

Provider Service Summit: Questions & Responses

September 28, 2006 Update

We appreciate the time and feedback shared by Georgia providers at our recent Provider Summit meetings. Below are answers to questions posed by Providers after the event. For more in-depth explanations, please contact your Provider Relations Representative or our Provider Hotline at: 1-866-231-1821.

Authorizations

Please clarify WellCare's authorization process with respect to elective hospital procedures, emergency room to hospital admissions and retro-active authorizations.

The process for requesting an authorization is outlined by service type in the provider in-service materials found on the WellCare website. Refer to the WellCare website for a complete listing of these codes at <http://georgia.wellcare.com>. Follow the links to the Provider section, then to Resources, then Forms & Documents. The two reference documents are titled "Quick Reference Guide" and "Provider Service Summit Meeting Kit".

Authorizations for Planned Services - Prior authorization is required for elective/non-urgent services as designated by the Plan. The prior authorization should include the patient's diagnosis, 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. The attending physician or designee is responsible for obtaining the prior authorization for the elective/non-urgent procedure or admission.

Authorizations for Urgent/Emergent Services - Emergency services are not subject to prior authorization requirements and are available to our members twenty-four (24) hours a day, seven (7) days a week.

Concurrent Review - Discharge coordination or 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 level of care, as needed. The concurrent review nurse coordinates services with the PCP, attending physician and/or the discharge planning personnel at the hospital. If a member requires a transfer from an acute care setting to a nursing care facility or home care setting, the hospital will coordinate with WellCare to identify alternative services and to maintain continuity of care.

Retrospective Review - Retrospective review is performed when a service has been provided, the claim has been adjudicated and no authorization has been given. Determinations for authorization involving health care services that have been delivered will be made within thirty (30) calendar days of receipt of necessary information.

What is the authorization process for Home Health / Hospice / DME?

The process for requesting an authorization is outlined by service type in the provider in-service materials found on the WellCare website. Refer to the WellCare website for a complete listing of these codes at <http://georgia.wellcare.com>. Follow the links to the Provider section, then to Resources, then Forms & Documents. The two reference documents are titled "Quick Reference Guide" and "Provider Service Summit Meeting Kit".

What OB/GYN follow up services require an authorization?

In support of obstetrical (OB) care, the Plan has adopted 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 must complete the Prenatal Notification Form at the first prenatal visit and fax the completed form to the Plan's OB department. Upon receipt, the Plan will give comprehensive authorization for prenatal, delivery and post partum care. Additionally, the member will be enrolled in the Prenatal Program and evaluated for enrollment in the High Risk OB Case Management program. If a pregnant member is currently 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. A notification followed by an authorization for ante partum admission is required when pregnancy complications need observation or inpatient admission.

Authorizations for OB Care - The OB physician or midwife must complete the Prenatal Notification Form at the first prenatal visit and fax the completed form to the Plan's OB department to obtain an authorization for OB care.

Initial OB Visit - All new Members who are pregnant or members who become pregnant while on the Plan should be encouraged to see their OB physician for their initial visit within 14 calendar days.

Are authorizations required for coordination of benefits?

Services that may be eligible for reimbursement by WellCare as a secondary payer require authorization if those services require authorization when WellCare is the primary payer.

What is WellCare's circumcision policy?

Circumcisions, performed with or without sedation, are a covered service. In the event the circumcision is performed during the initial newborn hospitalization, the service is covered under the delivery authorization. Prior authorization is required on any circumcision performed after the initial delivery hospitalization.

Please clarify the dental procedures.

Prior authorization is required for any dental service requiring inpatient or outpatient hospitalization. It is the responsibility of the attending dentist to obtain prior authorization and to provide the authorization number to the hospital. Failure by the attending dentist to obtain prior authorization and to provide the authorization number will result in denial of payment.

For prior authorization of Dental Services requiring hospitalization, contact the Plan's Utilization Management Department at the telephone numbers listed on the **Quick Reference Guide** refer to the WellCare website at <http://georgia.wellcare.com>. In the Providers area, go to Resources, then Forms & Documents and select the **Quick Reference Guide**.

If a procedure is authorized but not submitted on a claim, can the procedure be added on a subsequent claim for payment?

A subsequent claim can be submitted under the original authorization code. The additional service will be reimbursed if identified under the originating authorization.

Please explain how to handle procedures required by a presenting mom which are discovered at the time of delivery but are unrelated to the delivery.

Notifications are communications to the Plan that inform WellCare of a service rendered or admission to a facility. Notification is required for prenatal services as it enables WellCare to identify members for inclusion into the Prenatal Program and identify members who may benefit from the High Risk Pregnancy Program. OB providers are required to notify WellCare of pregnant members via fax, using the Prenatal Notification Form within 30 days of the initial visit to expedite case management and ensure timely claims reimbursement.

Please clarify WellCare's authorization process and how to resolve issues within the process like missing information on an authorization form.

Prior authorization allows for efficient use of covered healthcare services and helps ensure 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.

The process for requesting an authorization is detailed by service type on the provider in-service materials on the WellCare website at <http://georgia.wellcare.com>. Follow the links to the Provider section, then to Resources, then Forms & Documents and select the “**Quick Reference Guide**” for more information.

In the event there is missing information on the authorization request form, a WellCare representative will contact the provider office to obtain the missing information either by telephone or fax. If there is missing information on the authorization response, the provider should contact WellCare through the Provider Hotline at (866) 231-1821 and follow the prompts to the authorization team.

Utilization Management / Care Coordination

Please clarify what WellCare considered emergency services.

Emergency medical condition is a medical or mental 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 in 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 women, 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 women having contractions;
 - That there is not adequate time to effect a safe transfer to another hospital before delivery; or
 - That transfer may pose a threat to the health or safety of the women or unborn child.

Urgent care services are services furnished to treat an injury, illness or another type of condition, including a behavioral health condition, usually not considered life threatening which should be treated within twenty-four (24) hours. Urgent care services provided in urgent care centers are not subject to prior authorization requirements.

If presenting mom’s conditions are not urgent (based on medical necessity), they are subject to standard utilization management and authorization rules.

Please clarify WellCare’s emergency birth and transfer procedure.

Admissions, for the delivery of a newborn child, do not require an authorization. However, hospitals must notify the health plan of the admission within twenty-four (24) hours of the birth/stillbirth. Hospitals should provide basic information (gender, birth, weight, date of birth) at the time of notification. An authorization number will be issued to the hospital without regard to medical necessity.

If the newborn remains at the hospital after the mother is discharged (boarder baby, NICU patient, etc) or transferred to another facility for continued treatment, a separate medical necessity determination is required for an authorization to be issued.

If the baby’s or mother’s stay is expected to exceed 48 hours for vaginal delivery or 96 hours for C-section, WellCare requires notification via telephone (866-231-1821) within 24 hours to include the baby’s medical record number. The hospital must submit clinical information on the next business day for authorization.

What is WellCare’s policy for planned versus non-planned c-sections?

WellCare requires prior authorization for all planned repeat c-sections. A notification followed by an authorization for ante partum admission is required when pregnancy complications need observation or inpatient admission. The hospital must notify WellCare on the day of admission within twenty-four hours (24) and provide clinical information by the following business day. WellCare does not require an authorization or a clinical review for an inpatient admission of 48 hours for vaginal deliveries and 96 hours for c-sections.

What is WellCare’s discharge planning process?

Discharge coordination or 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 level of care, as needed. The concurrent review nurse coordinates services with the PCP, attending physician and/or the discharge planning personnel at the hospital. If a member requires a transfer from an acute care setting to a nursing care facility or home care setting, the hospital will coordinate with WellCare to identify alternative services and to maintain continuity of care.

Covered Services

Are flu shots covered?

Yes, flu shots are covered for children under the Health Check program – Georgia’s EPSTD program which has been described below. Flu shots are not covered for adults.

What is WellCare's OB ultrasound policy?

Two (2) obstetrical ultrasounds (CPT 76801 or 76805) may be conducted without prior authorization during a routine pregnancy, which is characterized by ICD-9 code V22.X. These tests must be used in the appropriate trimester as described in the CPT guidelines. Request for subsequent tests require review for medical necessity (usually for high risk pregnancies).

Note: Some high risk medical conditions may require regularly scheduled follow up ultrasounds. Multiple obstetrical ultrasounds may be authorized based on the review of a detailed plan of care that is determined to be medically necessary.

What is WellCare's policy on new HPV vaccine?

WellCare does not currently cover the HPV vaccine as this is not a currently covered benefit within the Medicaid FFS program. In the event this policy changes, WellCare will notify our providers through standard provider communication channels (i.e., banner messages, fax notices, etc).

Health Check Program

What are the procedures for the Health Check program?

The Health Check program, the State of Georgia's Early and Periodic Screening, Diagnostic and Treatment program, (EPSDT services) is available for Medicaid children less than 21 years of age. An initial health and screening visit is available for all newly enrolled Health Check eligible children within 90 calendar days and within 24 hours of birth to all newborns. EPSDT services include outreach and informing, screening, tracking and diagnostic and treatment services.

EPSDT services include:

- Importance of preventive care;
- Periodicity schedule and the depth and breadth of services;
- How and where to access services, including necessary transportation and scheduling services; and
- Services provided without cost.

Newly enrolled families with Health Check eligible children will be informed about the Health Check program within 60 calendar days of enrollment. This includes informing pregnant women and new mothers, either before or within seven days of the birth of their children, that Health Check services are available. The Plan will provide each PCP, on a monthly basis, a list of their Health Check eligible members that have not had an encounter during the initial 120

calendar days of enrollment, and/or are not in compliance with the Health Check periodicity schedule.

PCPs are required to contact members' parents or guardians by telephone or mail to schedule an appointment.

Screening - Such screens must include all of the following:

- A comprehensive health and developmental history;
- Developmental assessment, including mental, emotional and behavioral health department;
- Measurements (including head circumference for infants);
- An assessment of nutritional status;
- A comprehensive unclothed physical exam;
- Immunizations according to the Advisory Committee of Immunization Practices (ACIP);
- Certain laboratory tests (including the federally required blood lead screening);
- Anticipatory guidance and health education;
- Vision screening;
- Tuberculosis and lead risk screening;
- Hearing screening;
- Dental and oral health assessment; and
- Lead screening to identify children with elevated blood lead levels and recommend follow-up treatment and education.

Tracking - The Plan will utilize provider encounter data to track information on compliance with Health Check requirements. The Plan will track at minimum:

- Initial newborn Health Check visit occurring in the hospital;
- Periodic and preventive/well-child screens and visits as prescribed by the periodicity schedule;
- Diagnostic and treatment services, including referrals;
- Immunizations, lead, tuberculosis and dental services; and
- A reminder/notification system.

Diagnostic and Treatment Services

If through the screening examination a problem is suspected, the child shall be evaluated as necessary for further diagnosis as deemed medically necessary. Such medically necessary diagnostic and treatment services must be provided regardless of whether such services are covered by the State Medicaid Plan, as long as they are Medicaid-Covered Services as defined in Title XIX of the Social Security Act.

Certain therapy services may be covered as medically necessary health care to correct or ameliorate a condition under identified circumstances. Those include, but are not limited to:

- Children up to and including age three when provided as part of Georgia's early intervention programs with an individualized family service plan (IFSP)
- Children ages four and older when supported through medical record documentation and when not already provided in an individualized services plan (IEP) program through the Georgia educational system.

To request an authorization for physical, occupational and/or speech therapy for children chronic health conditions, providers should submit the following by fax to (877) 431-8859:

- *Ancillary Services Authorization Request form* – Copies of the Ancillary Services Authorization Request form can be obtained at <http://georgia.wellcare.com> in the Provider Resources area on the Forms & Documents page, or by calling our Provider Hotline at (866) 231-1821.
- *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 members. 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:
 - Outline of the member's current level of function, services needed, frequencies, duration and goals for each therapy modality;
 - Assessment on which the plan of care is based, performed no more than six (6) months prior to the request for authorization;
 - Level of function expressed as a percentile rank on a standard functional assessment;
 - Description of the modality if the service for which authorization is sought is not a standard therapy;
 - Caregiver education for purposes of members at home care.
- *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 services for which provider seeks authorization under an Individualized Education Program (IEP) or an Individual Family Service Plan (IFSP). Refer to the WellCare website at <http://georgia.wellcare.com>.

Follow the links to the Provider section, then Forms & Documents. The document is titled "Provider Attestation for Outpatient Therapy Services."

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

Is a sports physical covered under the Health Check program?

A sports physical can be covered as part of a routine physical as long as the physical does not include tests or procedures outside the routine physical.

Outreach and Enrollment

How do patients select WellCare if they are currently with AmeriGroup?

Anyone who applies for Medicaid can choose to apply in person (by going to the local Department of Family and Children Services, health department, or Social Security office), or by requesting forms to be mailed to them to fill out at home. There are several different ways to apply for Medicaid.

The member can contact the Department of Family and Children Services (DFCS) in your county. The DFCS office will take the member's application or help them find other places to apply, such as schools, hospitals, or community centers near their home. The Right from the Start Medicaid (RSM) outreach project has workers available to take applications early in the morning, in the evenings, and on weekends.

For more information, call (800) 809-7276. If the member is pregnant, she can contact the county health department, primary health care center, or hospital. (Call the Georgia Division of Public Health at (404) 657-2700 to find out where to apply.) If the member is pregnant and eligible, she can get a Medicaid certification form on the same day.

If the member is aged (65 years old or older), blind, or disabled, he or she can apply for the SSI (Supplemental Security Income) program by contacting the local Social Security office. If the member is approved for SSI, he or she will automatically receive Medicaid.

Telephone Numbers and Web Sites:

- To locate the county DFCS office, look in the blue pages of the telephone book for Family and Children Services
- To locate a county health department, call: (404) 657-2700 or look in the blue pages

- To locate the nearest Social Security Administration office, call: (800) 772-1213
- For questions about Right from the Start Medicaid (RSM), call: (800) 809-7276
- For questions about Georgia Better Health Care (GBHC), call: (866) 211-0950 (or (770) 570-3373 in Atlanta).

Will existing patients who enroll with WellCare require an “initial” visit?

WellCare encourages our contracted PCPs to develop/strengthen the relationship with our members. Prevention is the cornerstone of the managed Medicaid. While a member may have a long standing relationship with you at the time they enroll in the managed Medicaid program, transitioning to the managed Medicaid program may serve as an appropriate catalyst for promoting prevention through an annual well-person visit. Also, this initial visit provides an opportunity for you and the member to review the basic tenets of the managed Medicaid program – like prevention, working together in identifying care needs and the like.

For new patients, a WellCare contracted PCP has the responsibility to see our members within the first 90 days of enrollment in the Plan (or within 14 days of enrollment for pregnant women).

Provider Relations

When can a Specialist be a PCP?

There are two typical and standard situations when Specialists may act as a member's PCP – oncologists and OB/GYN providers during the course of treatment. In these instances, the physician may contact WellCare to formally request to act as the patient's PCP. They must be able to demonstrate their ability perform all traditional PCP duties and services such as immunizations for newborns and children (in the case of EPSTD patients) and the like. To formally request permission to act as a PCP, please contact the Provider Hotline at (866) 231-1821.

Please clarify WellCare's policy for specialist visits.

Primary Care Providers (PCP) may “refer” patients (members) to Specialists for an initial consultation and treatment without notifying the health plan (i.e., does not require an authorization). During the initial visit the Specialist may conduct diagnostic tests and procedures that are listed as not requiring an authorization if done in the physician office (e.g., place of service 11).

If a patient requires medically necessary Specialist care beyond the initial visit, the Specialist must contact WellCare for an authorization. The authorization request may include a plan of care that encompasses the number of subsequent visits needed to resolve the issues for this episode of care. WellCare will evaluate the request for medical necessity.

Are services covered at a specialist office if they are located across the Florida border?

The referring PCP must follow standard authorization protocols for referring patients to specialists. If the specialist is not contracted with WellCare, he or she must seek an authorization as a non-participating (or non-PAR) provider.

Eligibility Verification, Claims Processing & Billing

What is WellCare's eligibility verification process?

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.

PCPs may also refer to their current monthly membership listing to verify eligibility. If the member does not appear on the list, you may do one of the following to verify eligibility:

- Access the WellCare website at <http://georgia.WellCare.com>. (Contact your Provider Relations Representative to schedule a website in-service).
- Access WellCare's Interactive Voice Response (IVR) system. You will need your Provider ID number to access member eligibility.
- Contact the Provider Hotline at (866) 231-1821. 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.

What happens when a member seeks treatment with prior PCP after the member has been re-assigned?

If the performing PCP follows standard treatment protocols for services rendered and is still contracted with WellCare, payment will not be affected. If the performing PCP is not contracted with WellCare, he or she must seek an authorization as a non-participating (or non-PAR) provider.

WellCare encourages providers to verify eligibility prior to services rendered. Eligibility can be verified online if you are a registered provider of the WellCare of Georgia website. For more information on how to verify eligibility please go to <http://georgia.wellcare.com>. Follow the links to the Provider section, then to Resources, then Forms & Documents for a copy of the "How to Verify Eligibility guide."

Please outline WellCare's claims processing procedure.

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

- Electronic Claims Submission (EDI)
- CMS 1500 Form
- UB92 Form

Providers are required to use the Standard CMS codes for ICD-9, CPT and HCPCS regardless of the type of submission. The largest driver of payment turnaround time is the accuracy of the data on the claim form and completion of all required elements, regardless of whether electronic or paper claim submission.

To assist Providers in submitting the correct data in the correct fields on the claim, the Plan has prepared Claim Submission Guidelines. These guidelines identify all the fields the Plan requires for claims processing as well as the data source to complete the field.

Electronic Claim Submission - The Plan currently utilizes the four clearinghouses listed below to process the 837 Health Care Claims transactions:

- ACS EDI Gateway, Inc.
- Emdeon (WebMD[®] Corporation)
- Availity
- SSI Group, Inc.

Since most clearinghouses can exchange data with one another, providers should work with their existing clearinghouse, if other than listed above, to establish EDI with the Plan. If you do not have a clearinghouse, or have been unsuccessful in submitting claims to your clearinghouse, please call the WellCare EDI team directly at (800) 960-2530 Ext. 4096.

All files submitted to the Plan must be in the ANSI ASC X12N format, version 4010A. Implementation Guides for all of the HIPAA transaction sets are available at <http://www.wpc-edi.com>.

Advantages of EDI - Submitting claims electronically is much 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. WellCare has options with ACS including connectivity and software that are FREE. Contact the WellCare EDI team for more information at (800) 960-2530 Ext. 4096. Contact your clearinghouse or billing software vendor to see if they offer FREE options.

Payer ID - Each Payer has a unique Payer ID number that must be included in the electronic claims submission. WellCare's Payer IDs for each of the four clearinghouses is listed below:

Availity, Emdeon (WebMD) and SSI

WellCare 14163

ACS

WellCare 77004

How do we bill for some hospital-based providers (e.g., radiologists and CRNAs) that don't have a provider number?

Non participating hospital-based providers (Anesthesia, Pathology and Radiology) will be paid if their professional services are part of an authorized facility service. A separate authorization for these services is not required.

Appeals

Is member consent required in order for a provider to appeal?

No. Member consent is not required for a provider to appeal a decision. A provider may file a Claim appeal by submitting a letter with supporting documentation such as medical records.

The appeal must be submitted within 90 days of the date of the Remittance Advice/Explanation of Benefits. Appeals 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. For written appeals, 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.

- The Plan is not responsible for payment of medical records generated as a result of a provider appeal. 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. The Plan is required to submit a quarterly report on all Claim Appeals filed and the resolution of each.

CLIA

What is WellCare's procedure for verifying CLIA?

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) established quality standards for laboratory testing to ensure the accuracy, reliability and timeliness of patient results. CLIA requires that any facility examining human specimens for diagnosis, prevention and or treatment of disease or for assessment of health must register with the federal Centers for Medicare and Medicaid (CMS) and obtain a CLIA certification.

Once a facility has obtained a CLIA certification, they may submit it in hard copy to WellCare in a variety of ways: via fax, mail or given directly to the assigned provider service representative. For more information about submitting a CLIA certification, please contact the Provider Hotline at (866) 231-1821.