
Overview

The Plan's Utilization Management (UM) program is designed to meet contractual requirements with federal regulations and the state of Georgia while providing members access to high quality, cost effective medically necessary care.

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 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 and medical health care services.

Medically necessary services are defined as the following:

- 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, health care provider or hospital;
- Not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage; and
- There must be no other effective, more conservative or substantially less costly treatment, service and setting available.

**Affirmative
Statement**

WellCare of Georgia's utilization management program includes components of prior authorization, prospective, concurrent and retrospective review activities, each designed to provide for evaluation of health care and services based on WellCare members' coverage and the appropriateness of such care and services and to determine the extent of coverage and payment to providers of care.

WellCare does not reward its associates or any practitioners, physicians or other individuals or entities performing utilization management activities for issuing denials of coverage, services or care and financial incentives, if any, do not encourage or promote under-utilization.

**Plan Criteria for
UM Decisions**

The UM program uses review criteria that is nationally recognized and based on sound scientific, medical evidence. Physicians with an unrestricted license in the state of Georgia with professional knowledge and/or clinical expertise in the related health care specialty actively participate in the discussion, adoption and application of all utilization decision-making criteria on an annual basis.

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

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

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

The review criteria and guidelines are available to the providers upon request. Providers may request a copy of the criteria used for specific determination of medical necessity by calling Customer Services department.

UM Process

The UM process is comprehensive and includes the following review processes:

- Notifications
- Referrals
- Prior Authorizations
- Concurrent Review
- Retrospective Review

WellCare forms for the submission of notifications and authorization requests can be found in the **Forms** section of this manual and on the WellCare Web site.

Notification

Notifications are communications to the Plan with information related to a service rendered to a member or a member's admission to a facility. Notification is required for:

- Notification of prenatal services which enables WellCare to identify pregnant members for inclusion into the Prenatal Program and distinguish those who might benefit from the High Risk Pregnancy Program. OB providers are required to notify WellCare of pregnancies via fax using the Prenatal Notification Form within 30 days of the initial visit. This process will expedite case management and claims reimbursement.
- Notification of urgent or emergent services rendered allows WellCare to log the occurrence of care. Medical review is not necessary and authorization is not required for payment. WellCare should be notified via fax using the Inpatient or Outpatient Authorization Request Form.
- Notification of a member's admission to a hospital allows WellCare to log the hospital admission and follow-up with the facility on the following business day to receive clinical information. The notification should be received by telephone and include member demographics, facility name and admitting diagnosis.

Referrals

A *referral* is a request by a PCP for a member to be evaluated and/or treated by a specialty physician. For an initial referral, WellCare does not require authorization as a condition of payment. Certain

diagnostic tests and procedures considered by the Plan to be routinely part of an office visit may be conducted as part of the initial visit without an authorization. A complete list of approved CPT Codes for services that do not require an authorization is available on our Web site at <http://georgia.wellcare.com>.

Prior Authorization

Prior authorization allows for efficient use of covered health care services and ensures that members receive the most appropriate level of care, within the most appropriate setting. Prior authorization may be obtained by the member's PCP or treating specialist.

Reasons for requiring authorization may include:

- Review for medical necessity
- Appropriateness of rendering provider
- Appropriateness of setting
- Case and disease management considerations

Prior authorization is the process of obtaining authorization in advance of a planned inpatient admission or an outpatient procedure or service. An authorization decision is based on clinical information provided with the request. WellCare may request additional information and including a medical record review.

Prior Authorization is **required** for elective or non-urgent services as designated by the Plan. Guidelines for prior authorization requirements by service type may be found on the **Quick Reference Guide** or by calling the Plan.

Some prior authorization guidelines to note are:

- The prior authorization request should include the diagnosis to be treated and the CPT code describing the anticipated procedure. If the procedure performed and billed is different from that on the request but within the same family of services, a revised authorization is not required.

- An authorization may be given for a series of visits or services related to an episode of care. The authorization request should outline the plan of care including the frequency and total number of visits requested and the expected duration of care.

The attending physician or designee is responsible for obtaining the prior authorization of the elective or non-urgent admission. An authorization is the approval necessary for payment of covered services and is provided only after the Plan agrees the treatment is necessary. Refer to the **Quick Reference Guide** for a list of services requiring prior authorization. Post-service requests for authorization will be reviewed only if the service was provided urgently and submitted within a few days of the service. In all other circumstances, providers are expected to meet standard non-urgent prior authorization guidelines and late submission of a request for authorization will result in a denial.

Concurrent Review

Concurrent review activities involve the evaluation of a continued hospital, skilled nursing or acute rehabilitation stay for medical appropriateness, utilizing appropriate criteria. The concurrent review nurse follows the clinical status of the member through telephonic or onsite chart review and communication with the attending physician, hospital UM, Case Management staff or hospital clinical staff involved in the member's care.

Concurrent review is initiated as soon as the Plan is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the member, complexity, treatment plan and discharge planning activity. The continued length of stay authorization will occur concurrently based on InterQual™ criteria for appropriateness of continued stay to:

- Ensure that services are provided in a timely and efficient manner;

- Make certain that established standards of quality care are met;
- Implement timely and efficient transfer to lower level of care when clinically indicated and appropriate;
- Complete timely and effective discharge planning; and
- Identify cases appropriate for case management.

The concurrent review process incorporates the use of InterQual™ criteria to assess quality and appropriate level of care for continued medical treatment. Reviews are performed by licensed nurses under the direction of the Plan medical director.

To ensure the review is completed timely, providers must submit clinical information on the first business day following the admission, as well as upon request of the WellCare review nurse. Failure to submit necessary documentation for concurrent review may result in non-payment.

Discharge Planning

Discharge planning begins upon admission and is designed for early identification of medical and/or psycho-social issues that will need post-hospital intervention. The Concurrent Review Nurse works with the attending physician, hospital discharge planner, ancillary providers and/or community resources to coordinate care and post-discharge services to facilitate a smooth transfer of the member to the appropriate level of care.

Retrospective Review

The Plan performs two types of retrospective reviews.

1. Retrospective Review initiated by the Plan

The Plan requires documentation and coding

in the medical record that justify and support the diagnosis, treatment and clinical outcomes accurately. Medical records are subject to retrospective audit by the Plan to ensure accurate coding and claims submission.

2. Retrospective Review initiated by Providers

In exceptional circumstances, when a service has been provided but no authorization from the Plan has been obtained, a provider may request authorization for the service prior to the submission of the claim. Upon submission of all pertinent information, the Plan will make a determination within 30 calendar days. In the event of an adverse determination, the provider may request an appeal (See **Administrative Reviews and Grievances** section).

Peer-to-Peer Reconsideration of Adverse Determination

In the event of an adverse determination following a medical necessity review, **Peer-to-Peer Reconsideration** is offered to the treating physician on the "Notice of Action" communication. The treating physician is provided a toll-free number to the Medical Director Hotline to request a discussion with the WellCare medical director who made the denial determination. Peer-to-Peer Reconsideration is offered within three business days following the receipt of the written review determination notification by the provider.

The review determination notification contains instructions on how to use the Peer-to-Peer Reconsideration process.

Services Requiring No Authorization

The Plan has determined that many routine procedures and diagnostic tests are allowable without medical review to facilitate timely and effective treatment of WellCare members.

- For routine office procedures, a "No Authorization

Required” list is available on our Web site at <http://georgia.wellcare.com>.

- Certain diagnostic tests and procedures are considered by the Plan to routinely be part of an office visit, such as colposcopies, hysteroscopies and plain film X-rays. A complete list of approved CPT Codes that do not require an authorization is available on our Web site.
- Clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories and physician offices under a CLIA waiver do not require prior authorization. There are exceptions to this rule for specialty laboratory tests which require authorization regardless of place of service:
 1. Reproductive laboratory tests
(89250-89356)
 2. Molecular laboratory tests
(83890-83916, 83950)
 3. Cytogenetic laboratory tests
(88230-88299)
- Certain tests described as CLIA waived may be conducted in the physician’s office if the provider is authorized through the appropriate CLIA certificate, a copy of which must be submitted to WellCare.

All services performed without prior authorization are subject to retrospective review by WellCare.

Second Medical Opinion

A second medical opinion may be requested in any situation where there is a question concerning a diagnosis, options for surgery or other treatment of a health condition. A second opinion may be requested by any member of the health care team, a member, parent(s) and/or guardian(s) or a social worker exercising a custodial responsibility.

The second opinion must be provided at no cost to the

member by a qualified health care professional within network, or a non-participating provider if there is not a participating provider with the expertise required for the condition.

**Members
With Chronic or
Life Threatening
Conditions**

Members with chronic conditions are defined as adults and children who have:

- Any ongoing physical, behavioral or cognitive disorder including chronic illnesses, impairments and disabilities;
- An expected duration of a medical condition of at least 12 months with resulting functional limitations, reliance on compensatory mechanisms (medications, special diet, assistive device, etc.) and service use or need beyond that which is considered routine.

Physicians who render services to members who have been identified as having chronic or life threatening conditions should:

1. Allow the members needing a course of treatment or regular care monitoring to have direct access through standing (referral) authorization or approved visits, as appropriate for the member's condition or needs:
 - a) To obtain a standing (referral) authorization request the provider should complete the Outpatient Authorization Request form and document the need for a standing authorization request under the pertinent clinical summary area of the form.
 - b) The authorization request should outline the plan of care including the frequency, total number of visits and the expected duration of care.

2. Coordinate with the Plan to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member; and
 - a) Members may request a specialist as PCP through the Customer Service department or their case manager. If the medical director agrees that the specialist is appropriate as a PCP and the specialist agrees to act as the PCP, the member will be assigned to the specialist by the Customer Service department.

3. Ensure that members requiring specialized medical care over a prolonged period of time have access to a specialty care provider.
 - a) Members will have access to a specialty care provider through standing (referral) authorization requests, if appropriate.

**Standard,
Expedited and
Extensions of
Service
Authorization
Decisions****Standard Service Authorization**

WellCare is committed to a two business day turn-around-time on requests for prior authorizations. WellCare will fax an authorization response to the provider fax number(s) included on the authorization request form. However, by contract the Plan has up to 14 calendar days from receipt of the request to determine whether non-urgent services are covered and medically appropriate. An extension may be granted for an additional 14 calendar days if the member or the provider requests an extension, or if WellCare justifies to DCH a need for additional information and the extension is in the member's best interest.

Expedited Service Authorization

In the event the provider indicates, or WellCare determines, that following the standard time frame could seriously jeopardize the member's life or health, WellCare will make an expedited authorization determination and provide notice within 24 hours. WellCare may extend the 24 hour time period up to five business days if the member or the provider requests an extension, or if WellCare justifies to DCH the need for additional information. **Requests for expedited decisions for prior authorization should be requested by telephone, not fax.** Please refer to the **Quick Reference Guide** for the appropriate contact information.

Members and providers may file a verbal or written request for an expedited 24-hour decision. To file a verbal or written request, the provider must call the Plan and request an expedited review.

**Emergency/
Urgent Care**

Emergency services are not subject to prior authorization requirements and are available to our members 24 hours a day, seven days a week.

An *Emergency Medical Condition* is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;

- Serious harm to self or others due to an alcohol or drug abuse emergency;
- Injury to self or bodily harm to others; or
- With respect to a pregnant woman having contractions;
 1. That there is insufficient time to effect a safe transfer to another hospital before delivery, or
 2. That the transfer may pose a threat to the health or safety of the woman or the unborn child.

Urgent Care services are non-life threatening services provided to treat an injury, illness or another type of medical or behavioral condition that should be treated within 24 hours. Urgent care services provided in urgent care centers are not subject to prior authorization requirements.

Transition of Care

During the first 30 days of enrollment, authorization is not required for certain members with previously approved services by DCH or another CMO. However, notification to WellCare is necessary to properly document these services and determine any necessary follow-up care.

Transition of Care rules apply when one of the following criteria is met:

- Member was diagnosed with a significant medical condition within the last 30 calendar days;
- Member must have a tissue or organ replacement;
- Member is receiving ongoing services such as chemotherapy or radiation therapy;
- Member received prior authorization for services

such as surgeries or out-of-area specialty care from another CMO, the state or its agents.

After the initial 30 days providers are required to follow WellCare's prior authorization or concurrent review requirements.

When relinquishing members, the Company will cooperate with the receiving Health Plan regarding the course of on-going care with a specialist or other provider.

When the Company becomes aware that a covered member will be disenrolled from WellCare and will transition to a GA Medicaid FFS program or another CMO, a WellCare Review Nurse/Case Manager who is familiar with that member will provide a Transition of Care (TOC) report to the receiving plan, or appropriate contact person for the designated FFS program.

When a covered member is hospitalized, and is disenrolled from WellCare during the hospital stay, the Company shall maintain responsibility for the coordination of care, and discharge planning for that member.

When a covered newborn remains hospitalized, and is disenrolled from a WellCare during the hospitalization, the Company shall remain responsible for the coordination of care and discharge planning, until the child has been appropriately discharged from the hospital and placed in an appropriate care setting.

If a provider receives an adverse claim determination which they believe was a transition of care issue, the provider should fax the adverse claim determination to the Appeals Department with documentation of DCH/CMO approval for reconsideration. Refer to the **Quick Reference Guide** for the appropriate contact information.

**Authorization
Request Forms**

WellCare utilizes three authorization request forms and a Prenatal Notification Form to ensure receipt of all pertinent information and enable a timely response to your request.

The **Inpatient Authorization Request Form** is used for services such as planned elective/non-urgent inpatient, observation, skilled nursing facility and rehabilitation authorizations. All Inpatient Authorization Request forms should be submitted via fax to the number listed on the form. Refer to the **Quick Reference Guide** for the related contact information.

The **Outpatient Authorization Request Form** is used for services such as follow-up consultations, consultations with treatment, diagnostic testing, office procedures, ambulatory surgery, home care services, radiation therapy, out-of-network services and transition of care. All Outpatient Authorization Request forms should be submitted via fax to the number listed on the form. Refer to the **Quick Reference Guide** for the related contact information.

The **Ancillary Authorization Request Form** is used for services such as DME, dialysis, PT/OT/ST and transition of care. All Ancillary Authorization Request forms for non-urgent/elective ancillary services should be submitted via fax to the number listed on the form. Refer to the **Quick Reference Guide** for related contact information.

To ensure timely and appropriate claims payment, the form must:

- Have all required fields completed;
- Be typed or printed in black ink for ease of review; and
- Contain a clinical summary or have supporting clinical information attached.

Incomplete forms are not processed and will be returned to the requesting provider. If prior authorization is not granted, all associated claims will not be paid.

A **Prenatal Notification Form** should be completed by the OB/GYN provider during the first visit and faxed to WellCare within 30 days of initial visit. Notification of OB services enables WellCare to identify members for inclusion into the Prenatal Program and/or members who might benefit from WellCare's High Risk Pregnancy Program. Refer to the **Quick Reference Guide** for the related contact information.

**Non-Covered
Services**

The following list is representative of non-covered services and procedures, and is not meant to be exhaustive:

- Services not considered to be medically necessary;
- Cosmetic surgery or mammoplasties for aesthetic purposes;
- Investigational or experimental services such as new treatment that has not been accepted universally as a form of treatment;
- Heart, lung and heart/lung transplants for members age 21 and older;
- Nursing Facility Services stays over 30 days (long-term nursing facility stays);
- Acupuncture;
- All procedures listed in the CPT or HCPCS description as "unlisted" or "unspecified";
- Educational supplies, medical testimony, special reports, travel by the physician, no-show or canceled appointments, additional allowances for services provided after office hours or between 10:00 p.m. and 8:00 a.m. or on Sundays, holidays, calls, visits or consultations by telephone and other related services;

- Routine lab and x-ray services required on hospital admissions;
- Biofeedback or hypnotherapy;
- Services and/or procedures performed without regard to the policies contained in this handbook;
- Hospital visits to members awaiting placement in a nursing home, unless medically necessary;
- Hospital visits if the hospital admission and/or length of stay are disallowed by WellCare;
- Radiological procedures performed by a portable X-ray service;
- Services provided in a state-owned facility;
- Tubal reanastomosis;
- Penile prosthesis;
- Infertility procedures and related services;
- Thermography;
- Sensitivity training, encounter groups or workshops;
- Sexual competency training;
- Education testing and diagnosis;
- Marriage or guidance counseling; and
- Abortions or abortion –related services performed for family planning purposes.

**Limits to
Abortion,
Sterilization, and
Hysterectomy
Coverage****Abortion**

Abortions are covered for eligible WellCare members if the life of the mother would be endangered if the fetus were carried to term, or if the mother was a victim of rape or incest.

Abortions are not covered if used for family planning purposes.

A Certificate of Necessity for Abortion, form DMA-311, must be properly executed and submitted to WellCare with the provider's claim. This form may be filled out and signed by the physician. See the **Forms** section for a copy of this form. Claims for payment will be denied if the required consent is not attached or if incomplete or inaccurate documentation is submitted. Prior authorization is required for the administration of an abortion to validate medical necessity per federal regulations. The consent form does not need to be submitted with the request for authorization.

In addition to the above-mentioned documentation, WellCare also requires the submission of History, Physical and Operative Report and the Pathology Report with all claims that have the following ICD-9-CM codes to ensure that abortions are not being billed through the use of other procedure codes:

- 69.0 Dilation and curettage of uterus
- 69.02 Dilation and curettage following delivery or abortion
- 69.09 Other dilation and curettage
- 69.5 Aspiration curettage of uterus
- 69.52 Aspiration curettage following delivery or abortion
- 69.59 Other aspiration curettage of uterus
- 69.6 Menstrual extraction or regulation
- 69.93 Insertion of Laminaria
- 70.0 Culdocentesis
- 72.7 Vacuum extraction
- 72.71 Vacuum extraction with episiotomy
- 72.79 Other vacuum extraction
- 74.99 Other cesarean section of unspecified type

- 96.49 Genitourinary installation

The following procedure codes require abortion certifications:

- 69.01 Dilation and curettage for termination of pregnancy
- 69.51 Aspiration curettage of uterus for termination of pregnancy
- 74.91 Hysterectomy to terminate pregnancy
- 75.0 Intra-amniotic injection for abortion

Sterilizations

WellCare will not and is prohibited from making payment for sterilizations performed on any person who:

- Is under 21 years of age at the time he/she signs the consent;
- Is not mentally competent; or
- Is institutionalized in a correctional facility, mental hospital or other rehabilitation facility.

See the **Forms** section for a copy of the required consent form (DMA-69). Prior authorization is not required for sterilization procedures. However, WellCare will deny any provider claims submitted without the required consent form or with an incomplete or inaccurate consent form. Documentation meant to satisfy informed consent requirements, which has been completed or altered after the service was performed, will not be accepted.

For sterilization procedures, the mandatory waiting period between signed consent and sterilization is 30 calendar days.

The signed consent form expires 180 calendar days from the date of the member's signature.

In the case of premature delivery or emergency abdominal surgery performed within 30 calendar days of signed consent, the physician must certify that the

sterilization was performed less than 30 calendar days but not less than 72 hours after informed consent was obtained. Although these exceptions are provided, the conditions of the waiver will be subject to review.

In the case of premature delivery or emergency abdominal surgery, the sterilization consent form must have been signed by the member 30 calendar days prior to the originally planned date of sterilization. A sterilization consent form must be properly filled out and signed for all sterilization procedures and attached to the claim at the time of submission to WellCare. The member must sign the consent form at least 30 calendar days, but not more than 180 calendar days, prior to the sterilization. The physician must sign the consent form after the sterilization has been performed.

The following is a list of ICD-9-CM procedure codes associated with sterilization. All claims with these procedure codes will be reviewed prior to payment to ensure proper coding and to ensure that the sterilization consent form is attached to those claims requiring a form.

Always Requires Sterilization Consent Form:

- 63.70 Male sterilization procedure, not otherwise specified
- 66.39 Other bilateral destruction or occlusion of fallopian tubes

If Done for Sterilization Purposes Requires Sterilization Consent Form:

- 63.7 Vasectomy and ligation of vas deferens
- 63.73 Vasectomy
- 65.6 Bilateral Salpingo-oophorectomy
- 65.61 Removal of both ovaries and tubes at same operative episode
- 65.62 Removal of remaining ovary and tube
- 66 Operations on fallopian tubes
- 66.0 Salpingostomy
- 66.2 Bilateral endoscopic destruction or

- occlusion of fallopian tubes
- 66.21 Bilateral endoscopic ligation and crushing of fallopian tubes
- 66.22 Bilateral endoscopic ligation and division of fallopian tubes
- 66.29 Other bilateral endoscopic destruction or occlusion of fallopian tubes
- 66.3 Other bilateral destruction or occlusion of fallopian tubes
- 66.31 Other bilateral ligation and crushing of fallopian tubes
- 66.32 Other bilateral ligation and division of fallopian tubes
- 66.4 Total unilateral salpingectomy
- 66.5 Total bilateral salpingectomy
- 66.51 Removal of both fallopian tubes at same operative episode
- 66.52 Removal of remaining fallopian tube
- 66.6 Other salpingectomy
- 66.63 Bilateral partial salpingectomy, not otherwise specified
- 66.69 Other partial salpingectomy

Hysterectomy

WellCare reimburses providers for hysterectomy procedures only when the following requirements are met:

- The provider ensured that the individual was informed, verbally and in writing, prior to the hysterectomy that she would be permanently incapable of reproducing (this does not apply if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy);
- Prior to the hysterectomy, the member/individual and the attending physician must sign and date the Patient's Acknowledgement of Prior Receipt of Hysterectomy Information form DMA-276.
- In the case of prior sterility or emergency

hysterectomy, a member is not required to sign the consent form; and

- The provider submits the properly executed Patient's Acknowledgement of Prior Receipt of Hysterectomy Information form with the claim prior to submission to WellCare. See **Forms** section for a copy of this form. WellCare will deny payment on any claims submitted without the required documentation or with incomplete or inaccurate documentation. WellCare does not accept documentation meant to satisfy informed consent requirements which has been completed or altered after the service was performed.

Regardless of whether the requirements listed above are met, a hysterectomy is considered a payable benefit when performed for medical necessity and not for the purpose of family planning, sterilization, hygiene or mental incompetence. Prior authorization is required for the administration of a hysterectomy to validate medical necessity. The consent form does not need to be submitted with the request for authorization but does need to be submitted with the claim.

The following is a list of ICD-9-CM procedure codes associated with hysterectomies. All claims with these procedure codes will be reviewed prior to payment to ensure proper coding and to ensure that the hysterectomy acknowledgement form is attached. All hysterectomy codes listed require a hysterectomy acknowledgement form.

- 68.3 Subtotal abdominal hysterectomy
- 68.4 Total abdominal hysterectomy
- 68.5 Vaginal hysterectomy
- 68.6 Radical abdominal hysterectomy
- 68.7 Radical vaginal hysterectomy
- 68.8 Pelvic evisceration
- 68.9 Other unspecified hysterectomy

**Delegated
Entities**

WellCare delegates some utilization management activities to external entities and provides oversight and accountability of those entities.

In order to receive a delegation status for utilization management activities, the delegated entity must demonstrate that ongoing, functioning systems are in place and meet the required utilization management standards. There must be a mutually agreed upon written delegation agreement describing the responsibilities of WellCare and the delegated entities.

Delegation of select functions may occur only after an initial audit of the utilization management activities has been completed and there is evidence that WellCare's delegation requirements are met. These requirements include:

- A written description of the specific utilization management delegated activities;
- Semi-annual reporting requirements;
- Evaluation mechanisms; and
- Remedies available to WellCare if the delegated entity does not fulfill its obligations.

On an annual basis, or more frequently audits of the delegated entity are performed to ensure compliance with WellCare's delegation requirements.