

July 14, 2006

WELLCARE HEALTH PLANS, INC
THE WELLCARE GROUP OF COMPANIES

Dear Provider,

Re: Therapy Authorization Guidelines for Children with Chronic Conditions

WELLCARE OF FLORIDA, INC.

HEALTHEASE OF FLORIDA, INC.

WELLCARE OF GEORGIA, INC.

WELLCARE OF NEW YORK, INC.

FIRSTCHOICE HEALTHPLANS
OF CONNECTICUT, INC.

HARMONY BEHAVIORAL HEALTH, INC.

WELLCARE OF LOUISIANA, INC.

COMPREHENSIVE HEALTH
MANAGEMENT, INC.

HARMONY HEALTHSYSTEMS, INC.

HARMONY HEALTH PLAN OF ILLINOIS,
INC.

The following guidelines are designed to assist you when seeking an authorization from WellCare of Georgia, Inc. for physical, occupational and/or speech therapy services for children with health conditions.

Under the Georgia Healthy Families program, certain therapy services may be covered as medically necessary health care to correct or ameliorate a condition under identified circumstances including but not limited to: (i) for children up to and including age three when provided as part of Georgia's early intervention programs with an individualized family service plan (IFSP), and (ii) for children ages four and older when supported through medical record documentation and when not already provided pursuant to an individualized service plan (IEP) program through the Georgia educational system and as indicated below.

To request an authorization for therapy services, providers should submit the following to WellCare's Health Services department *via facsimile* at 866-455-6487:

1. Ancillary Services Authorization Request form - Copies of the Ancillary Services Authorization Request form can be obtained on WellCare's website at <http://georgia.wellcare.com> in the Provider Resources area on the Forms and Documents page, or by calling our Provider Hotline at (866) 231-1821.
2. Plan of Care or Written Service Plan– In addition to the Ancillary Services Authorization Request form, providers seeking authorization must submit a copy of the plan of care for the member. The plan of care or written service plan should be a multi-disciplinary assessment of the member evaluated, agreed upon and signed by the member's primary care provider which contains the required elements indicated below:
 - a. Outline of the member's current level of function, services needed, frequencies, duration and goals for each therapy modality;
 - b. Assessment on which the plan of care is based performed no more than six (6) months prior to the request for authorization;
 - c. Level of function expressed as a percentile rank on a standard functional assessment;

211 Perimeter Center Parkway
8th floor
Atlanta, GA 30346

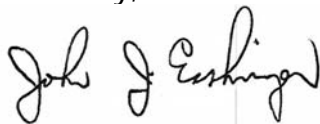
- d. Description of the modality if the service for which authorization is sought is not a standard therapy;
 - e. Caregiver education for purposes of members at home care; and
3. Provider Attestation - In addition to the Ancillary Services Authorization Request form and Plan of Care or Written Service Plan, providers seeking authorization for therapy services for children ages four and older must include a Provider Attestation documenting that the child is not already receiving the services through the school for which provider seeks authorization under an IEP or IFSP.

If the child is receiving services under an IEP or IFSP, then the provider must include the reasons why the treatment for which authorization is requested is medically necessary to correct or ameliorate a condition, in addition to those provided under the IEP or IFSP. The provider must also ensure the requested services will be coordinated with the IEP or IFSP. See 42 CFR 438.210.

When seeking authorization for continuation of services beyond the initial authorization, the provider's clinical documentation provided to WellCare must substantiate the need for continued services

For assistance with an authorization request, please contact us through our Provider Hotline at **(866) 231-1821**.

Sincerely,



John Esslinger, MD
Senior Medical Director
WellCare of Georgia, Inc.



**WellCare of Georgia, Inc.
Provider Attestation for Outpatient Therapy Services**

WellCare Member Name

WellCare Member Identification Number

I conducted a reasonable review of the facts regarding the therapy services recommended for the above referenced member. Based upon my review findings and to best of my knowledge, information and belief, the member is not receiving the same type of or similar therapy services as those requested in the attached Ancillary Services Authorization Request and Plan of Care from local education agencies. In addition, in the event the above referenced member is receiving services under an IEP or IFSP at the school, and the therapist is requesting additional coverage outside of the school, the additional requested treatment is medically necessary to correct or ameliorate a health condition.

I understand that under my provider participation agreement, WellCare and applicable regulators including the Centers for Medicare & Medicaid Services, and the Georgia Department of Community Health, or their representatives may inspect and evaluate my records related to members and the provision of and payment for services to audit compliance with this review requirement, and other contractual requirements and federal and state laws and regulations.

Provider Signature

Print Name

Title

Provider Medicaid Identification Number

Date

Contact Phone Number

Contact Fax Number