



The Medicaid Care Management Organization Act (GEORGIA HOUSE BILL 1234)

Frequently Asked Questions

June 30, 2008

GENERAL

When will the Medicaid Care Management Organizations Act (AKA: House Bill 1234) be effective?

The bill has been signed into law by the Governor and will be effective July 1, 2008. However, DCH has allowed a phased implementation. Some provisions to be established by July 1, others shortly thereafter.

How will this law affect my day to day interactions with WellCare?

The Medicaid Care Management Organizations Act aims to bring consistency in the Care Management system administration across the state. As WellCare begins its' implementation in alignment with HB1234 requirements, the following changes will take place:

- Revised emergency room claims processing methodology.
- Improved online provider search functionality to include search by specialty, location or zip code.
- Online eligibility verification will be available on the Georgia Health Partnership (GHP) portal. The Georgia Department of Community Health has chosen the GHP portal as the single source for eligibility verification for all care management organizations.
- Complaints and Appeals Processes:
 - Updated to use the same timeline as all CMOs and DCH, now **30 days** from the notice date on the Explanation of Payment (EOP) or Proposed Action Letter.
 - Providers may submit (bundle) more than one issue in their complaint or appeal.
- Claims:
 - Interest will be applied on adjusted claims as appropriate.
 - Online claims editing functionality will be enhanced.

Will WellCare be in compliance with the provisions regarding dental provider participation?



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WellCare will be in compliance the dental related portions of the law through its delegated vendor. This will include adding providers who participate in the state loan forgiveness program subject to the specific access criteria dictated in the law.

CONTRACTS

Does WellCare employ exclusivity language in its contracts?

WellCare does not employ exclusivity language in its contracts at this time.

Will my contract need to be amended or will I have to sign a new contract to incorporate the provisions of the law?

All WellCare provider contracts include a provision requiring compliance with any State or federal laws. No changes to your contract are necessary.

How do hospitals request and obtain a copy of their Hospital Statistical & Reimbursement (HS&R) Report and how quickly can they expect receipt once requested?

Please refer to the revised Hospital Manual which provides guidance on how to request and obtain your HS&R report. From the date of request, WellCare has 30 days to respond with the report.

EMERGENCY SERVICES

Does WellCare require an authorization for emergency service?

WellCare does not require an authorization for medically necessary services during an emergency and this will not change under the new law. However, once a patient is stabilized and is moved to an inpatient status, different requirements apply. Please refer to the Quick Reference Guide for instructions.



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Will the Plan use the criteria specified for payment of ER services that includes age of the patient; time and day of the week; severity and nature of presenting symptoms; initial and final diagnosis?

Yes, WellCare is updating its ER claims payment policies and processes to accurately align with all parameters as stated in the law. It is important to note that the law does not dictate payment methodology but provides criteria which must be considered during the adjudication of ER services.

Will WellCare still use the ER reconsideration process?

Yes, providers may continue to request reconsideration of claims paid at a triage rate. The request must be submitted within the new 30-day time frame from the date on the Explanation of Payment and include appropriate additional documentation including medical records if needed.

What about non-contracted providers? How are they paid in regard to ER services?

Providers not contracted with WellCare will be reimbursed at the rates equal to those paid by DCH.

ELIGIBILITY VERIFICATION

How should I verify member eligibility?

Effective July 1, 2008 providers must only use the GHP portal for eligibility verification. WellCare will be removing eligibility spans from its portal and will instead provide a link to the GHP site for eligibility verification.

Once I confirm eligibility on the GHP site, how can I verify specific member information like co-pays, WellCare member ID's or other Plan-specific data?



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You may still access the WellCare Web site to verify specific WellCare member information. A new feature to the WellCare site will be Other Insurance (OI) or Coordination of Benefits (COB) information. A link to the GHP portal will be available from WellCare's member page.

How do I verify responsible payer for newborns?

Newborn member assignment will be determined by DCH and will be displayed on the GHP portal. WellCare will process claims in accordance with the information on the GHP portal.

My claim was denied due to "member not eligible"; what do I do?

You have three options:

1. Verify eligibility a second time and submit the claim to the appropriate payer.
2. Submit an appeal documenting that eligibility was verified and services were subsequently rendered within 72 hours. Acceptable documentation is a screen print of the GHP Web portal showing the appropriate member eligibility including a date and time stamp.
3. If the patient is no longer covered under the Medicaid or PeachCare programs you may bill the member or any commercial carrier for these services.

If I determine in reviewing eligibility that the responsible party has changed and I then submit my claim to the responsible party; will my claim be processed and paid?

The responsible party shall reimburse all medically necessary services without application of any penalty for failure to file claims in a timely manner, for failure to obtain prior auth, or for the provider not being a participating provider in the responsible party's network, and the amount of reimbursement shall be at the responsible party's applicable rate for the service if the provider is under contract with that responsible party.



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WellCare is requesting that I refund a previously paid claim but I verified eligibility on this member prior to delivering services. How should I respond?

Submit an appeal documenting that eligibility was verified and services were subsequently rendered within 72 hours. Acceptable documentation is a screen print of the GHP Web portal showing the appropriate member eligibility including a date and time stamp. If you do not have the appropriate verification you must repay the claim and submit the claim to the payer indicated currently on the GHP portal.

WellCare is requesting an overpayment and stating that the member has primary coverage through a commercial carrier like United, Aetna, CIGNA or Blue Cross but I verified coverage as directed and within 72 hours prior to performing services. Do I owe the refund ?

Under federal law a Medicaid plan is considered the payer of last resort so if a member has other insurance that coverage will always supercede the Medicaid plan. You must repay the overpayment regardless of state law and then may file a claim with the primary carrier. We suggest submitting the claim as an appeal and show your Medicaid EOP as proof of timely filing.

APPEALS / COMPLAINTS

Will providers be able to bundle appeals together for same issues?

Yes, providers will be able to bundle similar payment or claims issues together.

Is there a specific form I need to use to submit my appeal or reconsideration?

WellCare does not require the use of a form. However, an Appeal Request Form and a Reconsideration Form are available on our Web site for your convenience at http://georgia.wellcare.com/WCAssets/georgia/assets/AdminReview_GA_RequestFormProvider.pdf.



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Does WellCare allow binding arbitration after an Appeal has been exhausted?

Yes, providers may choose binding arbitration in lieu of an administrative law hearing. Please refer to the Provider or Hospital Manual for guidance.

CLAIMS

What are WellCare's timeframes and deadlines for claim submission, processing, denials and appeals?

Claim Submission –

- Timely filing remains at 180 days.
- Timely resubmission is 90 days from original submission.
- Clean Claims Payment is 15 days from the date of receipt.

Claim Appeals

- WellCare's previous policy allowed for 90 days from the date on the EOP. Effective 7/1/08, the new standard for appeal submissions is within **30 days** from the date on the EOP.

Coordination of Benefits (COB)

- WellCare will continue COB recoupment notification for up to 12 months from the original date of service.

Outlier Claims

- WellCare will allow **3 months** from the date of the original EOP to request the outlier payment.

Under what circumstances, will WellCare pay interest on claims?



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- WellCare is required to pay interest on any clean claim not processed within 15 business days from the date of WellCare's receipt.
- A clean claim is defined as a claim received by the CMO for adjudication, in a nationally accepted format in compliance with standard coding guidelines, which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the CMO. The following exceptions apply to this definition: i. a claim for payment of expenses incurred during a period of time for which premiums are delinquent; ii. a claim for which fraud is suspected; and iii. a claim for which a third party resource should be responsible.
- Claims that are initially denied or underpaid by WellCare fall into one of two categories:
 - For claims originally submitted as clean claims and subsequently determined that they must be paid or adjusted, WellCare will adjust the claim and pay interest at 20% per annum on the unpaid balance.
 - Providers may submit corrected claims or additional information which changes a previously submitted unclean claim to a clean claim. The timeline for processing these claims starts over from the date of receipt of the corrected claim or additional information. WellCare has 15 business days from the date of receipt to process the claim and pay interest on any unpaid balance.
- Interest penalty will not be paid if the provider submits a claim containing a material omission or inaccuracy in any of the data elements required for a complete standard health care form claims submission whether electronic or paper as specified under DCH's 45 C.F.R. Part 162.

Where on my EOP can I find if any interest was paid on the claim?

Interest payments will appear as a separate claim line item on the respective EOP.

Will WellCare be in compliance with the requirement of payment and remittance advice issuance within one business day?



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WellCare will continue to issue payment and remittance advices within one business day.

WEB

What type of changes will be made to the provider search functionality on the Web site?

The provider search functionality will be enhanced to allow for greater flexibility in search criteria to include specialty, location and zip code.

Will I be able to make claim submission and changes online?

WellCare's Web site has allowed for claims submissions and changes for some time. However, we are enhancing this functionality to make it more user-friendly.