

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.

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- Submit an encounter for each visit where the provider sees the member or the member receives a HEDIS® (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.

**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**

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;

- 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.

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.

- 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.

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- 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.

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.

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.