form must be completed by the provider in order to obtain an authorization from the Plan. Copies of these forms are included in the **Forms** section of this manual.

- Forms must be filled out completely and legibly in order to be processed quickly;
- A current and operating fax number with area code must be included in order to receive an authorization number;
- If an office does not have a fax machine, contact Outpatient Services at the telephone number listed on the **Quick Reference Guide**.

#### **Services Requiring Referrals and Authorizations**

For specific instructions on services requiring a Plan authorization and/or a referral, refer to the **Quick Reference Guide** or visit the WellCare of Ohio Web site at [ohio.wellcare.com](http://ohio.wellcare.com).

#### **Process of Requesting an Authorization**

Providers may request a routine in-network or out-of-network authorization by:

- Faxing an Authorization/Certification Request form to the Plan, at least 14 calendar days prior to the start of the service or procedure.

#### **Service Authorization Decisions**

Providers may request immediate consideration for services that if delayed, could affect the member's health or functional capabilities and should be performed as soon as possible by:

- Calling Outpatient Services (have the member's name and ID number available when calling).

For **Initial Determinations**, the Plan will make a determination within 14 calendar days following the receipt of the request for service.

All pharmacy prior authorizations for medications to be administered to members in a physician's office, hospital inpatient or outpatient department, clinic, dialysis center or infusion center must be completed no later than the end of the second working day or as expeditiously as the member's condition warrants. All pharmacy service authorizations are completed in the Pharmacy department, not the Health Services/Utilization Management department.

The provider will be notified by telephone, fax, or through our Web site within two business days of making the initial determination. The provider and member will be notified of any decision to reduce, suspend, terminate or deny a service authorization request or a decision to authorize a service in amount, duration or scope that is less than requested.

For **Concurrent Review Determinations** (extended stay or additional services), the Plan will make the determination within three business days\* of obtaining all necessary information.

*\*Necessary information includes the results of any face-to-face clinical evaluation or second opinion that may be required.*

The provider and member will be notified by telephone, fax or through our Web site within two business days of making the determination.

Members and providers may file a verbal or written request for an **expedited authorization decision**. To file a verbal or written request please contact the Utilization Management department by telephone. Please refer to the **Quick Reference Guide** for contact information.

The Plan will document the verbal request in writing. Specifically state, "I would like an expedited decision," or "I believe that my health/the health of my patient could be seriously harmed by waiting the 14 days for a standard decision."

If a provider indicates, or the MCP determines that following the standard authorization time frame could seriously

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jeopardize the member's life or health or ability to attain, maintain or regain maximum function, the MCP must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the member's health condition requires but no later than three working days after receipt of the request for service.

If requested by the member or MCP, expedited authorization decisions may be extended up to 14 additional calendar days. If requested by the MCP, the MCP must submit to ODJFS for prior-approval, documentation as to how the extension is in the member's interest. If ODJFS approves the MCP's extension request, the MCP must give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. The MCP must carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

Service authorization decisions not reached within the time frames specified in paragraphs (A)(7)(c)(v) and (A)(7)(c)(vi) of this rule constitute a denial, and the MCPs must give notice to the member as specified in paragraph (B)(2)(d) of rule 5101:3-26-08.4 of the Administrative Code.

It is the provider's responsibility to respond as quickly as possible to any requests for further information as requested from the Plan. Non-receipt of essential information may cause a denial of requested services.

If the decision is to deny a service request, the Plan will send a written denial notification that provides the following:

- The utilization review criteria or covered benefits provision used in the adverse determination;
- The specific reason(s) for denial;
- The member's or authorized representative's right to file an appeal;
- The member's right to request a state hearing, if applicable;

- Procedures for exercising the member's rights to appeal or grieve the action;
- Circumstances under which expedited resolution is available and how to request it;
- Suggest a level of service that is covered under the member's benefit plan, when appropriate;
- Identify the physician who rendered the adverse determination; and
- The date the notice is being issued.

All medical claims are subject to retrospective review by WellCare.

**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 telephonic or faxed chart review, 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 psychosocial factors.

Licensed nurses perform reviews under the direction of the Plan medical director. Admission and/or continued stay denials are determined by the medical director.

**Discharge Planning**

Discharge 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.

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The concurrent review nurse coordinates services with the Primary Care Provider, attending physician and/or the discharge planning personnel at the hospital. Coordination of discharge planning activities should be implemented upon the member's admission to the hospital or other health care facility.

**Emergency/  
Urgent/Post  
Stabilization  
Care**

Emergency services are available to members 24 hours a day, seven days a week to treat an emergency medical condition.

Emergency and post-stabilization services and care do not require prior authorization. Members are instructed, in case of an emergency, to call **911** or proceed to the nearest hospital emergency room. Members should notify their PCP as soon as possible following emergency treatment in order to receive appropriate follow-up care.

WellCare has an Emergency department diversion program that is described in the **Care Management** section of this manual.

Once the member's condition is stabilized, the Plan may require pre-certification for hospital admission or prior authorization for follow-up care.

**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.

**Second  
Medical  
Opinion**

Members may request a second medical opinion concerning surgical procedures or serious injury or illness. The member may choose a qualified physician that is participating with the Plan. If a qualified physician is not available within the Plan, the PCP must obtain prior authorization for the member to obtain a second medical opinion outside the network, at no cost to the member.

It is the responsibility of the PCP to coordinate tests ordered as a result of a second opinion with participating providers and develop a treatment plan for the member after review of the second medical opinion.

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

WellCare offers 24-hour utilization management to assist physicians and facilities with inpatient admissions and after-hours discharge planning. Providers needing after-hours assistance should refer to their **Quick Reference Guide** for the appropriate telephone number.

#### **Request for Ancillary Services**

Requests for ancillary services require the provider to complete an Authorization/Certification Request Form, as identified within the **Quick Reference Guide**. Also see the **Forms** section of this manual.

The additional information needed for each service is outlined below.

#### **Home Health Care**

1. Initial Home Health Care request:

- Medical reason for the home health service;
- MD prescription with the type of skilled service, frequency and duration;
- Meet Home Care Dependent status\*
- Name of participating/in-network home health provider.

2. Continuation of Home Health Care request:

- Complete home health evaluation note and most recent home health progress summary note;
- Meet Home Care Dependent status\*

3. Home Infusion Therapy and IV Drug request<sup>†</sup>:

- Drug name;
- Dosage;
- Frequency and duration;
- Type of access IV line;

- Mode of delivery (gravity or pump);
  - If member received this IV drug before;
  - Available caregiver to teach and train.
4. Home Wound Care and Wound Care Supplies request:
- Wound location;
  - Dimensions;
  - Necrotic tissue;
  - Viable tissue;
  - Drainage;
  - Odor;
  - Surrounding tissue;
  - Skin condition.

*\*Home Care Dependent means an individual who resides in a private home or other non-institutional and unlicensed living arrangement, without the presence of a parent or guardian, but has health and safety needs that require the provision of regularly scheduled home care services to remain in the home or other living arrangement because one of the following is the case: (1) The individual is at least 21 years of age but less than 60 years of age and has a physical disability or mental impairment. (2) The individual is 60 years of age or older, regardless of whether the individual has a physical disability or mental impairment.*

*†Home Infusion therapy and IV drugs administered in a patient's residence are covered by the Ohio Medicaid fee-for-service pharmacy benefit. The home health care visit is covered by WellCare under the medical benefit.*

### **Durable Medical Equipment**

1. Home Oxygen Therapy:
- Most recent ABG PO<sub>2</sub> rate of 55 percent or lower, Pulse Oximetry saturation rate of 88 percent or lower;
  - Flow rate, frequency and duration;
  - Delivery device and type of system.

- 
2. Continuous Positive Air Way Device (CPAP, Bi-PAP):
    - Most recent polysomnogram narrative results with and without titration
  3. Manual Wheelchairs and Accessories:
    - Most recent functional mobility status report (non-ambulatory, ability to self-propel etc.)
    - Height and weight;
    - Any specific body characteristic or limitations that need to be accommodated in the wheelchair by an extra optional device.
  4. Electric Wheelchairs, Electric Scooters and Accessories:
    - Same information as manual wheelchair;
    - Upper body limitations that prevent the effective use of a manual wheelchair (i.e. inability to move upper extremities or severe reduction in movement).
  5. Hospital Bed and Accessories:
    - Medically necessary bed positioning not feasible on a regular bed;
    - Height and weight;
    - Special needs to be accommodated by an optional device.
  6. Orthotic and Prosthetic Devices:
    - Covered HCPCS code for the orthotic or prosthetic item.

### Outpatient Therapy

1. Initial Outpatient Therapy requests:
  - Medical reason for the skilled therapy service;
  - Specific type of skilled therapy service;

- 
- MD prescription with frequency and duration;
  - Name of participating / in-network free-standing center.
2. Continuation of Outpatient Therapy requests:
- Complete initial therapy evaluation and progress summary notes with objective, measurable, clinical findings and updated goals;
  - MD prescription with frequency and duration.

**Delegated Entities**

All participating providers or entities delegated for utilization management shall apply the same standards as defined in this section. Compliance of delegated entities is monitored on a monthly basis and formal audits are conducted annually.

**Contact Information**

Refer to the **Quick Reference Guide** for telephone and fax numbers for the Utilization Management department.

#### **Preferred Drug List**

Beginning February 1, 2010, prescription coverage for members of Medicaid Managed Care Programs (MCPs) will transfer to the state Medicaid fee-for-service (FFS) program. This includes the following services:

- Prescription drugs that are administered in the patient's home, home health settings or a nursing facility.
- Some medical supplies, such as diabetic testing supplies, supplies for injection of insulin and other drugs, inhaler spacers and peak flow meters.
- Retail pharmacy orders.

These prescription drugs need to be billed through the Ohio Medicaid FFS program. (Please note that prescriptions billed through the FFS program may be subject to co-payments.)

More information on the state pharmacy Preferred Drug List is available on the Ohio Department of Job and Family Services' (ODJFS) Web site at: <http://jfs.ohio.gov/Ohp/bhpp/meddrug.stm>.

#### **Prior Authorization List**

For a listing of drugs that require authorization in a physician's office, hospital inpatient or outpatient department, clinic, dialysis center or infusion center, please visit the WellCare Web site at [ohio.wellcare.com](http://ohio.wellcare.com).

#### **Injectable/ Infusion Services**

Covered drugs administered to members in a physician's office, hospital inpatient or outpatient department, clinic, dialysis center or infusion center are subject to existing WellCare coverage, authorization and billing requirements.

Certain specialty drugs, such as injectable drugs and infusions, may require prior authorization and are not available through the retail pharmacy network. To obtain authorization, the provider must submit the appropriate Prior Authorization form to the WellCare Pharmacy department via fax at **(877) 277-6892**.

The Pharmacy department will respond to all requests within 24 hours, and if authorized, will coordinate delivery of the product. Selected pharmaceuticals, including injectable drugs, are not covered as an outpatient pharmacy benefit if they are administered in a provider setting, other than a long-term care facility.

- Pharmaceuticals administered in the physician's office must be purchased by the physician's office and billed as a physician claim.
- Pharmaceuticals administered in a provider setting, other than a long-term care facility, cannot be billed by the pharmacy.

#### **Food Supplements, Nutritional Supplements, Infant Formulas**

WellCare will cover what is currently covered by the state Medicaid program.

All requests should be faxed to **(877) 431-8859**.

#### **Prior Authorization Process**

The goal of the Prior Authorization (PA) program is to ensure that medication regimens that are high-risk, have high potential for misuse or have narrow therapeutic indices are used appropriately and according to U.S. Food and Drug Administration (FDA)-approved indications.

**Obtaining a Prior Authorization** for medications administered in a physician's office, hospital inpatient or outpatient department, clinic, dialysis center or infusion center:

1. Complete a PA form located in the **Forms** section of this manual or on the Web site at: **ohio.wellcare.com**.
2. Fax the form to the Pharmacy department at **(877) 277 6892**. Our standard is to respond to requests within 24 hours.

Please provide medical history and/or other pertinent information when submitting a PA form for medical exception. If the PA form meets the approved Pharmacy & Therapeutics Committee's (P&T) protocols and guidelines, the provider and/or pharmacy will be contacted with the PA approval.

If the PA does not meet criteria for approval based on approved P&T Committee protocols and guidelines, it is initially reviewed by a clinical pharmacist and secondly reviewed by the medical director for final determination.

For those requests that are not approved, a follow-up Drug Utilization Review (DUR) form is faxed to the provider stating why the PA was not approved with a list of preferred drugs available as alternatives. A denial letter or Notice of Action is then sent to the member and will include a state hearing form.

To request an appeal of a PA decision, fax your request to the Appeals and Grievance department. Refer to the **Quick Reference Guide** for the fax number. The request will follow the appeals process described in the **Appeals and Grievances** section of this manual.

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**Overview**

The focus of the Claims department is to process claims timely, to investigate the basis for any issues and correct their root causes. The Claims department partners with Provider Relations to better assist providers with any claim-related questions.

In addition, the Provider Hotline enables providers to use the automated telephone system to check the status of a claim. Providers may also check claims status on the Web site. Please refer to the **Quick Reference Guide** for the Provider Hotline telephone number and the Web site address.

**Timely Claims Submission**

Claims must be submitted within 365 days of the date of service, unless otherwise specified by the provider agreement. Calculation of timely filing is based on the date of discharge reflected on claim.

WellCare as secondary payer must receive claims within 365 days from the date of service.

**Clean Claims**

Providers are required to submit clean claims. A *clean claim* is defined by the Ohio Administrative Code as any claim that can be processed without obtaining additional information from the provider of service or from a third party.

**Prompt Payment**

Clean claims must be paid within the number of days specified in the contractual payment arrangement between the provider and health carrier. Interest is to be paid to the provider based on the number of days that have elapsed between the date payments are due based on the contractual payment arrangement entered into, and the date payment is made.

**Coordination of Benefits**

*Coordination of Benefits* (COB) is the procedure used to process health care payments when a person has coverage with more than one insurer.

Prior to submitting a claim to the Plan, providers must identify if any other payer has primary responsibility for payment of a claim.

If determination is made that another payer is primary:

- The primary payer should be billed prior to billing the Plan;
- Any balance due after receipt of payment from the primary payer, should be submitted to the Plan for consideration; and
- The claim must include information verifying the payment amount received from the primary plan as well as a copy of the Explanation of Benefits.

Upon receiving the claim, the Plan will review using the COB rule or the Medicaid Crossover rule, whichever is applicable.

#### **Claim Submission Format**

Claims may be submitted to the Plan in one of the following formats:

- Electronic Claims Submission (EDI)
- CMS-1500 Form
- UB-04 Form

Claims should be submitted to the Plan according to the following standards. Failure to comply with these standards may result in delay of payment or the rejection (returned to provider as unprocessed) of the claim.

- Claims must contain the National Provider Identifier (NPI) for all primary and secondary provider fields on all electronic and paper claims (UB-04 and CMS-1500) submissions.
  - The NPI is a unique identification number for all health care providers mandated by the Health Insurance Portability and Accountability Act (HIPAA).

This number is a 10-position, intelligence-free numeric identifier (10-digit number).

- Information for obtaining a NPI is available by:
  - Telephone: (800) 465-3203 or  
TTY: (800) 692-2326
  - Email:  
  
[customerservice@npienumerator.com](mailto:customerservice@npienumerator.com)
  - Mail: NPI Enumerator  
P.O. Box 6059  
Fargo, ND 58108-6059

Answers to frequently asked questions regarding NPI are available on **[www.cms.gov](http://www.cms.gov)**.

- Claims must contain the Federal Tax ID (Employer Identification Number or Social Security number) for the provider of service or supplier.
- Claims/encounters will be considered non-compliant and **rejected** if the legacy identifiers such as Medicaid provider number, unique physician identification number (UPIN) or WellCare provider identification number are included.
- All data fields are to be completed.
- Claims should not be handwritten or altered in anyway.
- Only current standard procedural terminology is acceptable for reimbursement per the following coding manuals:
  - Current Procedural Terminology (CPT) for physician procedural terminology.

- International Classification of Diseases (ICD9-CM) for diagnostic coding.
- Health Care Procedure Coding System (HCPC).
- CMS-1500 paper claim submissions must be submitted on form OMB-0938-0999(08-05) as noted on the document's footer.
- The Plan accepts the revised CMS-1500 and UB-04 forms printed in Flint OCR Red, J6983, (or exact match) ink.
- Although a copy of the CMS-1500 form can be downloaded from the CMS Web site, copies of the form cannot be used for submission of claims since your copy may not accurately replicate the scale or color of the form when scanned using Optical Character Recognition (OCR).
  - This scanning technology allows for the data contained on the form to be read while the actual form fields, headings and lines remain invisible to the scanner. OCR technology allows the Plan to record and process paper claims faster.
- For EDI submissions, providers should follow the HIPAA transaction and code set requirements as found in the National Electronic Data Interchange Transaction Set Implementation Guides and the Companion Guide when provided by the Plan. HIPAA requires compliance with the Electronic Data Interchange (EDI) standards.
  - The National Electronic Data Interchange Transaction Set Implementation Guides for HIPAA transaction sets are available at **[www.wpc-edi.com](http://www.wpc-edi.com)**.
  - All files submitted to the Plan must be in the ANSI ASC X12N format, version 4010A.

- For further instructions for both paper and EDI claim submission including access to Plan EDI Companion Guides, visit [ohio.wellcare.com](http://ohio.wellcare.com).
- Refer to the **Quick Reference Guide** for claim mailing addresses.

### Electronic Claim Submissions

The Plan accepts electronic claim submissions through Electronic Data Interchange (EDI).

#### Advantages of EDI

- Submitting claims electronically is less costly than billing with paper.
- In most instances, the Plan can process your electronic claim in half the time of a paper claim.
- Clearinghouses charge varying fees. The Plan has options with ACS, including connectivity and software, which are free. Contact the EDI department to see if you qualify for this service. You may also contact your clearinghouse or billing software vendor to see if they offer free options.

There are six clearinghouses through which the Plan currently receives EDI transactions. Those companies are:

- Emdeon (former WebMD<sup>®</sup> Corporation)
- SSI Group Inc.
- Availity
- ACS EDI Gateway Inc.
- RelayHealth (McKesson)
- ZirMed

Since most clearinghouses can exchange data with one another, providers should work with their existing clearinghouse, if other than those listed, to establish EDI with the Plan.

If you do not have a clearinghouse or have been unsuccessful in submitting claims through your

clearinghouse, please contact our EDI team. The EDI team contact information can be found on the **Quick Reference Guide**.

**Payer ID**

There are unique Payer IDs that must be used to identify our Plan on electronic claim submissions.

The appropriate Payer IDs for each of the six clearinghouses through which WellCare claims may be submitted are listed as follow:

**ACS EDI Gateway\***

- 77004

**Availity, Emdeon (WebMD®), SSI\*, RelayHealth (McKesson) and ZirMed**

- 14163

**Encounter Data**

- 59354

*\*Subject to Change*

For further instructions on EDI claim submission including access to Plan Companion Guides, please visit **ohio.wellcare.com**.

**Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Services**

We have partnered with Payformance Corporation to offer you free Electronic Funds Transfer (EFT) and online Electronic Remittance Advice services (ERA, also known as electronic payment voucher), by registering with PaySpan Health®.

The benefits of enrolling for EFT/ERA through PaySpan Health include:

- A secure, self-service Web site;
- Absolutely no cost for participating;
- Improved cash flow through automated deposits;

- Convenient access to view remittance records online, at any time;
- Reporting mechanisms to access adjudicated claims information; and
- Ability to import payment data directly into your practice management or patient account system.

Online registration is simple and fast. PaySpan Health will mail a registration letter to network providers containing a unique registration code and PIN number.

Using the information contained in the registration letter, providers will proceed through an easy registration process that includes the following steps:

- Log on to PaySpan Health using the registration and PIN number provided in the letter;
- Enter Tax ID number (for security purposes);
- Enter banking information and set up account administrators and users;
- Select payment and remittance preferences; and
- Confirm receipt of fund transfer into provider bank account.

Once the fund transfer is confirmed, all payments will be sent via EFT.

Should a provider elect not to receive payments or vouchers electronically, they will continue to receive paper checks generated at the Payformance payment processing center.

For questions related to this service, please visit the PaySpan Health Web site at [www.payspanhealth.com](http://www.payspanhealth.com) or call the Provider Hotline (refer to the **Quick Reference Guide** for contact information).

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

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

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

### **Standard Guides**

Available online or by calling Member Services, providers may obtain the Plan's recommended transaction guidelines. These are:

- Electronic Data Interchange Transaction Set Implementation Guides
- Institutional Claims Companion Guide
- Institutional Encounter Companion Guide
- Professional Claims Companion Guide
- Professional Encounter Companion Guide

### **Standard Transactions**

Transactions, as defined by HIPAA, are activities involving the transfer of health care information for specific purposes, including claims and encounter information, payment and remittance advice, and claim status and inquiry. All providers who submit encounters and electronic claims to the Plan must do so in the formats established by HIPAA.

The following standard HIPAA electronic claim/encounter transactions must be submitted in the \*ANSI ASC X12N format, version 4010A1:

- 270/271–Health Insurance Eligibility/Benefit Inquiry & Response
- 276/277–Health Care Claim Status Request & Response
- 278–Health Care Services Review – Request for Review and Response

- 835–Health Care Claim Payment/Advice
- 837–Health Care Claims

**Standard Code Sets**

Standard Code Sets as required by HIPAA are the codes used to identify specific diagnosis and clinical procedures on claims and encounter forms. All providers are required to submit claims and encounters using current HIPAA compliant codes, which include the standard CMS codes for ICD9, CPT, HCPCS, NDC and CDT, as appropriate.

**Strategic National Implementation Process (SNIP)**

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

The SNIP validations used by the Plan to verify transaction integrity/syntax are available in the Forms section of this manual and on our Web site. The SNIP Validation Descriptions document may be a helpful resource to share with your billing agent or clearinghouse.

If your claim is rejected for lack of compliance to the Plan's claim and encounter submission requirements, please correct your claim and resubmit it to the Plan. For additional information, please contact your Provider Relations representative or the Member Services department.

**Prohibition on  
Billing Plan  
Members**

Your agreement with the Plan requires providers to accept payment directly from the Plan. Payment from the Plan constitutes payment in full, with the exception of applicable co-payments and any other amounts listed as member responsibility on the Explanation of Benefits/Provider Remittance Advice.

This means providers **cannot bill Plan members for:**

- The difference between actual charges and the contracted reimbursement amount;
- Services denied due to timely filing requirements;
- Covered services for which a claim has been returned and denied for lack of information;
- Remaining or denied charges for those services where the provider fails to notify the Plan of a service that required prior authorization – payment for that service will be denied;
- Covered services that were not medically necessary, in the judgment of the Plan, unless prior to rendering the service, the provider obtains the member's informed written consent and the member receives information that he/she will be financially responsible for the specific services.

**Non-Covered Services**

Plan members may be billed for non-covered services, such as cosmetic procedures and items of convenience (i.e., televisions).

**Encounter Data**

Health care encounter data includes:

- All data captured during the course of a single health care encounter that specifies the diagnoses, co-morbidities, procedures (therapeutic, rehabilitative, maintenance or palliative), pharmaceuticals, medical devices and equipment associated with the member receiving services during the encounter;
- The identification of the member receiving and the provider(s) delivering the health care services during the single encounter;
- A unique, i.e., unduplicated, identifier for the single encounter.

**If a provider is paid on a capitated basis, encounter data must be submitted to the Plan according to the claim submission standards noted above.**

This requirement is mandated to meet the reporting requirements of the Plan, as well as those established by regulatory agencies and the Balanced Budget Act. Under capitation, encounter data is generally submitted in the form of a claim, and such claims are usually referred to as encounter data.

The Plan will record the encounter data received. The Plan recognizes these services as under a capitated contract and will not make payment to the provider.

**A capitated provider who does not submit encounter data is subject to corrective action measures and penalties under applicable state and federal law and could be terminated from the Plan.**

### **Explanation of Payment**

An Explanation of Payment (EOP) is issued for each claim submitted. The EOP contains all of the information that was submitted on the claim form. The EOP will show all reimbursement information along with any specific messages regarding the claim.

### **Overpayment Recovery**

WellCare may initiate overpayment recovery no later than 12 months after the last date of service (DOS) or discharge, for reasons that include but are not limited to:

- Adjustments to previously processed claims
- Duplicate payments
- Improper benefit interpretations
- Fee schedule corrections
- Ineligible member
- Fee-for-service payments for capitated services

Providers should follow the instructions in the refund request notice to ask for additional information or contest the overpayment.

**Payment Methods**

Providers will receive a one-time 45 day notice that an off-set will be performed against future payments unless a refund is received or we have been contacted with an explanation of a correct payment. Providers will be informed of amounts recovered via the Explanation of Payments (EOP).

**Delegated  
Entities**

All participating providers or entities delegated for claims management are to use the same standards as defined in this section. Compliance is monitored on a monthly basis and formal audits are conducted annually.

#### Overview

The Plan maintains distinct grievance and appeals processes for members and providers, as well as access to the State Hearing system. Providers have the right to participate in these processes on behalf of patients and to challenge the failure of the Plan to cover a specific service. Members or their representatives can call the Provider Hotline to file an appeal or a grievance.

#### Definitions

An *appeal* is a request for review of an action taken by or on behalf of the Plan. A member, a member's representative, or a provider acting on behalf of the member and with the member's written consent may file an appeal. Examples of actions that can be appealed include but are not limited to the following:

- Denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the state.

A *grievance* is an expression of dissatisfaction about any matter other than an action that could be appealed. Specifically, a *grievance* is an expression of dissatisfaction with any aspect of the managed care Plan or provider's operation, provision of health care services, activities or behaviors. A member or a member's representative, acting on behalf of the member and with the member's written consent, may file a grievance within 90 days of the date the member became aware of the issue.

Possible subjects for grievances include but are not limited to the following:

- Quality of care of services provided
- Rudeness of the provider or staff

- Failure to respect the member's rights

The Plan ensures that decision-makers on grievances and appeals were not involved in previous levels of review or decision-making. These decision-makers are health care professionals with clinical expertise in treating the member's condition/disease, or have sought advice from providers with expertise in the field of medicine related to the request when deciding any of the following:

- An appeal of a denial based on lack of medical necessity;
- A grievance regarding denial of expedited resolution of an appeal;
- A grievance or appeal involving clinical issues.

No health care provider may be penalized by a managed care plan for providing testimony, evidence, records or any other assistance to an enrollee who is disputing a denial, in whole or in part, of a health care treatment or service or claim thereof.

**Submission  
of Member  
Appeals**

Any party to an action appropriate for appeal, including a member or a member's authorized representative, may request that the action be reconsidered.

The member, member's representative or provider (with member's written consent) may file a request for an expedited or standard appeal determination. A provider may file a statement with the member's appeal request supporting the need for an expedited resolution. The request must be a statement by the physician him/herself and not from an office staff member.

The Plan will not take, or threaten to take, any punitive action against any provider acting on behalf or in support of a member requesting a standard or expedited appeal.

The Plan gives members reasonable assistance in completing forms and other procedural steps for an

appeal, including, but not limited to, providing interpreter services and TTY/TDD toll-free telephone numbers with interpreter capability. To arrange interpreter services, please contact Member Services for assistance.

Members are provided reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. If the request for reconsideration is submitted after 90 calendar days, then good cause must be shown for the Plan to accept the late request. Examples of good cause include but are not limited to the following:

- The member did not personally receive the Notice of Action, or he/she received it late;
- The member was seriously ill, which prevented a timely appeal;
- There was a death or serious illness in the member's immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limit;
- The member had incorrect or incomplete information concerning the appeal process;
- The member lacked capacity to understand the time frame for filing a request for reconsideration.

Questions regarding the filing or status of an appeal should be directed to Member Services, which will coordinate with Appeals as appropriate.

A member of the Member Services or Appeals team will be in contact with the provider within two business days of the inquiry.

A member, a member's representative or a provider may file an appeal request verbally or in writing within 90 days of the date on the Notice of Action.

If filed verbally through Member Services, the request must then be supplemented with a written, signed appeal request to the Plan. For verbal filings, the time frame for resolution begins on the date the verbal request was called into Member Services. The Plan will assist the member to ensure that a written appeal is filed immediately by converting a verbal filing into a written record. If the member follows the verbal filing with a written appeal, this appeal will supersede the written record.

If the member wishes to use a representative, then he/she must complete an Appointment of Representative statement. The member and the person who will be representing the member must sign the statement. An Appointment of Representative form is available in the **Forms** section of this manual.

An acknowledgement of receipt will be provided to the person filing the appeal within three business days. If the appeal is filed verbally, a verbal acknowledgement will be provided. If filed in writing, written acknowledgement will be provided.

The Plan must make a determination on an appeal within the following time frames:

- Expedited Request: **3 business days**
- Standard Request: **15 calendar days**

Members have the right to request continuation of benefits during an appeal or State Hearing. The member may be liable for the cost of any continued benefits if the Plan's action is upheld at the discretion of the Ohio Department of Job & Family Services (ODJFS).

The Plan will continue the member's benefits if:

- The appeal or hearing request is filed timely, meaning on or before the later of the following:
  1. Within 10 business days of the date on the Notice of Action (add five calendar days if the notice is sent via U.S. mail).

2. The intended effective date of the Plan's action.

- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered under the original authorization has not expired; and
- The member requests continuation of benefits.

If the Plan continues or reinstates member benefits while the appeal is pending, the member's benefits will be continued until one of following occurs:

- The member withdraws the appeal;
- Ten calendar days pass from the date of the Plan's Notice of an Adverse Appeal Decision and the member has not requested a State Hearing with continuation of benefits within the 10-day time frame (add five calendar days if the notice is sent via U.S. mail);
- A State Hearing or appeal decision adverse to the member is made; or
- The authorization expires or authorized service limits are met.

This process shall also be available for dissatisfaction concerning the timeliness of services or the timeliness of grievance responses.

### **Request for Appeal Determinations**

### **Request for Expedited Determination**

A request for an expedited appeal may be made verbally by calling Member Services or in writing by mail to the Appeals department.

A written appeal is not required.

The plan has a responsibility to review all appeals and expedite those that warrant quicker action. In order to meet criteria for expedited review, it must be shown that applying the standard procedure could seriously jeopardize the member's life, health or ability to regain maximum function.

The Plan will make a determination on whether processing will be expedited or standard within one business day from the receipt of the request.

Appeals selected for expedited processing will be determined within three business days from receipt of the request. The Plan will make reasonable efforts to notify the member of the disposition of their request verbally and also in writing.

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

### **Denial of Expedited Request**

If the Plan denies the request for an expedited determination, the Plan will automatically transfer the request for an expedited determination (no later than one business day from the date the Plan received the request) to the standard reconsideration process. The Plan will then make its determination as expeditiously as the member's health condition requires but no later than 15 calendar days from the date the initial appeal request was received.

### **Request for Standard Pre-Service Determination**

A request for a standard appeal determination may be made verbally by calling Member Services or in writing by mail to the Appeals department. The Plan will make a determination and provide notification within 15 calendar days from receipt of the standard request.

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**Request for Retrospective Determination**

The provider and member must complete an Appointment of Representation statement, which can be found in the **Forms** section of this manual to file a request for a retrospective determination.

The Plan will make a determination and provide notification within 30 calendar days from receipt of the retrospective request.

**14-Day Extension**

The Expedited and Standard Appeal determination periods noted above may be extended up to 14 calendar days if the member requests an extension or if the Plan justifies a need for additional information and documents how an extension is in the best interest of the member. If an extension is not requested by the member, the Plan will obtain prior approval from ODJFS, and if approved, will provide the member with written notice of the reason for the delay and the date by which a decision must be made.

**Affirmation of Denial**

If the Plan upholds the action and/or denial, then the member, the member's representative or the provider will be notified in writing of the decision, as well as any additional appeal rights.

**Reversal of Denial**

If the Plan overturns the action, it will notify the member and provider verbally and in writing.

The Plan will authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires if the services were not furnished while the appeal was pending and the decision is to reverse a decision to deny, limit or delay services.

The Plan also will pay for disputed services, in accordance with state policy and regulations if the

services were furnished while the appeal was pending and the disposition reverses a decision to deny, limit or delay services.

**State Hearing**

The member has the right to request a State Hearing in addition to pursuing the Plan's appeals process.

Parties to the State Hearing include the Plan, as well as the member and his/her representative, or the representative of a deceased member's estate. A provider can be a representative or a witness in a hearing process.

The member or a member's representative with written consent may request a State Hearing within 90 days from the date on the State Hearing notice. The request may be sent to the following address:

Ohio Department of Job & Family Services  
Bureau of State Hearings  
P.O. Box 182825  
Columbus, OH 43218-2825

The Plan will continue the member's benefits while the State Hearing is pending if:

- The State Hearing is filed timely, meaning on or before the following:
  - Within 15 days of the mailing date on the State Hearing notice (add five calendar days if the notice is sent via U.S. mail).
- The State Hearing involves the termination, suspension or reduction of a previously authorized course of treatment.

If the Plan continues or reinstates the member's benefits while the State Hearing is pending, the benefits will be continued until one of following occurs:

- The member withdraws the request for State Hearing;

- A State Hearing decision adverse to the member is made; or
- The authorization expires or authorized service limits are met.

The Plan will authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, if the services were not furnished while the State Hearing was pending and reverses a decision to deny, limit or delay services.

The Plan will pay for disputed services, in accordance with state policy and regulations, if the services were furnished while the State Hearing was pending and reverses a decision to deny, limit or delay services.

At the discretion of ODJFS, the member may be liable for the cost of continued benefits if the Plan's action is upheld.

### Submission of Provider Appeals

Providers have 90 days\* from the original utilization management denial or claim denial to file a provider appeal. Cases appealed after that time will be denied for untimely filing. There is no second level consideration for cases denied for untimely filing. If the provider feels they have filed their case within the appropriate time frame, they may send proof. Acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of the Plan, or similar receipt from other commercial delivery services.

A Provider may file an appeal by submitting a letter of appeal and/or an appeal form with supporting documentation such as medical records. Appeal forms may be found in the **Forms** section of this manual.

- The Plan is not responsible for payment of medical records generated as a result of a provider inquiry. Any invoices received by the Plan for such charges will be redirected to the provider.

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\* *Subject to change*

- Cases received without the necessary documentation will be denied for lack of information.

The Plan has 60 days to review the case for medical necessity and conformity to Plan guidelines. During this time, the Plan may request additional information from the provider in order to complete a review of the case.

- It is the responsibility of the provider to provide the requested documentation within 60 days of the denial to re-open the case. Records and documents received after that time frame will not be reviewed and the case will remain closed.

If it is determined that the provider has complied with Plan protocols and that the appealed services were medically necessary, the denial will be overturned. The provider will be notified of this decision in writing.

The provider may file a claim for payment, if they have not already done so. If a claim has been previously submitted and denied, it will be adjusted for payment after the decision to overturn the denial has been made. The Plan will ensure that claims are processed and comply with the federal and state requirements.

**Submission  
of Provider  
Termination  
Appeal  
Request**

If a provider termination is initiated by the Plan, regardless of whether the termination is for cause or not, the Plan will notify the provider of the termination decision in writing, via certified mail.

Providers will be informed as to their right to petition the termination action, the process and timing for reconsideration of the termination decision. The termination reconsideration request must be filed within 15 days of receipt of the Plan's termination notice.

The Plan will send the provider an acknowledgement of the termination reconsideration request in writing within five business days of receipt. The Plan may request additional information from the provider in order to review the termination reconsideration request. If this is

the case, the provider has three business days to submit the required documentation. If not received within three business days, the Plan will continue to process the termination reconsideration request.

A panel reviews the termination reconsideration request and upon determination will send an outcome letter to the provider stating that the termination reconsideration request is either overturned or upheld.

### **Termination Overturn**

If the Plan overturns the termination of the provider, the Plan will ensure there is no lapse in the period of the provider's participation with the Plan.

### **Termination Upheld**

If the Plan upholds its termination of the provider, the Plan will notify members 45 calendar days prior to the effective termination date. The notification will include the following:

- PCP's name and last date the PCP is available to provide care; and
- The name, location, telephone number and effective date of the member's newly assigned PCP.

Members will also be informed on how to select a different PCP and the Plan telephone number they can call for further assistance.

The Plan will also notify members who:

- Were seen two or more times within the past 12 months
- Have an open OB authorization (as applicable)
- Received an open authorization

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Members with these circumstances will be notified 45 days prior to the termination effective date of a participating hospital, specialist or a significant ancillary provider.

### Submission of Grievances

A member or a member's representative acting on behalf of the member, may file a grievance either verbally or in writing within 90 calendar days of the date that the member became aware of the issue. A verbal request may be followed up with a written request, but the time frame for resolution begins the date the Plan receives the verbal filing.

If the member wishes to appoint another person as their representative, he/she must complete an Appointment of Representative statement. The member and the person who will be representing the member must sign the statement. This form is available in the **Forms** section of this manual.

The Plan will send an acknowledgement of receipt to the person filing the grievance within three business days. If the grievance is filed verbally, a verbal acknowledgement will be provided. If filed in writing, written acknowledgement will be provided.

The Plan will make a determination on the grievance notification within the following time frames:

- Within **two business days** of receipt if the grievance is regarding access to Medicaid-covered services
- Within **30 calendar days** of receipt for non-claims related grievances
- Within **60 calendar days** of receipt of claims-related grievances

The Plan gives members reasonable assistance in completing forms and other procedural steps, including but not limited to the provision of interpreter services and TTY/TDD toll-free telephone numbers with

interpreter capability. Refer to the **Quick Reference Guide** for the appropriate contact information.

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

**Request for Expedited Grievance Reconsideration**

A member, a member representative or a provider acting on behalf of a member may file a request for an expedited grievance determination verbally or in writing. A verbal request can be filed by calling Member Services. A written request can be mailed or faxed directly to the Grievance department. A determination on the expedited request will be made within 72 hours of receipt of the expedited request.

A request for an expedited grievance determination can be made for complaints related to Plan's decisions to:

- A grievance regarding denial of expedited resolution of an appeal; or
- A grievance or appeal that involves clinical issues.

**Request for Standard Grievance Determination**

A grievance will be investigated, a determination made and a closure letter sent to the complainant (and ODJFS upon request), within two, 30 or 60 calendar days of receipt of the standard request.

The closure letter will include:

- The results and date of the grievance resolution;
- Notice of the right to request a Second-Level grievance to the Plan;
- The time limit to file a Second-Level request (standard is 30 calendar days from the date of the notice); and
- Information on how to present the case at the Second-Level Grievance Committee either in

person or via teleconference.

**14-Day Extension**

The Plan may extend the time frames for a determination on a standard grievance by up to 14 calendar days if the member requests an extension or if the Plan shows that there is need for additional information (to the satisfaction of the state, upon its request) and includes how the delay is in the member's interest.

**Grievances  
Filed Against  
a Provider**

If a member files a grievance against a provider in reference to the quality of care or service provided, the Plan will fax and mail a request to the provider for a response. The provider is given 10 business days to respond and submit medical records for review. If a provider has not responded within the 10 business days, a second fax and letter is sent giving an additional five business days to respond.

Continued failure to respond may result in the provider's panel being closed to new patients and/or will be interpreted as the provider not in disagreement with the member's issue.

The case is then forwarded to the Quality Improvement department for further investigation.

If the provider does respond, the case is referred to a Plan nurse who reviews the medical records to determine if a quality issue exists. If the nurse feels a quality issue may exist, the case is referred to a Plan medical director for review. If he/she determines a quality issue exists, the case is referred to the Quality Improvement department for further investigation. If no quality issue is identified, the case is entered into the Plan's database for tracking and trending purposes.

**Submission  
of Provider Claim  
Reconsiderations****Claim Reconsiderations**

A Provider may file a Claim Reconsideration by submitting a letter with supporting documentation such

as medical records. The Claim Reconsideration must be submitted within 90 days of the Remittance Advice/Explanation of Benefits issue date. Claim Reconsideration requests received after that time will be denied for untimely filing. If a provider feels they have filed their case within the appropriate time frame, they may send proof to the Plan.

For written requests, acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of the Plan, a similar receipt from other commercial delivery services or a fax confirmation.

- The Plan is not responsible for payment of medical records generated as a result of provider initiated claim reconsideration requests. Any invoices received by the Plan for such charges will be redirected to the provider.
- Cases received without the necessary documentation will be denied for lack of information.

A decision on a claim reconsideration request will be made within **60 days** of receipt.

#### Overview

Credentialing is the process used by the Plan to evaluate the qualifications and credentials of providers, including Physicians, Allied Health Professionals and Ancillary Facilities/Health Care Delivery Organizations. Providers are required to be credentialed prior to being listed as participating network providers of care or services to Plan members.

The Credentialing department is responsible for gathering all relevant information and documentation through a formal application process. Primary source verifications are obtained in accordance with federal, state and accreditation agency requirements and Plan policies and procedures.

An appropriate peer review by the Plan evaluates the background, education, training, experience, demonstrated ability, patient admitting capabilities, license, regulatory compliance, health status and, as applicable, accreditation status of each individual applicant.

Satisfactory site inspection evaluations are required at the office locations of all Primary Care Providers (PCPs) and Obstetrics and Gynecology specialist physicians' offices. Some facilities also need a site inspection evaluation to be completed, relative to accreditation status.

Credentialing may be done directly by the Plan or by an entity approved by the Plan for delegated credentialing. Prior to delegation of credentialing to an outside agency, the Plan is required to evaluate and establish the agency clearly meets all regulatory requirements and is able to perform credentialing on behalf of the Plan.

All participating providers or agencies 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, the annual review of policies and procedures and credentialing forms and files.

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#### Practitioner's Rights

Please note that practitioners have the following rights in connection with the credentialing processes:

Practitioners have the right to be informed of the status of their credentialing or re-credentialing application upon request:

- Upon receipt of a written request, the Plan will provide practitioners with the status of their credentialing or re-credentialing application within 15 business days. The information provided will advise of any items still needing to be verified, any non-response in obtaining verifications and any discrepancies in verification information received compared to information provided by them. Status request should be emailed to [credentialing@wellcare.com](mailto:credentialing@wellcare.com).

Practitioners have the right to review information submitted in support their credentialing or re-credentialing application:

- Practitioners may review any documentation submitted by them in support of their credentialing or re-credentialing application, together with any discrepant information relating, but not limited to education or training; liability claims history; state licensing; certification boards; professional societies, etc. Peer review information obtained by the Plan may not be reviewed.

Practitioners have the right to correct erroneous information and receive notification of the process and time frame:

- In the event the credentials verification processes reveal information submitted by a practitioner that differs from the verification information obtained by the Plan, the practitioner is allowed to submit corrections for the erroneous information. Discrepancies will be notified by the Plan to the practitioner in writing within 15 business days.

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The Plan's notification communication will include:

- The nature of the discrepant information;
- The process for correcting erroneous information submitted by another source;
- The format for submitting corrections;
- The time frame for submitting the corrections;
- The addressee to whom corrections must be sent;
- The Plan's documentation process for receipt of the corrected information from the applicant; and
- The Plan's review process.

The Plan's notification process will include:

- A cover sheet indicating the name and address of the person to whom a response should be sent;
- A copy of the application with the discrepant information identified;
- A request to make the necessary corrections on the page(s) provided, to initial and date the corrected information and return the documentation to the Plan together with a written explanation within 15 business days of receipt of the request;
- A request that the correction information be mailed to the credentialing specialist named on the cover sheet at the address also provided on the cover sheet;
- Upon receipt of the correction information by the Plan, the completed credentialing application which includes the appropriate verifications and

also the correction information provided by the practitioner is then submitted through the Plan's credentialing approval process;

- Notification of the credentialing decision is provided to the practitioner within applicable state required notification time frames. In the absence of a state required notification time frame, notifications are made within 60 days.

Any questions or concerns regarding the credentialing processes should be emailed to the Credentialing department at [credentialing@wellcare.com](mailto:credentialing@wellcare.com).

#### **Applicant's Right to be Informed of Credentialing Application Status**

An applicant has the right to be informed of the status of credentialing. Upon receipt of a written request, the Plan will provide written information to the applicant on the status of the credentialing application within 15 business days. The information provided will advise of items still needing to be verified, any non-response in obtaining verifications and any discrepancies in verification information received compared to information provided by the applicant.

#### **Applicant's Right to Review and Correct Erroneous Credentialing Information**

In the event the credentials verification process reveals information submitted by the applicant that differs from the verification information obtained by the Plan, the applicant shall be notified by the Plan in writing within 15 business days and will be allowed to submit a correction for the erroneous information.

The Plan's notification to the applicant shall include:

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

- The addressee to whom corrections must be sent;
- The Plan's documentation process for receiving the correction information from the applicant;
- The Plan's review process.

The applicant may review any documentation submitted by him/her in support of the application, together with any discrepant information received from professional liability insurance carriers, state licensing agencies and certification boards.

The applicant may not review peer review information obtained by the Plan.

The Committee shall review the correct information and explanation at the time of considering the applicant's credentials for provider network participation.

### **Baseline Criteria**

Baseline criteria for provider network participation:

#### License to Practice

Practitioners must have a current valid license to practice.

#### Board Certification

Physicians (M.D., D.O., D.P.M.) must maintain Board Certification in the specialty being practiced as a provider for the Plan; or must have accredited training that renders a physician eligible to sit for the board certification examination.

#### Hospital Admitting Privileges

Specialist practitioners shall have hospital admitting privileges at a Plan participating hospital (as applicable to specialty). PCPs may have hospital admitting privileges or may enter into a formal agreement with another Plan participating practitioner who has admitting privileges at a Plan participating hospital, for the admission of members.

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**Professional Liability Insurance**

Plan providers (all disciplines) shall be required to carry and continue to maintain professional liability insurance.

**Covering Physicians**

PCPs in solo practice must have a Plan-participating covering physician willing to care for their members in their absence.

**Allied Health Professionals**

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

Dependant AHPs include the following and are required to provide collaborative practice information to the Plan:

- Advanced Registered Nurse Practitioner (ARNP)
- Certified Nurse Midwife (CNM)
- Physician Assistant (PA)
- Osteopathic Assistant (OA)

Independent AHPs include but are not limited to the following:

- Licensed clinical social worker
- Licensed mental health counselor
- Licensed marriage and family therapist
- Physical therapist
- Occupational therapists
- Audiologist
- Speech/Language therapist/pathologist

**Ancillary Facility/Health Care Delivery Organizations**

Ancillary Facility/Health Care Delivery Organizations must complete a credentialing application and provide information on accreditation, license, regulatory status, liability insurance coverage and rating. In addition, depending on accreditation status, a site inspection evaluation may be required as part of the credentialing process.

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**Re-Credentialing** In accordance with regulatory requirements and Plan policy and procedure, re-credentialing of all provider types shall be conducted at least once every three years.

**Updated Documentation** Providers must provide evidence of current Professional Liability Insurance and maintain License and DEA Certification, as applicable to provider type, prior to or concurrent with expiration.

**Office of Inspector General Medicaid Sanctions Report** On a regular and ongoing basis, the Plan accesses the listings of the Department of Health & Human Services, Office of Inspector General Medicaid Sanctions (exclusions and reinstatements) Report and the state's list of excluded providers. This information is crosschecked against the network of Plan providers. If providers are identified as being currently sanctioned, they are subject to immediate suspension and termination. Notifications of termination of contract are given in accordance with Plan policies and procedures.

**Hearing and Appellate Review** A practitioner whose provider status with the Plan is recommended for termination for reason(s) that may require a report to be made to the National Practitioner Data Bank shall be entitled to a hearing and appellate review.

Notification of the termination recommendation, together with reasons for the action, hearing and appellate review rights, and the process for obtaining a hearing and appellate review shall be provided to the practitioner within 30 days of the date of the termination recommendation. Notification to the practitioner shall be mailed by certified return receipt mail.

The practitioner shall have a period of 30 days in which to file a written request for a hearing and appellate review. The request shall be mailed via certified return receipt mail.

Upon timely receipt of the request, the Chief Executive Officer or his designee shall notify the practitioner of the date, time and place of the hearing. Such a hearing shall not take place less than 30 days from the date of the notice of the hearing.

The personal appearance of the practitioner requesting the hearing and appellate review shall be required. A practitioner who fails, without good cause, to appear and proceed at such hearing, shall be deemed to have waived rights to a hearing and appellate review.

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

The Hearing and Appellate Review Committee shall consider and decide the case objectively and in good faith. Within 30 days after final adjournment of the hearing and appellate review, the Committee shall make a written report and forward its decision to the QI Committee. Notification of the Plan's final decision will be provided to the practitioner within 30 days.

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**Quality Improvement Program**

The Quality Improvement Program (QI Program) is an ongoing, comprehensive and integrated system that exists to actively initiate, monitor and evaluate standards of health care practice and infrastructure essential to the delivery of quality clinical care, behavioral health and services to enrolled members.

The goals of the Program are to:

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

The WellCare of Ohio board of directors has chartered the Plan's Quality Improvement Committee (QIC) for the purpose of monitoring and evaluating the results of the QI Program initiatives and initiating corrective action

when the results are less than desired or when areas needing improvement are identified.

QI Program activities which involve physicians include but are not limited to:

- Member medical record reviews;  
Types of reviews may include:
  - Medical record content;
  - Continuity of care;
  - Adult health screening;
  - Pediatric health screening;
  - Diagnostic specific screening;
  - Maternity care;
  - Healthcare Effectiveness Data and Information Set (HEDIS) Review;
  - State reviews;
  - Quality of care reviews to investigate a complaint, grievance or adverse unexpected event;
  - Requests for internal QI data from delegated credentialing entities; and
  - External Quality Review Organizations (EQRO).
  
- Disease management initiatives to improve health outcomes for members;
  
- Review of physicians' office sites;
  
- Participation in application of Clinical Practice Guidelines, as detailed by contract;
  
- State QI Projects as established by the EQRO;
  
- Completion of the re-credentialing process; and
  
- Corrective Action Plan (CAP) follow-up.

The Quality Improvement Program incorporates ongoing screening of the medical record to assure compliance with all regulatory and accreditation agency guidelines.

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A plan of action will be instituted when opportunities to improve patient care or documentation are present. Providers may be asked to participate in formulating the plan of action, as collaborative input will provide the key for a workable solution.

The Quality Improvement department will assess the minimum guidelines of care and documentation, required by regulatory agencies, external quality review and accreditation organizations, for medical record review, health screening and high-risk diagnoses on an ongoing basis. A Plan representative will make an appointment to review these items in the provider's office, as necessary.

Upon completion of the review, providers will be provided with a preliminary summary of findings during the exit meeting to outline any deficiencies found during the review. The report will assist provider offices with making any necessary corrections. If the provider's aggregate score is less than 80 percent a corrective action plan will be requested.

**Quality Improvement Participation**

Providers contracted with the Plan are required to participate in all quality improvement functions and tasks required by the Ohio Department of Job & Family Services (ODJFS), federal laws and the Plan.

These activities may include, but are not limited to, the following:

- Compliance with requests for medical records for quality improvement studies and audits;
- Cooperation with quality improvement initiatives related to collaborative projects;
- Cooperation with efforts to improve care for chronic disease and/or preventive care measures;
- Compliance with requests for information and recommendations formulated by the Plan and ODJFS, in the process of reviewing/resolving

beneficiary and/or provider complaints.

The Plan and ODJFS may also perform annual audits. Providers will need to copy office records for these audits. It is very important that any time a copy of a record is requested the entire record is sent.

In addition to monitoring the guidelines in this manual, continuity of all patient care will be monitored (see the **Medical Records** section of this manual).

The results of all reviews are maintained in a Physician Profile and utilized at the time of re-credentialing.

**Provider  
Participation  
with QI  
Activities**

The Quality Improvement Program seeks out and invites input from the physician community regarding the implementation of the Program. Ohio-licensed physicians are members of the following Program committees and work groups:

- Medical Advisory Committee
- Credentialing Committee
- Pharmacy and Therapeutics Committee

Provider input is also integral to the development of Preventive Health Guidelines, Clinical Practice Guidelines, Performance Improvement Projects (PIP's) and Care and Disease Management Programs.

In accordance with regulatory contracts and accreditation guidelines, the Plan and its providers contractually agree to participate in Quality Improvement projects and medical record review activities to:

- Promote the appropriate medical record documentation and management of patients with designated diagnoses;
- Identify areas of medical record documentation and management that may be improved;

- Oversee the quality of the medical record;
- Provide periodic feedback to the physicians;
- Identify areas of practice that require peer review;
- Provide a performance profile to be utilized during the credentialing process.

**Access to Records**

- Access to the Plan member's medical record in the office or facility for review is required.

**Other Requirements**

- Copying and providing office records as needed for quality review activities;
- Requests for internal QI data from delegated credentialing entities;
- Copying and providing office records for state, federal or Plan review.

**Quality Improvement Activities**

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

- Access and availability studies:
  - PCP turnover rates
  - Children's access to primary care
  - Adults access to preventive/ambulatory health services;
- Hospital readmission reviews;
- Referrals for quality issues;
- Mortality reviews;
- HEDIS<sup>®</sup> reviews and initiatives;

- Performance Improvement Projects (PIP's):
  - Identifying children with special health care needs
  - Well-child visits during the first 15 months of life
  - Dental visits for children 2 through 21 years of age;
  
- Care management outcomes;
  
- Disease management outcomes;
  
- Appointment availability;
  
- After-hours availability;
  
- Accuracy, timeliness and completeness of encounter/claims submissions;
  
- Over- and under-utilization of services;
  
- Member satisfaction surveys;
  
- Provider specific issues identified through tracking and trending of complaints or referrals; and
  
- Medical Record Content Reviews – See the **Medical Records** section of this manual for specific documentation standards and requirements and the **Provider and Member Education Materials** for associated materials.

Results of all reviews will be housed in a Provider Profile to utilize during re-credentialing and re-contracting.

### Quality of Care Issues

Quality of care referrals may be generated by the Appeals and Grievances department, Risk Management department, Utilization Management department, member or family complaint department or may be identified through routine record review.

Record review identifying possible quality of care issues will be referred for peer review. In the event the peer reviewer/panel feels there is a possible quality of care issue, the physician will be asked, in writing, to provide additional information to address the issue. The response is reviewed and a final determination is rendered.

**Quality of Care Categories:**

- Procedural issues
- Medication issues
- Delay/Omission of care
- Death or serious disability
- Post-op complications
- Patient safety during confinement
- Member perception

**Quality Of Service Categories:**

- Access/Availability issues
- Referral issues
- Billing issues
- Environmental
- Interactions

**Determination:**

- Substantiated
- Unsubstantiated
- Unable to make a determination based on available information

**Outcome:**

- No adverse outcome
- Adverse outcome
- Sentinel event

**Action:**

- Close Case
- Track & Trend
- Request additional information
- Refer to peer reviewer for recommendation
- Refer to external review organization
- Refer to the Credentialing (Peer Review) Committee

- Corrective Action Plan

**Reporting By Action***Reportable:*

- Termination as a result of a quality of care issue
- Imposing restriction on privileges

*Not Reportable:*

- Track & Trend
- Focus review
- Deferment of members
- Requiring CMEs
- Counseling

**HEDIS<sup>®</sup> Indicators**

The following HEDIS indicators may be reviewed and reported on an annual basis. Based on ODJFS and/or the Plan initiatives, performance indicators may be added or deleted.

- Adolescent Well-Care Visits
- Adult Access to Preventive/Ambulatory Health Services
- Appropriate Treatment of Children with URI
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Use of Appropriate Medication with People with Asthma
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening for Women
- Childhood Immunization Status
- Children and Adolescents' Access to Primary Care Practitioners
- Comprehensive Diabetes Care
- Controlling High Blood Pressure
- Frequency of Ongoing Prenatal Care
- Prenatal and Postpartum Care
- Weight Assessment and Counseling for Nutrition

and Physical Activity for Children/Adolescents

- Well-Child Visits for Children Ages 3-6 years
- Well-Child Visits in the First 15 months of Life
- Annual Dental Visits
- Lead Screening
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Pharmacotherapy Management of COPD Exacerbation
- Cholesterol Management for Patients with Cardiovascular Conditions/LDL-C Screening Performed
- Follow Up After Hospitalization for Mental Illness

### **Health Quality Improvement and Disease Management Initiatives**

The Quality Improvement Program includes programs for the Covered Families and Children (CFC) population for Care and Disease Management for members with asthma, diabetes, HIV/AIDS, elevated lead levels, teen pregnancy, high-risk pregnancy, pediatrics and other complex conditions. In addition, programs to ensure members are receiving Healthchek screenings, lead screenings and immunizations are instituted to encourage members to obtain needed preventive health care screenings.

Included in the **Provider and Member Education Materials** are items ranging from Adult Health Screening guidelines, Tools for Documentation, Guidelines for Medical Record Review to Fax Alerts, which are faxed to provider offices, regarding members' unique health care needs.

**Overview**

The Plan conducts reviews of medical records of Primary Care Providers (PCPs) and OB/GYN physicians to determine compliance with established documentation standards and goals that are adopted by the Quality Improvement Committee (QIC). An average score of 80 percent or greater is considered to meet documentation standards. A physician who scores less than 80 percent will receive a letter outlining the deficiencies and a corrective action plan will be requested. If the physician fails to improve the score to 80 percent during a re-audit, the information will be forwarded to the QIC for review.

**Requirements and Guidelines**

Medical record requirements and guidelines are as follows:

- Each provider shall maintain an adequate and complete patient record for each patient and may maintain electronic medical records provided the record keeping format is capable of being printed for review;
- Safeguard member confidentiality in accordance with HIPAA state and federal guidelines, the Plan's Quality Improvement and Risk Management programs and professional practice standards. This requirement includes the confidentiality of a minor's consultation and the examination and treatment for a sexually transmissible disease;
- Make the medical records available for quality care review studies by Plan reviewers, authorized representatives of the Ohio Department of Job & Family Services (ODJFS), Centers for Medicare & Medicaid Services (CMS), Plan member, organizations conducting accreditation audits and HEDIS® medical record reviews;
- Comply with corrective action plan requirements imposed as the result of any review or audit;
- When a member changes his/her PCP, the provider must forward a copy of a transferring member's medical record to the new PCP, without charge and within 10 business days;

- Patient records remaining under the care, custody and control of the physician shall be maintained by the physician, or the physician's designee, for minimum of six years from the date of termination of the agreement with the Plan or at the conclusion of an investigation, whichever is later;
- Any correction, addition or change in any patient record made more than 48 hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and the date, time and name of the person making the correction, addition or change shall be included, as well as the reason for the correction, addition or change;
- A consultative report shall be considered an adequate medical record for a radiologist, pathologist or a consulting physician;
- The member's medical record is the property of the provider who generates the record;
- The state agency is not required to obtain written approval from a member before requesting the member's record from the provider.

**Content and Review**

The following information applies to medical records for members.

- A member's medical record should contain the quality, quantity, appropriateness and timeliness of services performed.
- All entries in the medical record are signed. All entries must include the name and profession of the practitioner rendering services, for example: RN, MD, DO, including signature or initials of the practitioner.
- All entries in the medical record must be dated and recorded in a timely manner.

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- Medical records must be legible to readers and reviewing parties, and maintained in an orderly and detailed manner.
  - The following personal and biographical data must be included in the record: name, member ID number, date of birth, sex, address and telephone number, emergency contact and legal guardianship. This may include: marital status, name of spouse, next of kin or closest relative, address, employer, telephone numbers, insurance information or family history.
  - Medication allergies or “no known allergies” and untoward reactions to drugs, are to be prominently noted in the record. This may include a sticker inside of the chart or a prominent notation in a conspicuous place in the record.
  - Medical records from the previous provider have been obtained and are easily accessible. Old records include past medical history, physical examinations, necessary tests and a list of possible risk factors for the member relevant to treatment, used to assess the periodicity schedule and to maintain continuity of care.
  - An immunization history and/or record are on the chart, as appropriate.
  - A listing of all current and past medications the member is taking is in the chart. This includes prescribed medications, including dosages and dates of initial or refill prescriptions or sample medications.
  - A problem list, in the chart, of past and current diagnoses with procedures used to provide continuity of care. This includes a summary of significant surgical procedures, past and current diagnoses or problems, medication reactions, etc.
  - Screening for substance abuse of tobacco, alcohol and drugs with appropriate counseling/referrals, if needed, and documented follow-up.

- There is documentation of screening for domestic violence with appropriate counseling/referrals, if needed, and follow-up.
- There is evidence the member was asked about advance directives and documentation of acceptance or refusal. **Note:** The record must contain evidence that the member was provided written information concerning the member's rights regarding advance directives and whether or not the member has executed an advance directive. The record may also have evidence that the member does not need to have advance directives completed. A signed statement that a member has been asked if he/she has advance directives, and if not, asked if he/she wants advance directives will suffice.  
A stamp may be utilized. The provider shall not, as a condition of treatment, require the member to execute or waive an advance directive.
- All records must reflect the primary language spoken by the member and translation/communication needs of the member, if any. Translation/communication needs could reflect the need for an interpreter, sign language or Braille materials, etc., as appropriate.
- Documentation indicating diagnostic or therapeutic intervention as part of a clinical research study is clearly contrasted from those entries pertaining to usual care.
- There is documentation of member missed appointments and follow-up by the PCP staff.

**Continuity  
of Care  
Requirements  
Screen**

The medical record must show the physician's knowledge of the patient's course of care as evidenced by the following:

- There is documentation and reports of consultations and referrals to specialty physicians, if indicated;
- There are reports of diagnostic testing in the medical record. The medical record will show documentation of reports for diagnostic testing that was ordered: lab

results, X-ray reports, MRI/CT reports, etc;

- There is documentation and records for emergency room care. There is documentation in the record if a member was seen in the emergency room and the records from the emergency room visit are in the medical record;
- There is documentation of hospitalizations to include discharge summary and discharge planning. There is documentation of a plan for hospital discharge and a copy of the hospital discharge summary on the medical record for members who were hospitalized;
- Assessment and clinical impression of diagnosis;
- Any informed consent for office procedures.

The following patient information must be documented in the medical record for each visit:

- History and physical examination as related to the visit, chief complaint or purpose of the visit, objective findings of the practitioner, diagnosis or medical impression are documented for each visit.
- Plan of treatment with documentation of patient's input, referrals, disposition, diagnostic testing, studies ordered, therapy administered and prescribed regimens are documented for each visit, as indicated.
- There is documentation of follow-up plans for abnormal testing/consultation reports, referrals or missed/cancelled appointments. There is documentation that the abnormal results or consultations were reviewed by the provider and documentation of the follow-up to be done.
- There is documentation of patient education and instruction whether verbal, written or via telephone. The member is provided with verbal and/or written education/instruction as indicated and appropriate. Significant medical advice given via telephone is

entered in the member's record and appropriately signed and initialed (this includes medical advice provided by after-hours telephone patient information or triage telephone services).

- All entries must include the disposition, recommendations, instructions to the patient, evidence of whether there was follow-up and outcome of services.

**Medical Record Documentation**

The physician's medical records should be available for utilization and quality review studies.

Implementing the following documentation guidelines can reduce practice risks:

- **Documentation should be descriptive.**  
Clinical observations and/or patient symptoms should be documented in detail. Use of anatomical forms or drawings should be considered when documenting the presence, size, color and/or location of a lesion or deformity.
- **Clearly document follow-up instructions.**  
This includes activity limitations, medications, referrals to specialists, further testing and subsequent appointments. Make sure patients understand instructions given.
- **Obtain and document informed refusal.**  
Inform patients of adverse outcomes and consequences of not undergoing recommended tests or procedures.
- **Use of a problem list is recommended.**  
This is a significantly important documentation tool and is helpful only if used consistently. It should contain space for chronic diseases/conditions and any acute problems for follow-up. Columns for date and for problem identification and resolution should be included.

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- **Document all telephone calls from the patient and response to them.**

The date and time the call was received, by whom and the date and time it was returned needs to be detailed. Fully document any advice given or diagnosis made.
  - **A follow-up/recall system needs to be in place.**

To avoid failure to diagnose a system to follow-up on abnormal lab results, assure that the patient returns to re-check conditions as indicated by the physician and to assure that the patient sought consultation after referral needs to be established. Also, patients like to know if test results are normal. In addition, the physician should initial all test results to show verification of review.
  - **Always document attempts to contact the patient.**

Depending on the seriousness of the condition, physicians may want to send a certified letter with return receipt.
  - **Consistently adhere to standard medical record documentation guidelines, specifically:**
    - All entries should be neat, complete, clear, concise and timely; include all recommendations and essential findings;
    - Sign entries with complete name, date, time of occurrence, time of documentation and professional designation;
    - Records should not be altered. Corrections are to be made by a single line through the inaccurate material, dated and initialed;
    - Use only standard abbreviations and symbols;
    - If records are hand written, they must be legible;
    - Late entries should include date and time of occurrence and date and time of documentation;

- Record details of informed consent discussions.

All participating PCPs should maintain complete and accurate fiscal records, as well as medical and social records for all Plan members. Records should be made available for quality care review studies by the Plan, authorized representatives of ODJFS, CMS, accreditation agencies and should comply with requirements issued as a result any such review or audit.

**Medical Record Review Audits**

- Medical Record Content
- Continuity of Care
- Pediatric Health Screening/EPSTD Services
- Adult Health Screening

**Diagnosis Specific Audits**

- Maternity Care Review (OB/GYN only)
- Asthma Review
- Diabetes Review
- Healthcare Effectiveness Data and Information Set (HEDIS) Reviews

**Maternity Care  
(OB/GYN  
Review)**

Medical record requirements and guidelines:

1. Pre-term delivery risk assessment is rendered by the 28<sup>th</sup> week.
2. The member will be seen by an obstetrician **within the first trimester** of the pregnancy with the following assessments performed and documented:
  - Weight
  - Blood Pressure
  - Fetal Heart Tones
  - Hemoglobin and Hematocrit (H&H)
  - Urinalysis for protein and glucose levels
  - Blood Typing and Antibody screening
  - Rubella Antibody titer
  - Syphilis screening
  - HBsAG screening
  - Pap smear
  - Uterine Size

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- Nutrition assessment
3. The member will be seen **once every month in the second trimester** of pregnancy with the following assessments performed and documented:
- Weight
  - Blood Pressure
  - Fetal Heart Tones
  - Uterine Size
  - Hemoglobin and Hematocrit (H&H)
  - Urinalysis
  - Alpha-fetoprotein (between 15-20 weeks)
  - Diabetes screening/GTT (between 24-28 weeks)
  - Repeat antibody test for unsensitized RH negative patients (28 weeks)
  - Prophylactic administration of Rho(D) immune globulin (28 weeks), if indicated
4. The member will be seen **twice every month in the third trimester** of pregnancy and **one visit per week in the ninth month** with the following assessments performed and documented:
- Weight
  - Blood Pressure
  - Fetal Heart Tones
  - Uterine size
  - Hemoglobin and Hematocrit (H&H)
  - Urinalysis
  - Testing for STDs and HBsAg for high-risk members
  - Group B Strep screening for high-risk members (35-37 weeks)
5. The Maternity chart will contain documentation of the following:
- Physical findings on each visit with a plan of treatment and follow-up for any abnormalities;
  - Member education (childbirth/maternal care, avoidance of alcohol, smoking cessation if

needed, signs of labor, nutrition, signs and symptoms that should be reported);

- Postpartum care – at least one complication-free visit, or appropriate follow-up if complications exist;
- Family planning counseling and services for all pregnant women and mothers;
- HIV testing/counseling is offered; and
- Referrals to the Prenatal Program.

### **Healthchek Program**

The Healthchek Program screens, for ages 0 to 21 years, are to provide comprehensive, preventive, well-child care on a regularly scheduled basis and to ensure entry into the health care system.

#### **Healthchek Periodicity Schedule:**

Birth or neonatal examination in the hospital:

1 month  
2 months  
4 months  
6 months  
9 months  
12 months  
15 months  
18 months

Once per year for two through 21 year olds

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

A member should have an initial screening within 90 days of entering the Plan, within 24 hours of birth or when the member has changed to a new PCP. The medical record must contain documentation of a comprehensive health history, in addition an unclothed physical examination to determine if the child's development is within the normal

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range for the child's age and health history.

The following elements as appropriate for the child's age and health history should be addressed:

- Skin
- Head
- Eyes, ears, nose, mouth, throat, teeth, gums
- Nodes
- Height
- Weight
- Head circumference for infants 0 through 24 months
- Blood pressure beginning at 3 years and as indicated
- BMI
- Heart and femoral pulses
- Pulse and respiration
- Lungs
- Abdomen
- External genitalia
- Pelvic examination on all sexually active females and if not sexually active, may wish to consider beginning at age 18 (provider may wish to refer female recipients for this service)
- Hip abduction
- Gait
- Extremities
- Spine
- Neurological evaluation
- Nutrition
- Cardiovascular disease risk assessments and cholesterol screening from ages 2 through 21 years old
- Hearing and vision screening
- Sexually transmitted infections testing from age 11 through 21 years old
- Immunizations

There must be assessment of past medical history, developmental history and behavioral health status.

May include such information as: sibling history, growth history, conditions experienced by blood relatives, previous medications, immunizations or allergies or developmental history of the child or other family members.

There must be documentation that a developmental assessment was performed. The developmental assessment consists of a range of activities to determine whether the child's physical, cognitive and emotional developments are within the normal range for the child's age and cultural background.

The following elements as appropriate for age and cultural background should be considered:

- Gross motor development;
- Fine motor development;
- Communication skills or language development;
- Self-help and self-care skills;
- Social-emotional development; and
- Cognitive skills.

**Through school age:** Focus on visual motor integration, visual spatial organization, visual-sequential memory, attention skills, auditory processing skills and auditory sequential memory.

**For adolescents:** Focus on areas of special concern, such as potential learning disabilities, peer relations, psychological, psychiatric problems and vocational skills.

**1. Vision screening:** Vision status is assessed and the findings are documented in the medical record at each child health check-up.\* This includes age appropriate testing to determine if the child's vision is within the normal range.

\* *Document in the medical record if the child is uncooperative and re-screen at the next child health check-up or sooner if medically indicated.*

**2. Dental screening is documented:** Dental status is assessed and the findings are documented in the medical record. It is recommended that the provider refer children who are 6 months or older for an assessment by a dentist and document this referral in

the child's medical record.

**3. Hearing screening:** Hearing is assessed and the findings are documented in the medical record at each screen.\*

\* *Document in the medical record if the child is uncooperative and re-screen at the next Well-Child screen or sooner if medically indicated.*

**4. Nutritional assessment:** Nutritional status is assessed and the findings are documented in the medical record at each screen.

This includes height and weight (measured and plotted on standard chart), head circumference if 24 months or younger, dietary intake, eating habits, use of alcohol, drugs or tobacco

**5. Lead Risk Assessment:** All children are to be screened for lead poisoning. A Lead Risk Assessment is done at each screening between ages 6 months to 72 months and blood lead testing is performed as noted below. Recommended that providers use a verbal lead risk assessment to assess risk on children who are six months to six years of age. Federal regulation requires that all children receive a blood lead test screening at 12 months and 24 months of age, and for children between 36 and 84 months who have not been previously screened for lead poisoning.

**6. Anemia screening:** Hemoglobin and Hematocrit (H&H) recommended at the following ages with results documented in the child's medical record.

- 4,18,24 months (consider earlier for children at high risk)
- 3 years through 21 years old
- All menstruating adolescents should be screened annually
- When medically indicated

**7. Annual Tuberculosis (TB) skin testing** is done if the member is in a high-risk category. Only those children identified at high risk for TB disease should be recommended for testing. Results of tuberculosis

testing should be documented in the child's medical record.

**8. Urinalysis:** Urinalysis is recommended for children at age 5 and 16 and as indicated. Performing urine dipstick urinalysis for leukocytes is recommended annually for sexually active male and female adolescents.

**9. Serum cholesterol screening:** A serum cholesterol determination is recommended on children with a family history of familial hyperlipidemia.

**10. Immunizations** administered at required age parameters and intervals with dates documented. If the immunizations are not up to date according to age and health history, the provider should document why immunizations were not given at the time of the screen. "Catch up" on any shots that have been missed at an earlier age.

**11. Health education:** Health education, anticipatory guidance and counseling are provided to parent/guardian and child at each screen and documented in the child's medical record.

**12. Family planning:** Family planning services/counseling will be offered to appropriate members and documented in the medical records.

**13. Diagnostic services:** All members should be referred for further diagnostic and/or treatment services to correct or ameliorate defects and physical or mental illnesses and conditions discovered by the screens. Referral and follow-up may be made to the provider conducting the screening or another provider as appropriate.

## **Adult Health Screening**

An adult health screening is performed by a physician to assess the health status of a member, age 21 or older. It is used to detect and prevent disease, disability and other health conditions or monitor their progressions. The adult member will receive an appropriate assessment and

intervention as indicated or upon request.

**Adult Health Screening Periodicity Schedule**

Recommended periodicity (one screening allowed every 365 days):

- After age of 19 through 39, every one to three years;
  - Ages 40 through 64, every one to two years based on risk factors; and
  - Ages 65 and over, every year.
1. There is documentation of an initial health screening performed within 90 days of entering the Plan. If the member is seeing a new PCP there must be a screening within 90 days.
  2. There is a health history documented. See required content in this section.
  3. There is documentation of a physical examination. See required content in this section.
  4. There is documentation of a visual acuity testing. At a minimum, visual acuity testing must document a recipient's ability to see at 20 feet. Vision screening 65 years and older, periodically.
  5. There is documentation of a hearing screening. At a minimum, a hearing screen must document a member's ability to hear by air conduction.
  6. Tuberculosis (TB) skin testing is done if the member is in a high-risk category and the results are documented in the member's medical record.
  7. Annual influenza vaccination documentation for members 50 years of age or older or persons with pre-existing medical indications.

Medical indications: chronic disorders of the cardiovascular or pulmonary systems including asthma; chronic metabolic diseases including diabetes

mellitus, renal dysfunction, hemoglobinopathies, immunosuppression (including causes by medications or by HIV (human immunodeficiency virus), requiring regular medical follow-up or hospitalization during the preceding year; women who will be in the second or third trimester of pregnancy during the influenza season.

8. Pneumococcal vaccination is documented for members 65 years of age or older or for younger members with high-risk medical conditions.

Medical indications: chronic disorder of the pulmonary system (excluding asthma), cardiovascular diseases, diabetes mellitus, chronic liver diseases including liver disease as a result of alcohol abuse (e.g., cirrhosis), chronic renal failure or nephrotic syndrome, functional or anatomic asplenia (e.g., sickle cell disease or splenectomy), immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection, leukemia, lymphoma, multiple myeloma, Hodgkins disease, generalized malignancy, organ or bone marrow transplantation), chemotherapy with alkylating agents, anti-metabolites, or long-term systemic corticosteroids.

9. Screening for dyslipidemia is documented as indicated.

A complete fasting lipoprotein profile including major blood lipid fractions {total cholesterol, LDL, HDL and triglycerides}, should be obtained at least once every five years in adults ages 20 and over.

However, for persons with multiple (2+) risk factors, lipoprotein measurement is recommended as a guide to clinical management.

**Major Risk Factors:**

- Diabetes;
- History of coronary artery disease (CAD) or prior cardiac event;
- Cigarette smoking;
- Hypertension (BP greater than or equal to

140/90 mmHg or on antihypertensive medication);

- Low HDL cholesterol (less than 40 mg/dL); and
- Family history of premature coronary heart disease (CHD) (CHD in male first-degree relative less than 55 years; CHD in female first-degree relative less than 65 years) Age (men older than 45 years; women older than 55 years).

10. Colorectal cancer screening is documented.

Beginning at age 50, both men and women should follow one of these five testing schedules:

- Yearly fecal occult blood test (FOBT);  
(The take-home multiple sample method should be used.)
- Flexible sigmoidoscopy every five years;
- Yearly fecal occult blood test plus flexible sigmoidoscopy every five years;  
(The combination of FOBT and flexible sigmoidoscopy is preferred over either of these two tests alone.)
- Double-contrast barium enema every five years; and
- Colonoscopy every 10 years. All positive tests should be followed up with colonoscopy.

11. Urinalysis dipstick for blood, sugar and acetone.  
Manual or automated dipstick urine.

12. Hemoglobin and Hematocrit (H&H) testing is done.

13. Mammogram is done as indicated.  
Yearly mammograms starting at age 40 and continuing for as long as a woman is in good health. Clinical breast exams (CBE) should be part of a periodic health exam, about every three years for women in their 20s and 30s and every year for women 40 and older.

## 14. Pap test as appropriate.

- All women should begin cervical cancer screening about three years after they begin having vaginal intercourse, but no later than when they are 21 years old. Screening should be done every year with the regular Pap test. Beginning at age 30, women who have had three normal Pap test results in a row may get screened every 2 to 3 years. Women who have certain risk factors should continue to be screened annually.
- Women 70 years of age or older who have had three or more normal Pap tests in a row and no abnormal Pap test results in the last 10 years may choose to stop having cervical cancer screening. Women with a history of cervical cancer, diethylstilbestrol (DES) exposure before birth, HIV infection or a weakened immune system should continue to have annual screening as long as they are in good health.

**Diabetes  
Specific  
Screens**

Symptoms of diabetes and a casual plasma glucose greater than or equal to 200 mg/dL. Casual is defined as any time of day without regard to time since last meal. The classic symptoms of diabetes include polyuria, polydipsia and unexplained weight loss.

- Fasting Plasma Glucose of greater than or equal to 126 mg/dL. Fasting is defined as no caloric intake for eight hours;
- Two-hour Plasma Glucose greater than or equal to 200 mg/dL during OGTT (Oral Glucose Tolerance Test);
- On oral or parenteral medication or dietary restrictions to treat Diabetes Mellitus.

## Medical Record Documentation:

1. There is evidence of attempt to control the disease process through pharmacological or dietary

intervention as indicated by an individualized management plan with routine diabetes visits scheduled quarterly for patients who are not meeting goals and semiannually for other patients.

2. There is evidence of comprehensive education in self-management of blood glucose, nutrition therapy, insulin or oral medication therapy regimens, prevention and treatment of hypoglycemia and exercise.
3. The member's HbA1c level is less than 7 percent. (Two to four times an annually base on individual therapeutic goals)
4. The member will receive Lipid Profile testing at least once per year with the results documented in the medical record. LDL less than 100 mg/dl; HDL greater than 40 (men); HDL greater than 50 (women).
5. A dilated eye examination (screen for retinopathy) was performed within the last year with the results documented in the medical record.
6. Urinalysis for microalbuminuria (screen for nephropathy) was performed within the last year with the results documented in the medical record.
7. A comprehensive foot exam (including microfilament testing) is performed at every office visit. Foot exam includes sensation, structure and biomechanics, vascular status and skin integrity.
8. Blood pressure management less than 130/80, any changes in treatment, patient counseling/education and follow-up instructions.

**Chronic  
Pulmonary  
Disease/Asthma**

The patient with chronic pulmonary disease will receive a timely evaluation and appropriate medical intervention as evidenced by the following:

1. On each visit the member will receive a complete respiratory assessment, which will include

auscultation of breath sounds, use of accessory muscles and respiratory rate.

2. The member's medication is monitored and evaluated.
3. There is evidence of attempt to control the member's disease process as evidenced by ongoing assessments beyond the acute phase of illness.
4. There is evidence of member education related to disease process and self-management.

*For diagnosis of Asthma only:*

There is evidence of management of the member's disease process through the use of long-acting therapies.

**Review  
Criteria**

The criteria utilized for medical record standards and standards of care are not authored by the Plan. The criterion is based on regulatory requirements outlined in regulatory contracts, accreditation guidelines and accepted national organizations.

Reviews in a physician office may conclude with an Exit Review, to include the physician and designated office staff. The physician will be given the preliminary results of the review. Any area that is not compliant with regulatory standards will require a plan of correction.

**Corrective  
Action Plan**

In the event a corrective action plan is not received in the stated time frame a second request will be sent to the physician.

**References**

1. American Academy of Pediatrics, "Recommendations for Pediatric Preventive Health Care", "Recommended Childhood and Adolescent Immunization Schedule"  
Web site: <http://www.aap.org>
2. American Cancer Society Cancer Detection Guidelines.

- Web site: <http://www.cancer.org>
3. American Diabetes Association, “Standards of Medical Care for Patients with Diabetes Mellitus”  
Web site: <http://diabetes.org>
  4. Guide to Clinical Preventive Services, 2007 Report of the U.S. Preventive Services Task Force, 2007  
Web site: <http://www.ahrq.gov/clinic/prevnew.htm>
  5. Guidelines for Prenatal Care, American Academy of Pediatrics, The American College of Obstetricians and Gynecologists
  6. HEDIS® Guidelines  
Web site: <http://www.ncqa.org>
  7. Recommended Adult Immunization Schedule United States October 2007- September 2008, Department of Health and Human Services, Centers for Disease Control and Prevention  
Web site: <http://www.cdc.gov>
  8. Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7), August 2004 National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health, 2003. Web site:  
<http://rover.nhlbi.nih.gov/guidelines/hypertension/index.htm>
  9. The National Asthma Education and Prevention Program (NAEPP), National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health, 2003  
Web site: <http://rover.nhlbi.nih.gov/about/naepp>
  10. Centers for Disease Control and Prevention (CDC)  
Web site: <http://www.cdc.gov>
  11. QISMC Medical Record Review (Centers for Medicare and Medicaid Services)
  12. Managed Care Organization Policies and Procedures

13. National Committee on Quality Assurance. Standards for the Accreditation of Managed Care Organizations. Website: [www.ncqa.org/communications/publications](http://www.ncqa.org/communications/publications).

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**Overview**

While the provision of health care services and the exercise of professional medical judgment is the purview of treating physicians and other health care providers, Care Management is a clinical system that focuses on the accountability of an identified individual or group for coordinating a member's care (or group of members) across an episode or continuum of care.

Care Management includes negotiating, procuring and coordinating services and resources needed by the member/family with complex issues; ensuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual members; addressing and resolving patterns of issues that have a negative quality cost impact; and creating opportunities and systems to enhance health outcomes.

- PCPs serve as principal care managers and coordinators of care. The Plan's Care Management team serves in a support capacity to the PCP and assists in coordinating care among multiple physicians and providers.
- The Care Management team is comprised of qualified nurses who assist the physician in achieving member wellness and autonomy through advocacy, communication, education and service facilitation.
- The Plan has incorporated Care Management programs that identify members with specific diagnoses or that require high-cost or extensive services. The Care Management program supports these members with specific health care needs such as catastrophic diseases (adult and pediatric), transplant, wound care, HIV, prenatal and obstetrics and emergency room over-utilization. The physician may call to request Care Management services for any Plan member. PCPs and members are notified in writing when a member has been identified as meeting the criteria for Care Management.

- The Plan has adopted practice guidelines that are based on valid and reliable clinical evidence and the recommendations of national medical associations and societies.

**Tissue and Organ Transplant Program**

WellCare covers all services and supplies related to Medicaid covered transplant services for eligible members. All non-investigational medically necessary transplantation services are covered, when covered by Medicaid. Prior authorization is required for all transplant services.

When a participating provider identifies a member as a potential transplant candidate, the member must be referred to a transplant facility associated with Medicaid and the Plan must be notified to assist in care coordination.

**Obstetrical Care**

In support of OB care, the Plan has adopted current Guidelines of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists (ACOG). These clinical practice guidelines are based on valid and reliable clinical evidence.

The Plan contracts with participating providers for OB care that includes OB, as well as midwife services. The OB or midwife should complete the WellCare Prenatal Notification Form (see the **Forms** section in this manual) at the first prenatal visit and fax the completed form to the Plan's OB department. The Prenatal Notification form is used by the Plan to determine if the member is a potential candidate for WellCare's High-Risk OB Care Management program.

If a pregnant member is receiving care from a non-participating provider, the Plan will make special arrangements to reimburse the provider for the member's care through the postpartum period. The provider is required to provide the most appropriate and highest level of quality care for pregnant women.

**OB  
Physician  
Functioning  
as the PCP**

The OB physician may function as the PCP during the pregnancy as long as the OB physician agrees to accept the member as a primary care patient and accepts the responsibilities of a primary care provider. The OB physician may request referrals and authorizations for the member during their pregnancy.

**High-Risk  
OB Care  
Management**

The Care Management program for women with high-risk pregnancies provides additional assistance to members throughout their pregnancies in collaboration with their physicians. If a member is identified as having a high-risk pregnancy, the member is referred to the OB care manager for intensive follow-up.

Below are some of the circumstances for which a member may be considered to have a high-risk pregnancy:

- Premature labor between 20 and 35 weeks gestation;
- Newly diagnosed gestational diabetes or insulin-dependent maternal diabetes;
- PIH (Pregnancy Induced Hypertension);
- Chronic Hypertension;
- Hyperemesis;
- HIV/AIDS;
- Teenage pregnancy (17 and younger);
- Multiple Gestation (twins, triplets) if member has other risk factors;
- Oligohydramnios/Polyhydramnios, if member has had an admission or complication;
- History of preterm delivery – 17P (Alpha-Hydroxyprogesterone Caproate), prevention of premature delivery program.

Physicians should also notify the Plan of a member's non-compliance, potential for the member's condition to worsen as the pregnancy progresses or other concerns that may threaten the pregnancy. The High-Risk OB care manager will support the physician with necessary interventions.

The Prenatal High-Risk program:

- Encourages pregnant women to practice good prenatal care;
- Educates women regarding signs of early labor;
- Coordinates care through the continuum;
- Assists the member in being an active participant in their own health care; and
- Eliminates barriers to receiving care.

**The Prenatal Program**

The Prenatal Program assists in improving the care management of pregnant women by providing educational information early in their pregnancy and working in partnership with our OB providers to enable members to receive optimal prenatal care and avoid high-risk behaviors.

In addition, the program identifies members with potential risk factors that may adversely affect the outcome of their pregnancy.

**Pediatric Lead Care Management**

The Pediatric Lead Care Management Program identifies children with increased lead levels. The program works in partnership with our providers in developing and coordinating the appropriate plan of treatment including necessary referrals, coordination with specific agencies and aggressive pursuit of non-compliance with follow-up tests and appointments.

Members are monitored and their treatment plans are adjusted until the venous sample blood lead level is below 10 mcg/dl.

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**Children with Special Health Care Needs**

Children with special health care needs (CSHCN) are defined as children age 17 and younger who are pregnant, and members younger than 21 with one or more of the following:

- Asthma;
- HIV/AIDS;
- A chronic physical, emotional or mental condition for which they need or are receiving treatment or counseling;
- Supplemental security income (SSI) for a health-related condition; and/or
- A current letter of approval from the Bureau of Children with Medical Handicaps (BCMh), Ohio Department of Health.

CSHCN children are identified through administrative review, PCP referrals or outreach.

PCPs are encouraged to screen members for these conditions and refer the member to WellCare for the appropriate Care Management program. Once members are identified the Care Management department follows ODJFS CSHCN Program requirements.

**Emergency Department Diversion Program**

The goal of the WellCare Emergency Department Diversion Program is to minimize frequent Emergency Department (ED) utilization.

The program monitors ED utilization, identifies frequent ED users and intervenes to reduce avoidable ED utilization. It also identifies PCPs with the highest number of frequent ED users and reviews the PCPs accessibility to members. This program provides member and provider education.

**Delegated Entities**

All participating providers or entities delegated for Care Management will apply the same standards as defined in this section. Delegated provider compliance is monitored on a monthly basis and formal audits are conducted annually.

**Cultural Competency****Purpose**

The purpose of the Cultural Competency program is to ensure that the Plan meets the unique diverse needs of all members in the population; to ensure that the associates of the Plan value diversity within the organization and to make certain members in need of linguistic services have adequate communication support. In addition, the Plan is committed to ensuring our Providers fully recognize and care for the culturally diverse needs of the members they serve.

At the national level, WellCare is a member of the National Alliance for Hispanic Health, an organization with ties to the federal government that fosters the development of resources to improve Hispanics' access to, and quality of, health care. One of the Alliance's projects is the National Hispanic Family Health Helpline, (866) 783-2645. The Alliance also sponsored the report, "Genes, Culture and Medicines: Bridging Gaps in Treatment for Hispanic Americans," which WellCare will start using in 2005 in educating providers about ways to reduce health disparities.

**Objectives**

The objectives of the Cultural Competency program are to:

- Identify members that have potential cultural or linguistic barriers for which alternative communication methods are needed;
- Utilize culturally sensitive and appropriate educational materials based on the member's race, ethnicity and primary language spoken;
- Ensure resources are available to meet the unique language barriers and communication barriers that exist in the population;
- Ensure providers care for and recognize the culturally diverse needs of the population;

- Ensure associates are educated and value the diverse cultural and linguistic differences in the organization and the populations served.

**Goals**

The goals of the Cultural Competency program are to:

- Improve communication to members for whom cultural and/or linguistic barriers exist;
- Decrease health care disparities in the minority populations we serve;
- Improve associates' understanding and sensitivity to cultural diversity within the organization and the members served.

The delivery of culturally competent health care and services requires health care providers and/or employees to possess a set of attitudes, skills, behaviors and policies which enable the organization and staff to work effectively in cross-cultural situations.

Culturally and linguistically appropriate services (CLAS): Health care services that are respectful of, and responsive to, cultural and linguistic needs.<sup>1</sup>

The Plan endorses the view, promulgated by the federal government,<sup>2</sup> that achieving cultural competence will help the health Plan to:

- Improve services, care and health outcomes for current members (improved understanding leads to better adherence and satisfaction)
- Increase market penetration by appealing to potential culturally and linguistically diverse members

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

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

- Enhance the cost-effectiveness of service provision
- Reduce potential liability from medical errors and Title VI (Civil Rights Act) violations<sup>3</sup>

**The Components of the Plan's Cultural Competency program include:****Data Analysis**

- Needs assessment in the areas served, utilizing the state-supplied data for Medicaid and S-CHIP populations
- Analysis of claims and encounter data to identify the health care needs of the population
- Collection of data on race, ethnicity and language spoken for members

**Community-based support**

Outreaches to community-based organizations which support minorities and the disabled to be sure that the existing resources for members are being utilized to their full potential.

**Diversity of Health Plan Associates**

- The Plan does not discriminate with regards to race, religion or ethnic background when hiring associates.
- The Plan recruits diverse talented associates in

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

all levels of management.

- The Plan ensures that bilingual associates are hired for areas that have direct contact with members to meet the needs identified.

**Diversity of Provider Network**

- Providers are inventoried for their language abilities and this information is housed in the Diamond system and printed 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 that have potential linguistic barriers for which alternative communication methods are needed and contact the Plan 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 Member Services department.
- Interpreter services available include oral translation, oral 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 the Plan's Member Services department.
- Written materials are available for members in large print format and the prevalent non-English languages of the Plan's service areas.

**Electronic Media**

- Telephone system adaptations – members have access to the TTY/TDD line for hearing impaired services. The Member Services representatives have responsibility for any necessary follow-up phone calls to the member.

**Provider Education**

- Educated regarding the Cultural Competency program through the Provider Manual
- Receive a Cultural Competency Checklist to assess their Cultural Competency in their office

**Determination of Performance Improvement Projects**

- Focused assessments to identify opportunities for improvement
- Setting priorities and assignments

**Cultural Competency Survey**

Promoting Cultural and Linguistic Competency: Self-Assessment Checklist for Personnel Providing Primary Health care Services.

**Developed by: Tawara D. Goode, National Center for Cultural Competence, Georgetown University**

Target Group  
**Health care workers**

**Purpose**

1. To increase individual awareness of practices, beliefs, attitudes and values that promote and hinder cultural and linguistic competence in the delivery of health care.
2. To identify training needs.

**Length of Survey**

30-item list

**Distinguishing Characteristics**

Divided into 3 categories:

1. Physical Environment, Materials and Resources
2. Communication Styles
3. Values and Attitudes

Each item is rated on a 3-point scale.

**Self-Assessment Checklist for Personnel Providing Primary Health Care Services**

Georgetown University Center for Child and Human Development -National Center for Cultural Competence

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic cultural competence in health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values and practices, which foster cultural and linguistic competence at the individual or practitioner level.

DIRECTIONS: Select A, B or C for each item listed below.

- A = Things I do frequently  
B = Things I do occasionally  
C = Things I do rarely or never

**Physical Environment, Materials & Resources**

\_\_\_\_ 1. I display pictures, posters, artwork and other décor that reflect the cultures and ethnic backgrounds of clients served by my program or agency.

\_\_\_\_ 2. I ensure that magazines, brochures and other printed materials in reception areas are of interest to and reflect the different cultures of individuals and families served by my program or agency.

\_\_\_ 3. When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures and ethnic background of individuals and families served by my program or agency.

\_\_\_ 4. I ensure that printed information disseminated by my agency or program takes into account the average literacy levels of individuals and families receiving services.

**Communication Styles**

\_\_\_ 5. When interacting with individuals and families who have limited English proficiency I always keep in mind that:

- Limitation in English proficiency is in no way a reflection of their level of intellectual functioning
- Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin
- They may or may not be literate in their language of origin or English

\_\_\_ 6. I use bilingual/bi-cultural staff and/or personnel and volunteers skilled or certified in the provision of medical interpretation during treatment, interventions, meetings or other events for individuals and families who need or prefer this level of assistance.

\_\_\_ 7. For individuals and families who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.

\_\_\_ 8. I attempt to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment or other interventions.

\_\_\_ 9. When possible, I insure that all notices and

communiqués to individuals and families are written in their language of origin.

\_\_\_ 10. I understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method.

**Values & Attitudes**

\_\_\_ 11. I avoid imposing values which may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

\_\_\_ 12. I screen books, movies and other media resources for negative cultural, ethnic or racial stereotypes before sharing them with individuals and families served by my program or agency.

\_\_\_ 13. I intervene in an appropriate manner when I observe other staff or clients within my program or agency engaging in behaviors which show cultural insensitivity, racial biases and prejudice.

\_\_\_ 14. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

\_\_\_ 15. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).

\_\_\_ 16. I accept and respect that male-female roles may vary significantly among different cultures and ethnic groups (e.g. who makes major decisions for the family).

\_\_\_ 17. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decision of elders, the role of eldest male or female in families or roles and expectation of children within the family).

\_\_\_ 18. Even though my professional or moral viewpoints may differ, I accept individuals and families as

the ultimate decision makers for services and supports impacting their lives.

\_\_\_ 19. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

\_\_\_ 20. I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease and death.

\_\_\_ 21. I understand that the perception of health, wellness and preventive health services have different meanings to different cultural or ethnic groups.

\_\_\_ 22. I recognize and accept that folk and religious beliefs may influence an individual's or family's reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic disorder or special health care needs.

\_\_\_ 23. I understand that grief and bereavement are influenced by culture.

\_\_\_ 24. I seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by my program or agency.

\_\_\_ 25. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to the culturally and ethnically diverse groups served by my program or agency.

\_\_\_ 26. I keep abreast of the major health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my program or agency.

\_\_\_ 27. I am aware of the socio-economic and environmental risk factors that contribute to the major health problems of culturally, ethnically and racially

diverse populations served by my program or agency.

\_\_\_\_ 28. I am well versed in the most current and proven practices, treatments and interventions for major health problems among ethnically and racially diverse groups within the geographic locale served by my agency or program.

\_\_\_\_ 29. I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, ethnically, racially and linguistically diverse groups.

\_\_\_\_ 30. I advocate for the review of my program or agency mission statement, goals, policies and procedures to insure that they incorporate principles and practices that promote cultural and linguistic competence.

There is no answer key with correct responses. However, if you frequently responded “C”, you may not necessarily demonstrate beliefs, attitudes, values and practices that promote cultural and linguistic competence within health care delivery programs.

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**Overview**

The Plan provides a behavioral health benefit for Medicaid plans. For complete information regarding benefits and exclusions, contact the Plan's behavioral health services vendor, Magellan Health Services, as referenced in the **Quick Reference Guide** included with this provider manual. You may access Magellan's medical necessity criteria and clinical practice guidelines on Magellan's provider Web site at [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider).

**Behavioral Health Program**

All behavioral health services require prior authorization including services provided by non-participating providers. If you need to make a referral for a member to a behavioral health provider, contact Magellan Health Services at the toll-free number listed on the **Quick Reference Guide** or on the back of the member's benefit card.

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

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

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

### **Standard Guides**

Available online or by calling Customer Service, providers may obtain the Plan's recommended transaction guidelines. These are:

- Electronic Data Interchange Transaction Set Implementation Guides
- Institutional Claims Companion Guide
- Institutional Encounter Companion Guide
- Professional Claims Companion Guide
- Professional Encounter Companion Guide

### **Standard Transactions**

Transactions, as defined by HIPAA, are activities involving the transfer of health care information for specific purposes, including claims and encounter information, payment and remittance advice, and claim status and inquiry. All providers who submit encounters and electronic claims to the Plan must do so in the formats established by HIPAA.

The following standard HIPAA electronic claim/encounter transactions must be submitted in the \*ANSI ASC X12N format, version 4010A1:

- 270/271–Health Insurance Eligibility/Benefit Inquiry & Response
- 276/277–Health Care Claim Status Request & Response
- 278–Health Care Services Review – Request for Review and Response
- 835–Health Care Claim Payment/Advice
- 837–Health Care Claims

### **Standard Code Sets**

Standard Code Sets as required by HIPAA are the codes used to identify specific diagnosis and clinical procedures on claims and encounter forms. All providers are required to submit claims and encounters using current HIPAA compliant codes, which include the standard CMS codes for ICD9, CPT, HCPCS, NDC, Adjustment Codes, State and Zip Codes and CDT, as appropriate.

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

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

The SNIP validations used by the Plan to verify transaction integrity/syntax are available in the Forms section of this manual and on our Web site. The SNIP Validation Descriptions document may be a helpful resource to share with your billing agent or clearinghouse. If your claim is rejected for lack of compliance to the Plan's claim and encounter submission requirements, please correct your claim and resubmit it to the Plan. For additional information, please contact your Provider Relations representative or the Customer Service department.