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ALL ABOUT WELLCARE

Section 1

Introduction

WellCare Health Plans, Inc. provides managed care services exclusively for government-sponsored health care programs, focusing on Medicaid and Medicare.

Headquartered in Tampa, Florida, WellCare offers a variety of Medicaid and Medicare plans, including health plans for families, children, the aged, blind, disabled and prescription drug plans, currently serving more than 2.23 million members nationwide.

Help Us Build An Environment of CARE

WellCare knows that maintaining a healthy community starts with providing care to those who need it most. As the largest Medicaid- and Medicare-only contractor in the nation, we offer affordable health care plans to individuals eligible for government sponsored programs.

Since 1985, it has been our mission to support the well-being of these community members. In partnership with local health care professionals and government organizations, we build an environment of CARE to make it all possible:

C — Customer Service through a well-established and financially sound corporate infrastructure.
A — Affordable plans working to make the most of members’ Medicaid or Medicare coverage.
R — Reliable and responsible physician and provider partners.
E — Education and preventive care programs for members’ ongoing good health.

C — Customer Service

Managing care for Medicaid and Medicare populations is a tremendous responsibility. Our success is measured by our ability to provide superior service to our members and partners.

Our associates strive to maintain a high level of customer service for our growing membership base.
As an organization, we continue to look for ways to improve the services we provide and have established regional offices to help us meet the unique needs of each market.

By exclusively focusing on government health care programs, we are able to develop core skills and build efficiencies unique to them.

It is our objective to provide service to our health care practitioners in a way that allows them to focus on their patients' care. We pay claims promptly. We minimize administrative burdens through a variety of convenient, Web-based functions. We supply providers with valuable risk management data.

**A — Affordable Plans — Making the Most of Medicaid**

For Medicaid recipients, our programs promote greater access to the entire continuum of care. By providing the coordinated, holistic approach that managed care was originally envisioned to offer, we help keep our members healthy.

**R — Reliable and Responsible Partners**

Proper access to primary care can result in sustained, coordinated health care utilization. By forging strong relationships between our members and primary care providers, we ensure that beneficiaries enjoy better and timely access to care.

**E — Education and Preventive Care for Members**

By promoting well care — from childhood immunizations to routine checkups, prenatal care, diabetes monitoring, asthma medication, mammograms and disease management programs — in addition to comprehensive medical services, we help to identify and address medical problems early. This, in turn, improves outcomes and promotes members’ ongoing health.
ALL ABOUT WELLCARE

Section 1

Mission Statement and Core Values

Vision

To be the leader in government-sponsored health care programs in partnership with the members, providers, governments and communities we serve.

Mission Statement

WellCare will:

- Enhance our members’ health and quality of life.
- Partner with providers and governments to provide quality, cost-effective health care solutions.
- Create a rewarding and enriching environment for our associates.

Partnership

Members are the reason we are in business; Providers are our partners in serving our members; and regulators are the stewards of the public’s resources and trust. We will deliver excellent service to our partners.

Integrity

Our actions must consistently demonstrate a high level of integrity that earns the trust of those we serve.

Accountability

All associates must be responsible for the commitments we make and the results we deliver.

Teamwork

With our fellow associates, we can expect – and are expected to demonstrate – a collaborative approach in the way we work.
### Accreditation

WellCare’s health plans are accredited by the Accreditation Association for Ambulatory Health Care (AAAHC), one of the leading quality standard-setting organizations in the nation. AAAHC evaluates the structure and function of medical and quality management systems in health care organizations. The Plan’s compliance with these standards reflects its commitment to principals of quality and continuous improvement of the service provided.
The Georgia Department of Community Health (DCH) will provide health care benefits to certain eligible populations through the Georgia Families program, a full-risk, capitated care management system.

According to the DCH, the Program is designed to:

- Improve the health care status of the member population;
- Establish a “provider home” for members through its use of assigned primary care providers;
- Establish a climate of contractual accountability among the state, the care management organizations and the health care providers;
- Slow the rate of expenditure growth in the Medicaid program; and
- Expand and strengthen a sense of member responsibility that leads to more appropriate utilization of the health care system.

Certain populations will be automatically enrolled in the Program:

- Low income families;
- Transitional Medicaid;
- Pregnant women (presumptive), pregnant women (Right from the Start Medicaid - RSM);
- Children (Right from the Start Medicaid - RSM), children (newborn);
- Children with severe emotional disturbance whose care is coordinated under the Multi-Agency Team for Children (MATCH) program; and
- Women eligible for Medicaid due to breast and cervical cancer.
PeachCare for Kids is Georgia’s health insurance program for children less than 19 years of age who have a family income less than 235 percent of the federal poverty level, who are not eligible for Medicaid or any other health insurance program and who cannot be covered by the state health benefit plan.

The following individuals are excluded from enrollment in the Georgia Families program, even if the recipient is otherwise eligible:

- Recipients eligible for Medicare;
- Recipients that are members of a federally recognized Indian tribe;
- Recipients eligible for Supplemental Security Income;
- Children less than 19 years of age who are in foster care or other out-of-home placement;
- Children less than 19 years of age who are receiving foster care or other adoption assistance under Title IV-E of the Social Security Act;
- Children enrolled in the Children’s Medical Services program administered by the Georgia Division of Public Health;
- Children enrolled in the Georgia Pediatric Program (GAPP); and
- Recipients enrolled under group health plans for which DCH provides payment for premiums, deductibles, coinsurance and other cost sharing, pursuant to Section 1906 of the Social Security Act.
Medicaid Service Area

The Medicaid Service area is divided by service regions. Each county is included in one of six service regions. These service regions are being phased into the WellCare plan. Members will choose or be assigned to a Care Management Organization based on the service region in which the member resides. The service regions are:

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Overview
This section of the Hospital Services Handbook addresses the respective responsibilities of participating facilities.

Member Rights and Responsibilities
WellCare members have specific rights and responsibilities. These should be respected and followed at all times. The Member Rights and Responsibilities Statement is included in the Member Services section of this Handbook and is also in the Member Handbook.

All participating WellCare physicians and providers must accept all individuals without restrictions and may not discriminate against individuals on the basis of religion, gender, race, color or national origin. Providers will not use any policy or practice that has the effect of discriminating on the basis of color or national origin or on the basis of health, health status, pre-existing condition or need for health care services.

Domestic Violence and Substance Abuse Screening
Physicians should identify indicators of substance abuse or domestic violence. The screening tools for domestic violence and substance abuse are located in the Forms section of the Provider Handbook. If a member needs assistance regarding domestic violence, the provider should direct the member to contact Customer Service and ask to speak with the Case Management department. If a member needs assistance regarding substance abuse, the provider should direct the member to call the toll-free Provider Hotline number for the Plan. These telephone numbers are located on the Quick Reference Guide.

Living Will and Advance Directives
A member has the right to control decisions relating to his/her medical care, including the decision to withhold or take away the medical or surgical means or procedures to prolong his/her life.

The law provides that Plan members of sound mind, age 18 years or older or emancipated minors, and/or their legal representatives should receive information concerning advance directives and have the opportunity to execute an advance directive. This allows the member to designate another person to make a decision if he/she becomes
mentally or physically unable to do so. Forms must be made available in provider’s offices and/or facilities. Discussion with the member, as well as 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. However, the provider should include documentation in the member’s medical record regarding the discussion and/or include any executed advance directive forms.

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, regarding the privacy and/or confidentiality of medical records, personally identifiable information and/or protected health information and accreditation requirements, including without limitation the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Privacy, Security and Administrative Simplification Rules and Regulations promulgated there under, each as may be amended.

No health care provider may be penalized for considering, studying or discussing medically necessary or appropriate care with, or on behalf of, his/her patient.

All facility personnel should receive training and/or education regarding the confidentiality of the facility’s patient records and health information consistent with state law and HIPAA. The facility should ensure that there is: (i) a privacy officer on staff; (ii) a policy and procedure in place for confidentiality of members’ protected health information (PHI); and (iii) that the facility and its employees, agents and contractors are 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 provider is required to provide to members their Notice of Privacy Practice (NPP). Employees who have access to member records and other confidential information are required to sign a confidentiality statement.

Some examples of confidential information include:

- Communication between member and physician;
- Member’s medical records, personally identifiable information and/or other information as provided for under applicable state laws and/or accreditation requirements;
- All PHI 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.

HIPAA provides for the release of member medical records to the Plan for payment purposes and/or health plan operations. The Notice of Privacy Practice (NPP) informs the patient or member of his/her rights under HIPAA and how the provider and/or health plan may use or disclose the member’s PHI. HIPAA regulations require each provider and health plan to provide a NPP to each new patient or member.
### Provider Billing and Address Changes

Prior notice to the Plan is required for any of the following changes:

- 1099 mailing address
- Tax Identification Number or entity affiliation (W-9 required)
- Group name or affiliation
- Physical or billing address
- Telephone and/or fax number

Failure to provide adequate notice to WellCare of these changes will result in claims payment delays.

### Delegated Entities

All participating providers or entities delegated for Network Management and Network Development should meet all plan requirements, pre/post delegation assessments and applicable standards. Reviews are performed and compliance is monitored on a regular basis. The plan reserves the right to revoke or rescind any delegated activities, in whole or in part, based on delegated entity performance and continued ability to meet plan standards and requirements.

### Marketing and Sales

Providers are required to submit any marketing materials (including, but not limited to, posters, brochures, Web sites and any materials that contain statements regarding the member benefit package) to the Plan. Neither the Plan nor the providers may distribute any marketing materials without prior written approval from Georgia’s Department of Community Health (DCH).

Providers are required to follow all applicable federal guidelines related to Plan marketing and the provision of leads. Please contact WellCare if you have any specific questions around Georgia Families marketing rules or guidelines.

### 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 the Plan’s Customer Service department to request this information. The toll-free telephone number for Customer Service is listed on the member’s ID card.
## Overview

The Plan will ensure that members are aware of the role of Primary Care Physicians (PCPs), how to obtain care, what to do in an emergency or urgent medical situation and their rights and responsibilities. The Plan will convey this information through various methods, including a Member Handbook.

## Member Handbook

All newly enrolled members will receive a Member Handbook within 10 calendar days of receiving the notice from the Plan of enrollment. Thereafter, the Plan will mail all enrolled members a Member Handbook at least annually.

## Enrollment

Membership enrollment in WellCare’s Medicaid health plans is voluntary, as members may select from three participating MCOs, or by state-mandated assignment. Eligible Medicaid and PeachCare for Kids beneficiaries must enroll in one of the MCOs.

The Plan accepts members without consideration of the applicant’s health condition, gender, race, religious belief, national origin or disability.

Upon enrollment in the plan, members are provided with the following:

- Terms and conditions of enrollment
- Description of covered services
- Information about PCPs, such as location, telephone number and office hours
- Information regarding out-of-plan emergency services
- Grievance and disenrollment procedures
- “Over-the-Counter” brochure, if applicable

## Member Identification Cards

Member identification cards are intended to identify plan members and facilitate their interactions with physicians and other health care providers. Information found on the member identification card may include the member’s name, identification number, PCPs name and telephone...
number, co-payment information, health plan contact information and claims filing address. Possession of the member identification card does not guarantee eligibility or coverage. The physician or provider is responsible for ascertaining the current eligibility of the cardholder.

Eligibility Verification

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 filing them in the patient’s medical record.

You may verify eligibility in one of three ways:

1. Access the WellCare Web site at http://georgia.wellcare.com (contact your Provider Relations representative to schedule a Web site in-service presentation).

2. Access WellCare’s Interactive Voice Response (IVR) system. You will need your Provider ID number to access member eligibility.

3. Contact the Customer Service department. You will need your Provider ID number to request member eligibility.

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.

Member Rights and Responsibilities

Plan members, adults and children, have specific Rights and Responsibilities. These are included in the Member Handbook.

WellCare members have the right:

- To get information about WellCare, its services, its contracted doctors and providers, and members'
rights and responsibilities.

- To supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

- To know the names and titles of doctors and other health care people involved in your care.

- To be treated with respect and dignity and to have the right to privacy.

- To take part with providers in making decisions about your health care.

- To talk openly about care they need for their health, regardless of cost or benefit coverage, as well as choices and risks involved. The information must be given to them in a way they understand.

- To have the risks, benefits and side effects of medications and other treatments explained to them clearly.

- To know about their health care needs after being released from a hospital or office.

- To refuse medical or surgical care, as long as they agree to be responsible for this decision.

- To refuse to take part in any medical research projects.

- To complain about WellCare or the care it provides and to know that doing so will not affect how they are treated.

- To not be responsible for WellCare’s debts in the event of insolvency or failure to pay.

- To be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation.
MEMBER SERVICES

Section 4

- To have access to their medical records and to have those records kept private and confidential.

- To make their health care wishes known through advance directives.

- To have input into WellCare’s member rights and responsibilities policies.

- To appeal adverse medical or administrative decisions using WellCare’s grievance process and the state.

- To exercise these rights no matter what their sex, age, race, ethnic, economic, educational or religious background.

- To have all WellCare staff observe their rights.

- To have all the above rights apply to the person legally able to make decisions about their health care.

Members also have certain responsibilities. These include the responsibility:

- To give information that WellCare and its contracted doctors and providers need to provide care.

- To follow plans and instructions for care agreed upon with their doctor.

- To understand their health problems and share in developing treatment goals that they and their doctor agree to.

- To understand how WellCare works by reading the Member Handbook.

- To carry their member ID card and Medicaid ID card with them at all times. Show their ID cards to each provider (i.e., doctor, lab, hospital, pharmacy, etc.) when services are being given.
MEMBER SERVICES

Section 4

- To schedule appointments for all non-emergency care through their assigned doctor, to get a referral from their doctor for specialty care, and to cooperate with all persons providing care and treatment.

- To be on time for appointments.

- To notify the doctor’s office if they need to cancel or reschedule an appointment.

- To pay co-payments to providers as specified by the Georgia Families program.

- To respect the rights, property and environment of all providers, employees and other patients and not be disruptive.

- To understand the medicines they take, know what they are, what they are for and how to take them properly.

- To make sure their current doctor has been given copies of all previous medical records.

PeachCare for Kids members have the right:

- To get information about PeachCare for Kids, its services, its contracted doctors and providers and members’ rights and responsibilities.

- To know the names and titles of doctors and other health care people involved in their care.

- To be treated with respect and dignity and to have the right to privacy.

- To take part with providers in making decisions about their health care.

- To have the risks, benefits and side effects of medications and other treatments explained to them.
• To talk openly about care they need for their health, regardless of cost or benefit coverage, as well as choices and risks involved. The information must be given in a way they understand.

• To know about their health care needs after being released from a hospital or office.

• To refuse medical or surgical care, as long as they agree to be responsible for this decision.

• To refuse to take part in any medical research projects.

• To complain about PeachCare for Kids or the care it provides and to know that doing so will not affect how they are treated.

• To not be responsible for PeachCare for Kids debts in the event of insolvency or failure to pay.

• To be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation.

• To have access to their medical records and to have their records kept private and confidential.

• To make their health care wishes known through advance directives.

• To have input into PeachCare for Kids member rights and responsibilities policies.

• To appeal adverse medical or administrative decisions using PeachCare for Kids grievance process and the state.

• To exercise these rights no matter what their sex, age, race, ethnic, economic, educational or religious background.

• To have all PeachCare for Kids staff observe their
rights.

• To have all the above rights apply to the person legally able to make decisions about their health care.

PeachCare for Kids members have certain responsibilities. These include the responsibility:

• To give information that PeachCare for Kids and its contracted doctors and providers need to provide care.

• To follow plans and instructions for care agreed upon with their doctor.

• To understand their health problems and share in developing treatment goals that they and their doctor agree to.

• To understand how PeachCare for Kids works by reading the Member Handbook.

• To carry their member ID card and Medicaid ID card with them at all times. Show your ID cards to each provider (i.e., doctor, lab, hospital, pharmacy, etc.) when services are being given.

• To schedule appointments for all non-emergency care through their assigned doctor, to get a referral from their doctor for specialty care and to cooperate with all persons providing care and treatment.

• To be on time for appointments.

• To notify the doctor’s office if they need to cancel or reschedule an appointment.

• To respect the rights, property and environment of all providers, employees and other patients and not be disruptive.
MEMBER SERVICES

• To understand the medicines they take, know what they are, what they are for and how to take them properly.

• To make sure their current doctor has been given copies of all previous medical records.

Medical Necessity

Members will be informed that medically necessary services are those that are:

• 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 or the convenience of the health care provider or hospital; and

• Not primarily custodial care unless custodial care is a covered service or benefit under the members evidence of coverage.

Emergency Services

An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms. An 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 the absence of immediate medical attention to result in the following:
MEMBER SERVICES

• 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; or

• Injury to self or bodily harm to others.

The Plan shall base coverage decisions for emergency services on the severity of the symptoms at the time of presentation and shall cover emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

Once the member’s condition is stabilized, the Plan may require authorization for hospital admission or prior authorization for follow-up care.

Assignment of Primary Care Physician

All Plan members must choose their PCP or they will be assigned to a PCP within the Plan’s network. To ensure quality and continuity of care, the PCP is responsible for arranging all of the member’s health care needs from providing primary care services to coordinating referral to specialists and providers of ancillary or hospital services.
Overview

Credentialing is the process used by the Plan to evaluate the qualifications and credentials of providers, physicians, allied health professionals, hospitals and ancillary facilities/health care delivery organizations. Providers are required to be credentialed prior to being listed as participating network providers of care or services to Plan members.

The Credentialing department or its designee is responsible for gathering all relevant information and documentation through a formal application process. Primary source verifications are obtained in accordance with all accreditation agency requirements and Plan policies and procedures. An appropriate professional review body of the Plan evaluates the background, education, training, board certification, experience, demonstrated ability, patient-admitting capabilities, licensure, regulatory compliance, health status, and as applicable to provider type, accreditation status of each individual applicant.

Satisfactory site-inspection evaluations are required to be made at the office locations of all PCPs, and Obstetrics and Gynecology specialist physicians’ offices. Some facilities also need a site-inspection evaluation to be completed, relative to accreditation status.

Credentialing may be done directly by the Plan or by an entity approved by the Plan for delegated credentialing. Prior to delegation of credentialing to an outside agency, the Plan will evaluate and establish that the entity clearly meets all regulatory requirements and is able to perform credentialing consistent with plan policies and procedures.

All participating providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a regular basis and formal audits are conducted annually. Ongoing oversight includes regular exchanges of network information, and the annual review of policies and procedures and credentialing forms and files.
Applicants Right to be Informed of Credentialing Application Status

Upon receipt of a written request, the Plan will provide written information to the applicant of the status of the credentialing application, generally within 15 business days. The information provided will advise of any items still needing to be verified, any non-response in obtaining verifications and any discrepancies in verification information received compared to information provided by the applicant.

Applicant’s Right to Review and Correct Erroneous Credentialing Information

In the event the credentials verification process reveals information submitted by the applicant that differs from the verification information obtained by the Plan.

The Plan’s notification to the applicant will include:

- The nature of the discrepant information;
- The process for correcting erroneous information submitted by another source;
- The format for submitting corrections;
- The time frame for submitting the corrections;
- The addressee to whom corrections must be sent;
- The Plan’s documentation process for receiving the correction information from the applicant; and
- The Plan’s review process.

The applicant may review certain documentation submitted by him or her in support of the application, together with any discrepant information received from professional liability insurance carriers, state licensing agencies and certification boards, subject to any restrictions of the Plan. The Plan or its designee will review the corrected information and explanation at the time of considering the applicant’s credentials for provider network participation.

The applicant may not review peer review information obtained by the Plan.
Baseline Criteria

Baseline criteria for provider network participation:

License to Practice

Practitioners must have a current valid license to practice;

Board Certification

Physicians (M.D., D.O., D.P.M.) maintain Board Certification in the specialty being practiced as a provider for the Plan or accredited training that renders a physician eligible to sit for the Board Certification examination;

Hospital Admitting Privileges

Specialist practitioners shall have hospital admitting privileges at a Plan participating hospital (as applicable to specialty). PCPs may have hospital admitting privileges or may enter into a formal agreement with another Plan participating practitioner who has admitting privileges at a Plan participating hospital, for the admission of members.

Professional Liability Insurance

Plan providers (all disciplines) shall be required to carry and continue to maintain professional liability insurance in the following required limits:

Individual Practitioners
  $1,000,000 per occurrence;
  $3,000,000 aggregate;

Allied Mental Health Practitioners
  $1,000,000 per occurrence;
  $1,000,000 aggregate.

Covering Physicians

PCPs in solo practice must have a Plan participating covering physician willing to care for their members in their absence.
Allied Health Practitioners

Allied Health Professionals (AHPs), both dependent and independent, are credentialed by the Plan.

Dependent AHPs include the following, and are required to provide collaborative practice information to the Plan:

- Advanced Registered Nurse Practitioner (ARNP)
- Certified Nurse Midwife (CNM)
- Physician Assistant (PA)
- Osteopathic Assistant (OA)

Independent AHPs included, but not limited to the following:

- Licensed clinical social worker
- Licensed mental health counselor
- Licensed marriage and family therapist
- Physical therapist
- Occupational therapists
- Audiologist
- Speech/Language therapist/pathologist

Ancillary Health Care Delivery Organizations

Ancillary facilities, or health care delivery organizations, must complete a credentialing application and provide information on accreditation, licensure, regulatory status, claims history, liability insurance coverage and rating. In addition, depending on accreditation and/or Medicaid status, a site-inspection evaluation may be required as part of the credentialing process.

Re-Credentialing

In accordance with state requirements and Plan policy and procedure, re-credentialing of all provider types shall be conducted at least once every three years.

Updated Documentation

Providers must furnish copies of current Professional Liability Insurance, License, DEA Certificate and Accreditation information, as applicable, to the Plan, prior to or concurrent with expiration.
Office of Inspector General Medicaid Sanctions Report

On a regular and ongoing basis, the Plan accesses the listings from the Department of Health and Human Services, Office of Inspector General Medicaid Sanctions (exclusions and reinstatements) Report, and the state's list of excluded providers for the most current available information. This information is cross-checked against the network of Plan providers. If providers are identified as being currently sanctioned, such providers are subject to immediate suspension. Notifications of termination of contract are given in accordance with Plan policies and procedures.

Hearing and Appellate Review

A practitioner whose provider status with the Plan is recommended for termination for reason(s) that may require a report to be made to the National Practitioner Data Bank shall be entitled to a hearing and appellate review.

Notification of the termination recommendation, together with reasons for the action, hearing and appellate review rights and the process for obtaining a hearing and appellate review, shall be provided to the practitioner within 30 days of the date of the termination recommendation. Notification to the practitioner shall be mailed by certified return receipt mail.

The practitioner shall have a period of 30 days in which to file a written request for a hearing and appellate review. The request shall be mailed via certified return receipt mail.

Upon timely receipt of the request, the Chief Executive Officer or his designee shall notify the practitioner of the date, time and place of the hearing. Such hearing shall not take place less than 30 days from the date of the notice of the hearing.

The practitioner and the Plan shall be entitled to legal representation at the hearing. The practitioner has the burden of proving by clear and convincing evidence that the reason for the termination recommendation lacks any factual basis, or that such basis or the conclusion(s)
drawn there-from, are arbitrary, unreasonable or capricious.

The Hearing and Appellate Review Committee shall consider and decide the case objectively and in good faith. Within 30 days after final adjournment of the hearing and appellate review, the Committee shall make a written report and forward its decision to the Plan’s Quality Improvement Committee. Notification of the Plan’s final decision will be provided to the practitioner within 30 days.
<table>
<thead>
<tr>
<th>Overview</th>
<th>The Claims department partners with the Provider Relations, Health Services and Customer Service departments to assist providers with any claims-related questions. The focus of the Claims department is to process claims timely, investigate the basis for any issues and correct their root causes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely Claims Submission</td>
<td>Timely filing is 180 days from the date of service to the primary payers, secondary payers, or as required by law. Refer to the Quick Reference Guide for the appropriate mailing address.</td>
</tr>
<tr>
<td>Claim Submission Format</td>
<td>Claims may be submitted to the Plan in one of the following formats:</td>
</tr>
<tr>
<td></td>
<td>• Electronic Claim Submission (EDI)</td>
</tr>
<tr>
<td></td>
<td>• CMS 1500 Form</td>
</tr>
<tr>
<td></td>
<td>• UB04 Form</td>
</tr>
<tr>
<td>Provider ID and NPI Requirements</td>
<td>The Plan requires the use of the payer-issued tax ID and NPI on all claim submissions, both electronic and paper. However, the Plan-issued provider ID remains a key identifier on daily encounters with the Plan. For this reason, we highly recommend that it be included on your claim submissions.</td>
</tr>
<tr>
<td></td>
<td>• If submitting claims electronically, there is a required field in the file format for the Plan’s</td>
</tr>
</tbody>
</table>
provider ID number along with the referring, rendering or facility NPI numbers. Providers are encouraged to verify that their software management tool or clearinghouse has the correct provider ID and is placing it in the correct field.

- Providers submitting paper claims should include their Plan-issued provider ID or NPI on both CMS 1500 and UB-04 forms. Other forms of identification may be used in the absence of the provider ID or NPI number (see the guidelines for CMS 1500 and UB04 paper claims submission in the **Forms** section of this handbook).

**National Provider Identifiers**

Beginning May 23, 2007, standard transactions such as claims submitted electronically to the Plan must include the referring, rendering or attending, billing and facility provider’s National Provider Identifier (NPI), per requirements put forth in HIPAA’s NPI Final Rule Administrative Simplification.

The NPI and tax ID must be included with electronic claim submissions for proper adjudication. More information about NPI is available on the CMS Web site.

**HIPAA Electronic Transactions and Code Sets**

To improve the efficiency and effectiveness of the health care system, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA), which includes a series of administrative simplification provisions that require the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions.

Since October 16, 2003, payers like WellCare are required by federal regulation to have the capability to send and receive all applicable HIPAA-compliant standard transactions and code sets.

For example, a payer must be able to electronically accept a HIPAA-compliant 837 (I and/or P) electronic
claim transaction in standard format, and the provider must be able to send it to the payer in the required format for HIPAA-compliant 837 (I and/or P) electronic claim transactions.

**Standard Code Sets**

All providers are required to:

- Use the HIPAA Compliant codes, which include the standard CMS codes for ICD9, CPT and HCPCS; and

- Discontinue the use of all old HCPCS level III code sets, also known as local codes and/or home-grown codes, as they have been discontinued.

If you are unclear about standard code sets, please call your Provider Relations representative.

**Standard Transactions**

All providers who submit electronic claims to the Plan must do so in the new format established by HIPAA.

The provider-focused HIPAA transactions are (*ANSI X12N):

- 270/271–Health Insurance Eligibility/Benefit Inquiry & Response

- 276/277–Health Care Claim Status Request & Response

- 278–Health Care Services Review – Request for Review and Response

- 835–Health Care Claim Payment/Advice

- 837–Health Care Claims

The X12N – 837 Claims Submission transactions replaces the manual CMS 1500/UB04 forms.
All files submitted 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](http://www.wpc-edi.com).

**Electronic Claim Submissions**

The plan accepts electronic claim submissions through Electronic Data Interchange (EDI).

**Advantages of EDI**

- Submitting claims electronically is 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. The Plan has options with ACS, including connectivity and software, which are free. Contact the EDI department to see if you qualify for this service. You may also contact your clearinghouse or billing software vendor to see if they offer free options.

There are six primary clearinghouses through which we receive EDI transactions. Those companies are:

- ACS EDI Gateway, Inc.
- Availity
- Emdeon (former WebMD®)
- RelayHealth (McKesson)
- SSI Group
- ZirMed

Since most clearinghouses can exchange data with one another, providers should work with their existing clearinghouse, if other than those listed, to establish EDI with the Plan.

All files submitted to the Plan must be in the ANSI ASC X12N format, version 4010A. Implementation guides for

If you do not have a clearinghouse or have been unsuccessful in submitting claims through your clearinghouse, please contact our EDI team. The EDI team contact information can be found on the Quick Reference Guide.

Payer ID

There are unique Payer IDs that must be used to identify our Plan on electronic claim submissions. The appropriate Payer IDs for each of the six clearinghouses through which WellCare claims may be submitted are listed below: (subject to change)

ACS EDI Gateway, Inc.
- 77004

Availity, Emdeon (WebMD®), RelayHealth (McKesson), SSI Group and ZirMed
- 14163

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Services

We have partnered with Payformance Corporation to offer you free Electronic Funds Transfer (EFT) and online Electronic Remittance Advice services (ERA, also known as electronic payment voucher) by registering with PaySpan Health®.

The benefits of enrolling for EFT/ERA through PaySpan Health® include:

- A secure, self-service Web site;
- Absolutely no cost for participating;
- Improved cash flow through automated deposits;
- Convenient access to view remittance records online, at any time;
- Reporting mechanisms to access adjudicated claims information; and
- Ability to import payment data directly into your practice management or patient account system.
Online registration is simple and fast. PaySpan Health® will mail a registration letter to network providers containing a unique registration code and PIN number. The information contained in the registration letter will be all the guidance necessary to complete the registration process.

Should a provider elect not to receive payments or vouchers electronically, they will continue to receive paper checks generated at the Payformance payment processing center.

For questions related to this service, please visit the PaySpan Health® Web site at www.payspanhealth.com or call the Provider Hotline (refer to the Quick Reference Guide for contact information).

Paper Claim Submission Guidelines

Paper claims must be completed in full and include:

- The Plan member’s name and his or her relationship to the subscriber;
- The subscriber’s name, address and Social Security number;
- The subscriber’s employer group name and number (when applicable);
- Information on other insurance or coverage for the Plan member;
- The name, signature, place of service address, billing address and telephone number of the physician or provider performing the service;
- The tax ID number; and
- Medicaid and/or Plan-issued provider ID number for the referring physician or provider performing the service as well as for the facility (when applicable) including its respective qualifier.
Qualifiers

Each form of identification should be accompanied by a qualifier which will correctly allocate the information when transferred into our databases. Proper qualifiers for identification numbers submitted to the Plan are:

<table>
<thead>
<tr>
<th>ID Type</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax ID</td>
<td>24</td>
</tr>
<tr>
<td>WellCare ID</td>
<td>G2</td>
</tr>
<tr>
<td>Medicaid ID</td>
<td>1D</td>
</tr>
<tr>
<td>Taxonomy</td>
<td>ZZ</td>
</tr>
<tr>
<td>State License</td>
<td>0B</td>
</tr>
</tbody>
</table>

Notice that some form fields will include a box to submit the identification number’s qualifier. In others, however, the box will not be available and the qualifier should be included by preceding the identification number with a hyphen (Ex. XX-XXXXXXXXX).

- Appropriate ICD-9 codes;
- Standard CMS procedure or service codes (e.g., CPT-4 procedure codes and HCPC-I,II codes with appropriate modifiers, revenue codes);
- Number of service units rendered;
- Billed charges;
- Referring physician’s name and NPI number;
- Date(s) of service;
- Place(s) of service and facility NPI (where applicable);
- Authorization Number (if applicable);
- NDC for drug therapy (if applicable); and
• Job related, auto or other accident information.

CMS 1500 Paper Claim Submissions

The Plan accepts the revised CMS 1500 forms printed in Flint OCR Red, J6983, (or exact match) ink. Although a copy of the CMS 1500 form can be downloaded from the CMS Web site, copies of the form cannot be used for submission of claims since your copy may not accurately replicate the scale or color of the form when scanned using Optical Character Recognition (OCR).

This scanning technology allows for the data contained on the form to be read while the actual form fields, headings and lines remain invisible to the scanner. OCR technology allows the Plan to record and process paper claims faster.

There are key fields that will properly identify and adjudicate claims information on a paper CMS 1500 form when submitted to our Plan. Below are guidelines identifying those fields to ensure timely and accurate processing of your claims.

CMS 1500 Guidelines for Paper Claims

• Block 17a: The referring provider’s WellCare, Medicaid or tax ID number. Providers may also use their state license or taxonomy numbers should the others not be available.

• Block 17b: The referring provider’s NPI number. Please ensure the 10-digit NPI number is accurate.

• Block 24i (lines 1-6): The ID qualifier for the rendering provider’s WellCare, Medicaid or tax ID. Providers may also use their state license or taxonomy numbers should the others not be available. Refer to page six of this section for a list of qualifiers.

• Block 24j (lines 1-6): The rendering provider’s WellCare, Medicaid or tax ID. Providers may also use their state license or taxonomy
numbers should the others not be available.

- Block 25: The 9-digit federal tax ID number (TIN). The provider’s tax ID must be included or the claim will be denied.

- Block 32: Facility contact information (name, address and telephone number). Include when applicable.

- Block 32a: Facility’s NPI number. Please ensure the 10-digit NPI number is accurate.

- Block 32b: Facility ID Qualifier and respective ID number (Ex. xx-xxxxxxxxx). Refer to page six of this section for a list of qualifiers.

- Block 33: Billing provider’s (or billing vendor’s) contact information. Include when applicable.

- Block 33a: Billing provider’s NPI number. Please ensure the 10-digit NPI number is accurate.

- Block 33b: Billing provider qualifier and respective ID number (Ex. xx-xxxxxxxxx). Refer to page six of this section for a list of qualifiers.

**UB04 Paper Claim Submissions**

The Plan accepts UB04 forms printed in Flint OCR Red, J6983, (or exact match) ink. Although a copy of the form can be downloaded from the CMS Web site, copies of the form cannot be used for submission of claims since your copy may not accurately replicate the scale or color of the form when scanned using Optical Character Recognition (OCR).

This scanning technology allows for the data contained on the form to be read while the actual form fields, headings and lines remain invisible to the scanner. Photocopies cannot be scanned and therefore are not accepted.
There are key fields to properly identify and adjudicate claim information on a paper UB04 form when submitted to our Plan. Below are guidelines identifying these fields to ensure timely and accurate processing of your claims.

**UB04 Guidelines for Paper Claims**

- **Block 56**: Billing provider’s NPI number is entered here. It is optional on paper claims.

- **Block 57A&B**: Use this field if an identification number other than the NPI is being reported for the billing provider such as a Medicaid or tax ID. Providers may also use their state license or taxonomy numbers.

- **Block 57C**: Billing provider’s WellCare ID number.

- **Block 71 PPS Code**: Enter DRG code.

- **Blocks 76-79 QUAL**: Attending, operating or other physician’s qualifier. Refer to page six for a list of qualifiers.

- **Blocks 76-79**: Enter the attending, operating or other physician’s ID number related to the qualifiers listed above.

- **Blocks 76-79 NPI**: Include the attending, operating or other physician’s NPI number whenever possible.

- **Block 81CC**: Enter the taxonomy codes corresponding to providers listed in fields 76-79.

**Encounter Data Submissions**

If a provider’s payment method is on a capitation basis, claims still must be submitted to the Plan.

This requirement is mandated to meet the reporting requirements of the Plan as well as those established by regulatory agencies and the Balanced Budget Act.
Claims submitted under a capitation contract are usually referred to as encounter data. Encounter data can be submitted on CMS 1500 or UB04 forms or through EDI following the same rules as standard claim submissions.

Note: Encounter data submitted using paper forms must include the billing provider’s Medicaid ID or the claim submission will be rejected.

The Plan currently utilizes the six clearinghouses listed below to process the 837 Health Care Claims transactions. The encounter payer ID for all clearinghouses is **59354**.

- ACS EDI Gateway Inc.
- Availity
- Emdeon (former WebMD®)
- RelayHealth (McKesson)
- SSI Group
- ZirMed

The Plan will record all encounter data received. The Plan recognizes these services as under a capitated contract and will not make payment to the provider.

Any capitated provider who does not submit encounter data is subject to corrective action measures and penalties under applicable state and federal law and could be terminated from the Plan.

**Coordination of Benefits**

Coordination of Benefits (COB) is the procedure used to process health care payments when a person is covered by one or more insurers. Prior to submitting a claim to the Plan, providers must identify if any other payer has primary responsibility for payment of a claim.

If determination is made that another payer is primary:

- The primary payer should be billed prior to billing the Plan;
- Any balance due after receipt of payment from the
primary payer should be submitted to the Plan for consideration; and

- The claim must include information verifying the payment amount received from the primary plan as well as a copy of their Explanation of Payment (EOP) statement with the name of the primary payer and the member’s primary subscribed ID number.

If third party liability or the amount of third party liability cannot be determined, WellCare will consider a claim for processing of payment. If payment is not available within 60 calendar days, WellCare will also consider a claim for processing of payment.

Upon receipt of the claim, the Plan will review it using the COB rule or other, as applicable.

**Prohibition on Billing Plan Members**

Your agreement with the Plan requires providers to accept payment directly from the Plan. Payment from the Plan constitutes payment in full, with the exception of applicable co-payments, deductibles, co-insurance and any other amounts listed as member responsibility on the Explanation of Payment/Provider Remittance Advice.

**Providers may not bill Plan members for:**

- The difference between actual charges and the contracted reimbursement amount;

- Services denied due to timely filing requirements;

- Covered services for which a claim has been returned and denied for lack of information;

- Remaining or denied charges for those services where the provider fails to notify the Plan of a service that required prior authorization;

- Payment for that service will be denied; and
• Covered services that were not medically necessary, in the judgment of the Plan, unless prior to rendering the service, the provider obtains the member’s informed written consent and the member receives information that they would be financially responsible for the specific services.

Non-Covered Services

Plan members may be billed for non-covered services like cosmetic procedures and items of convenience (i.e., televisions).

Diagnosis Related Group (DRG) Payments

Diagnosis Related Group (DRG) payments for inpatient claims are initially paid at DRG inlier rates. Payment of the outlier portion of the claim will require medical record review. Please submit any outlier payment request to WellCare’s Retrospective Review department with the following information:

• Letter requesting an outlier payment review
• Itemized charges with revenue codes
• Copy of paid remittance advice
• Face sheet
• History and physical
• Physician orders
• Progress notes
• Consultation notes
• Operative notes (if applicable)
• Therapy notes (if applicable)
• Discharge summary
The deadline for submitting outlier payment requests is 90 days from the remittance date. These outlier cases can be mailed to:

WellCare Health Plans  
Attn: Retrospective Review  
8735 Henderson Road  
Ren 3, 1st Floor  
Tampa, Florida 33634

Covering Physician Reimbursement

In the event a covering physician agrees to act on behalf of another network physician, the following applies:

- The covering physician that is providing services to the network physician’s Plan members agrees to accept payment under the network physician’s agreement with the Plan.
- If covering for a network physician who is reimbursed on a capitation basis, the covering physician will be required to seek payment for services provided to Plan members from the network physician and not the Plan.
- Covering physicians will not be able to seek payment from the Plan or the Plan member, with the exception of those services for which the network physician would have been permitted to collect from the Plan pursuant to their contractual agreement.

Professional and Technical Component Payment

The Plan covers the professional and technical components of global CPT procedures. Therefore, the appropriate professional component modifiers and technical component modifiers should be used on the claim form.

Assistant Surgeon Payment

An assistant surgeon may be used if the procedure requires support. Assistant surgeons must be network providers unless specific authorization is obtained from the Plan. On-staff surgeons who are not participating
providers may be used to assist in the event of an emergency. Charges for assistant surgeons' fees will not be reimbursed if an assistant surgeon is not approved for the procedure to be performed.

**Overpayment Recovery**

WellCare may initiate overpayment recovery no later than 12 months after the last date of service (DOS) or discharge, for reasons that include but are not limited to:

- Adjustments to previously processed claims
- Duplicate payments
- Improper benefit interpretations
- Fee schedule corrections
- Ineligible member
- Fee for service payments for capitated services

In accordance with the Georgia Health Insurance Protection Act, O.C.G.A. 33-20A-60 through 62, et al. WellCare of Georgia will provide the claimant with a written notice stating the specific claim and reason for the retroactive denial.

Providers should follow the instructions in the refund request notice to ask for additional information or contest the overpayment.

**Payment Methods**

Providers will receive a one-time 45-day notice that an off-set will be performed against future payments unless a refund is received or the Plan is contacted with an explanation of a correct payment. Providers will be informed of amounts recovered via the Explanation of Benefits (EOB).

**Delegated Entities**

All participating providers or entities delegated for Utilization Management are to use the same standards as defined in this section. Compliance is monitored on a monthly basis, and formal audits are conducted annually.
SCOPE OF SERVICES

Overview

The Plan provides reimbursement to participating providers for inpatient or outpatient hospital services. Care provided to eligible members includes those services that are primarily for the treatment of acute illness, injury, or impairment or for maternity care.

WellCare establishes reimbursement limitations as required by the Georgia state contract to ensure medical necessity of services rendered and utilization control.

Medically necessary services are those that are:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition;
- Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Compatible with the standards of acceptable medical practice in the community;
- Not provided solely for the convenience of the member or the convenience of the Plan or hospital;
- Not primarily custodial care unless custodial care is a covered service or benefit under the member’s evidence of coverage; and
- No other effective, more conservative or substantially less costly treatment, service or setting may be available.

Coverage is provided for eligible members for preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. Care must be rendered under the direction of a doctor or by an institution which is licensed or formally approved as a hospital by an officially designated state standard-setting authority. The provider must be qualified to participate under Title XIX (Medicaid) of the Social Security Act.
In compliance with Section 1902 (a) (57) of the Social Security Act, hospitals must:

- Provide written information to patients regarding their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

- Provide written information to individuals regarding the institution's or program's written policies respecting the implementation of the right to formulate advance directives;

- Document in the patient's medical record whether or not an advance directive has been executed;

- Comply with all requirements of state law respecting advance directives;

- Provide (individually or with others) education for staff and the community on issues concerning advance directives; and

- Not condition the provision of care or otherwise discriminate against an individual who has executed an advance directive.

WellCare defines an *inpatient* as a patient who has been admitted to a participating hospital on recommendation of a licensed doctor and is receiving room, board and professional services in the hospital on a continuous 24-hour-a-day basis. Transfers between units within the hospital are not considered new admissions, unless it is a transfer from a medical unit to a psychiatric unit. Refer to the **Utilization Management and Care Coordination section** for more information.

WellCare defines an *outpatient* as a patient who is receiving professional services at a participating hospital, but who is not provided room and board and professional services on a continuous 24-hour-a-day basis. Observation services are also considered outpatient. Observation services usually do not exceed 24 hours.
However, some patients may require 48 hours of outpatient observation services. Refer to the **Utilization Management and Care Coordination section** for more information.

Free-standing (satellite) clinics, which are not operated as part of a hospital, are considered doctors’ offices by WellCare. Services provided in these clinics and other away-from-hospital settings are not covered as hospital services.

Hospital-based clinics, which are operated as part of a hospital, are considered outpatient hospital-based facilities by WellCare. As such, these facilities must follow authorization rules for hospital based services. Refer to the **Utilization Management and Care Coordination section** for more information.

Level of care determinations will be based on InterQual™ Criteria and Medical Director review.

**Documentation and Coding Requirements**

WellCare’s requirements for documentation and coding dictate that written records must be maintained and fully disclose the extent, medical necessity and appropriateness of the setting for services provided. The records must identify the member, support the diagnosis, justify the treatment and document the course of care and results accurately. Written records are subject to audit by WellCare, and coding will be evaluated against chart documentation for accuracy. Refer to the **Utilization Management and Care Coordination section** for more information on retrospective review.

Medical records for WellCare members must include the following:

- Identity of the patient;
- Medical history of the patient;
- Report of relevant physical examination;
- Diagnostic and therapeutic orders;
• Evidence of appropriate informed consent;

• Clinical observations, including the results of therapy;

• Reports and results of procedures and tests;

• Conclusions at termination of hospitalization, evaluation or treatment;

• Condition of the patient upon discharge and instructions given to the patient and family; and

• Signature and date for each entry.

Inpatient medical care records must contain at least the following:

• Identification data including the patient's name, address, date of birth, next of kin and a number that identifies the patient and the patient's medical record;

• Medical history completed within 24 hours of admission, including the chief complaint, details of the present illness, relevant past, social and family histories and an inventory of body systems;

• Relevant obstetrical records and prenatal information;

• Report of the physical examination, completed within 24 hours of admission;

• A statement of conclusions or impressions drawn from the admission history and physical examination;

• A statement of the course of action planned for the patient while in the hospital including a periodic review of the planned course of action, as appropriate;
• Diagnostic and therapeutic orders written by medical staff members (verbal orders must be authenticated);

• Appropriate informed consent;

• Clinical observations;

• Progress notes by the medical staff which give a chronological report of the patient's course in the hospital and reflect changes in condition and the results of treatment;

• Consultation reports that contain the consultant's written opinion and reflect, when appropriate, an actual examination of the patient and the patient's medical record;

• Nursing notes and entries by non-physicians that contain medically relevant observations and information;

• Reports of procedures, tests and their results;

• A pre-operative diagnosis recorded prior to surgery by the individual responsible for the patient;

• Operative report dictated or written on the medical record immediately after surgery containing a description of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis and the name of the primary surgeon and any assistants;

• Reports of pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatment, anesthesia records and any other diagnostic or therapeutic procedures;

• Clinical summary at termination of hospitalization which recapitulates the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient upon discharge and any significant instructions
given to the patient and family;

- In teaching hospitals, the medical record must make it clear that the attending physician is providing professional services independently of the student or resident and that the notes of the student or resident only reflect his/her role as student or resident. At a minimum, the medical record must contain signed or countersigned notes which clearly specify that the physician personally reviewed the history, gave a physical examination and confirmed or revised the diagnosis and prescribed treatment. The attending physician must be recognized by the member as the member's personal physician; and

- Documentation on the discussion of advance directives and/or a completed advance directive form.

WellCare requires all participating hospitals to properly code all relevant diagnoses and surgical and obstetrical procedures on all inpatient and outpatient claims submitted. WellCare utilizes the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) for all coding. In addition, the Physicians' Current Procedural Terminology, Fourth Edition (CPT-4) coding and/or HCPCS is required for all outpatient surgical, obstetrical, injectable drugs, diagnostic laboratory and radiology procedures. When coding, the hospital must select the code(s) that most closely describe(s) the diagnosis(es) and procedure(s) performed. When a single code is available for reporting multiple tests or procedures, that code must be utilized rather than reporting the tests or procedures individually.

WellCare tracks billing codes and providers who continue to apply incorrect coding rules. Providers will be educated on the proper use of codes as a part of the retrospective review process. Should a provider continue to repeat the inappropriate coding practice, the provider will be subject to an adverse action.

WellCare utilizes the National Uniform Billing Form for billing (inpatient and outpatient) hospital services.
Prior authorization is the process of obtaining authorization in advance of rendering a service which may or may not require a medical record review and is required for elective or non-urgent services designated by the Plan. Prior authorization is conducted prior to a member's admission, stay, other service or course of treatment in a hospital or other facility. The attending physician is responsible for obtaining the prior authorization of the elective and/or non-urgent admission. An authorization is the approval necessary for payment to be granted for covered services and is provided only after the Plan agrees the treatment is necessary and a covered benefit. Refer to the Utilization Management and Care Coordination section for more information.

Hospitals should use inpatient-qualifying criteria such as InterQual™ to determine the appropriateness of an inpatient admission as well as conduct concurrent review of the patient’s condition. The patient should remain hospitalized until the same criteria indicate hospitalization is no longer necessary. WellCare will notify providers at least 30 days prior to the date of any changes in the criteria or version of criteria being used to certify inpatient admissions via posting to WellCare Web site or other means.

In determining if a member's condition requires inpatient care, WellCare looks to the medical necessity using inpatient-qualifying criteria such as those published by InterQual™. If the member is admitted, he/she must remain hospitalized until concurrent review performed by the hospital indicates discharge is necessary.

There is no limit on the number of days Medicaid allows for medically necessary inpatient hospital care with the exception of a limitation for psychiatric care. If a member is re-admitted to the hospital for the same or related problem within three days of discharge, it is considered the same admission. All admissions are subject to medical justification and WellCare may request documentation to substantiate medical necessity and appropriateness of
setting. Documentation must be provided upon request in pre-payment or post-payment review. Failure to show appropriate medical justification may be cause for denial, reduction or recoupment of reimbursement.

WellCare defines *inpatient emergency medical services* as those that are medically necessary as a result of a sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily part or death of the individual.

For additional reimbursement for cost outliers or unusually expensive admissions, WellCare follows Georgia’s Department of Community Health (DCH) guidelines when determining payment for each submitted case.

Hospital admission for diagnostic purposes is covered only when the services cannot be performed on an outpatient basis.

Certain services may only be reimbursed when performed on an outpatient basis unless medical necessity for an inpatient admission is documented and authorized. Diagnostic procedures such as chest X-rays are covered as part of the inpatient admitting process only when:

- The test is specifically ordered by a physician responsible for the patient’s care;

- The test is medically necessary for the diagnosis or treatment of the individual patient’s condition;

- The test does not unnecessarily duplicate the same test done on an outpatient basis before admission, or done in connection with a recent admission; or

- The test is billed with the admission.

Any outpatient services performed three days prior to or after an inpatient admission are included in the inpatient reimbursement.
SCOPE OF SERVICES

Section 7

If a hospital determines that an outpatient hospital setting would have met the medical needs of a member after the services were provided in an inpatient setting, the services may be billed to WellCare as outpatient if the claim is received within 180 days of the ending date of the service month. If the claim is received more than 180 days after the ending date, the services are not covered.

To substantiate the determination, a physician’s order must document the member’s status at the time of admission and any changes in the member’s status.

Reimbursement for psychiatric services is limited to short term acute care. The maximum length of stay considered for reimbursement by WellCare, or WellCare’s Delegated Behavioral Health Agent, is 30 days. Psychiatric admissions which have a length of stay in excess of 30 days will be denied reimbursement.

If a member is admitted as an inpatient for less than 24 hours in duration, the admission is subject to a medical necessity of admission review by WellCare. A length of stay less than 24 hours is considered observation and is therefore considered an outpatient service. Outpatient services billed as inpatient are subject to denial or recoupment after review for medical necessity.

Intermediate care (i.e., step-down units) is reimbursable at the semi-private room rate.

Observation

WellCare defines *observation services* as those services furnished by a hospital, including use of a bed and periodic monitoring by a hospital’s nursing or other staff. Observation services are covered when it is determined they are reasonable and necessary to evaluate an outpatient’s condition or to determine the need for a possible admission to the hospital as an inpatient.

Such services are covered only when provided by the order of a physician or another individual authorized to admit patients to the hospital or to order outpatient tests. Observation services usually do not exceed 24 hours, however, some patients may require 48 hours of outpatient observation services.
In only rare and exceptional cases, outpatient observation services span more than 48 hours.

When a member is placed under observation by a hospital, the patient is considered an outpatient until the patient is admitted as an inpatient. While under observation, the hospital may determine the patient needs further care as an inpatient admission or the patient may improve and be released. When medical necessity dictates an inpatient admission of a patient in observation, this should be billed under revenue code 762, as referred to in the billing instructions, (see the Forms section) which reflects this transaction. Observation is a covered revenue code on an inpatient claim.

WellCare does not cover outpatient observation services in the following situations:

- Complex cases requiring inpatient care, post-operative monitoring during the standard recovery period;
- Routine preparation services furnished prior to diagnostic testing in the hospital outpatient department and the recovery afterwards; or
- Observation billed concurrently with therapeutic services such as chemotherapy, physical therapy, etc.

A member may only transfer from outpatient status to inpatient status if it is determined that that inpatient services are medically necessary and meet InterQual™ criteria. In order for the services to be covered, certification must be obtained within one business day of the beginning date of this episode of care. To receive authorization for an inpatient admission, WellCare must receive documentation indicating the admission is medically necessary and appropriate.

The date of the inpatient admission will be the actual date the patient is formally admitted as an inpatient and will count as the first inpatient day. When a patient is admitted to the hospital from outpatient observation, all observation charges must be combined and billed with the inpatient
charges beginning from the date of initial observation. Outpatient observation services should not be used for services for which an overnight stay is normally expected. Services such as complex surgery, clearly requiring inpatient care may not be billed as outpatient.

WellCare only covers services that are medically appropriate and necessary. Failure to obtain the required authorization will result in denial of reimbursement of all services provided and extends to all professional services, not just the hospital.

Medical appropriateness and necessity including that of the medical setting must be clearly substantiated in the member's medical record. If it is determined the outpatient observation is not covered, then all services provided in the observation setting are also not covered. Services provided for the convenience of the patient or physician and that are not reasonable or medically necessary for the diagnosis are not covered.

**Hospital-Based Physicians, Certified Registered Nurse Anesthetists and Nurse Practitioners**

All inpatient and outpatient professional services must be billed on the physician's claim form.

Hospital-based physicians, Certified Registered Nurse Anesthetists (CRNAs), specified nurse practitioners and Physician Assistants (PAs), may designate the hospital as payee by agreement. The hospital must maintain each agreement authorizing such payments on file.

Services rendered to eligible members by hospital-based physicians, CRNAs, designated nurse practitioners and PAs will be covered both on an inpatient and outpatient basis as long as the services are medically necessary and within the contractual or financial agreement with the hospital. These services are subject to retrospective review by WellCare or its authorized agents.

**Transplant Services**

WellCare covers all services and supplies related to covered transplant services for eligible members. All transplants for eligible WellCare members under the age of 21 are covered as required by the DCH contract.
Heart, lung and heart/lung transplants are not covered for members ages 21 and older.

Prior authorization is required for all transplants regardless of the member’s age.

**Dialysis** Services for dialysis require prior authorization and must be rendered at a contracted facility.

**Rehabilitation Services** Rehabilitation services as defined by federal regulation are not covered by WellCare. However, short-term rehabilitation services are covered by WellCare for members if services are received immediately following treatment for acute illness, injury or impairment. Short-term rehabilitation services include physical therapy, occupational therapy and speech therapy and are covered when the conditions listed below are met:

- The member’s physician must establish a written treatment plan that includes the services received as well as identifies the rehabilitation potential, sets realistic goals and measures progress. The plan must also include the type of modalities and procedures, frequency of visits, estimated duration, diagnosis, functional goals and recovery potential.

- Authorizations must be obtained by the physician every five business days to ensure the services rendered are necessary. When requesting an extended authorization, the physician must include the date of the initial acute illness, injury or impairment, the diagnosis and an estimate of the duration of service.

- The services must be of such a level of complexity and sophistication or the member’s condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified therapist.

- The physician’s prognosis must include an expectation that the member’s condition will improve significantly in a reasonable period of time,
or the development of an effective maintenance program relies on the services being provided to treat a specific disease state.

- The plan for the member’s treatment must include an amount, frequency and duration of services that are reasonable under accepted standards of practice.

**Hospitalist Program**

Hospitalists provide attending physician coverage in selected markets for members admitted to contracted facilities. Hospitalists provide the following services:

- Emergency room assessment of a member;
- Direct admissions to facilities where the PCP may not provide that service;
- Manages care as needed throughout the inpatient medical admission for members, excluding obstetrical and gynecological cases; and
- Refer members to the PCP upon discharge for follow-up care and communicating the treatment/discharge plan verbally within 24 hours and in writing within seven days.

**Emergency Room and Outpatient Services**

Emergency services shall be available 24 hours a day, seven days a week to treat an emergency medical condition.

An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms. An 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 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: (i) that there is not adequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

WellCare provides payment for emergency services when furnished by a qualified provider, regardless of whether that provider is in the WellCare network. These services are not subject to prior authorization requirements. WellCare will pay for all emergency services that are medically necessary until the member is stabilized. WellCare will also pay for any medical screening examination conducted to determine whether an emergency medical condition exists.

WellCare bases coverage decisions for emergency services on the severity of the symptoms at the time of presentation and shall cover emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

The attending emergency room physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding to WellCare, who shall be responsible for coverage and payment.

WellCare will not retroactively deny a claim for an emergency medical screening examination because the condition, which appeared to be an emergency medical
condition under the prudent layperson standard, turned out to be non-emergency in nature. The determining factor for payment liability shall be whether the member had acute symptoms of sufficient severity at the time of presentation. Payment shall be at either the rate negotiated under the provider agreement, or the rate paid by WellCare under the Medicaid Fee-for-Service Agreement.

WellCare may establish guidelines and timelines for submittal of notification regarding provision of emergency services, but will not refuse to cover an emergency service based on the emergency room provider, hospital or fiscal agent’s failure to notify the member’s PCP, or WellCare representative, of the member’s screening and treatment within said time frames.

The member can not be billed for the screening and/or treatment needed stabilize the patient.

Once the member’s condition is stabilized, unplanned urgent admissions must be followed by:

1. Notification to WellCare by calling the Provider Hotline and reporting the urgent or emergent admission.

   The caller should provide the following:

   a) Member’s name
   b) WellCare member ID number
   c) Name of admitting hospital
   d) Referring physician
   e) Diagnosis of member

2. Additional clinical information submitted to WellCare by the next business day for utilization in making a final authorization determination.

Emergency room visits that cannot be documented as true medical emergencies or potential medical emergencies will be reimbursed at a triage rate of $50, or as otherwise specified in the Hospital contract. The $50 rate covers all ancillary services rendered as well as the fee for use of the emergency room. The rate of $50 may be subject to the hospital's contracted reimbursement rate; in other words,
$50 may not be the reimbursement rate in all cases. This $50 rate includes any applicable member co-payment. The $50 rate is for the medical screening examination and stabilization services provided in the emergency room without regard to prior authorization.

If the hospital believes the medical record supports the existence of a true emergency situation, but the initial presenting information on the claim may not be identified as a true emergency, the claim may be submitted by hard copy with documentation. The claim will pend for medical review against the prudent layperson criteria and applicable payment applied.

If a $50 triage rate was received, and the presenting claim did not clearly provide information for determining the presence of an emergency, additional documentation may be submitted for a medical retrospective review. A single form can be submitted with one or multiple claims. Each claim submitted should contain new information which provides complete insight on the member’s visit to the ER. All claims will be reviewed within an average of 15 business days and a follow-up letter of determination (upheld or overturned) will be sent for each claim. In the event a claim decision is overturned, WellCare will automatically reprocess the claim at the appropriate ER payment rate determined by the provider contract. In the event the ER Triage decision is upheld through this informal ER reconsideration process, you can still submit the claim for review under the formal appeals process. Submit all retrospective ER review requests utilizing the **ER Medical Review Request form**.

If, after medical review, the determination is made that an emergency or potential emergency did in fact exist, the services will be reimbursed at the hospital's specific outpatient rate. Accurate coding is critical to ensure proper reimbursement.

In non-emergency situations where the provider may be able to identify a chronic abuser of the emergency room, the provider may exercise its right to advise the member that they will not be accepted as a WellCare member and in the event the member elects to receive services, the member will be responsible for all charges incurred.
If a member is not accepted for treatment as a WellCare member, hospitals should offer the following alternatives to the member:

- Refer the member to a specific alternate health care setting where he/she can obtain care the same day or next day;

- Instruct the member as to the generally appropriate setting for treatment for such a condition in the future.

There is no limit imposed on the number of visits allowed per day per member in true medical emergencies. However, more than one non-emergency visit, by the same member, to the same hospital, in one day is subject to review for medical necessity and possible denial depending on the individual situation.

**Non-Covered Inpatient Services**

WellCare does not cover the services and procedures listed below. In addition, any services related to, required in preparation for, or as a result of non-covered services are also not covered.

- Services and supplies which are inappropriate or not medically necessary as determined by WellCare or other authorized agent;

- Services or procedures performed which are not in compliance with the policies and procedures contained in this handbook;

- Miscellaneous and non-specific charges;

- Non-acute levels of care;

- Utilization review;

- Differential service charges; i.e., "STAT" or priority, after-hours or "call-back" fees;

- Late charges defined as a portion of the charges for a given service omitted from the original billing, which included some of the charges for that given
service, are non-covered. If the total charges for a given service were omitted from the original billing, a positive adjustment may be requested.

- Services mandated to be performed only on an outpatient basis;

- Clinic services while the member is an inpatient;

- Inpatient leave of absence;

- Patient or family education or supplies;

- Nursing services, including services traditionally accepted as nursing care even though provided by other ancillary departments;

- Private duty nurses, sitters or companions;

- Service charges for individual areas within the hospital; i.e., pharmacy dispensing fee, IV admixture fee (except for hyper alimentation), cover charge for central supply, charges for handling and distribution of supplies, transportation within the hospital, equipment installation, specimen collection, venipuncture, standby equipment, staff time and evaluations;

- Resuscitation, code, CPR (cardiopulmonary resuscitation), etc are non-covered. However, supplies associated with this service will be reimbursed.

- Investigational items and experimental services, drugs or procedures;

- Any services or items furnished for which the hospital does not normally charge;

- Services provided by an institution for mental disease or special disorders;

- Separately billed equipment and supplies which are integral parts of hospital care and the area in which care is being provided; i.e., cardiac monitor in ICU,
light source in or, call system, blood pressure cuffs and monitors, specimen collection devices and containers, etc.;

- Hospital based therapy services for treatment of chronic conditions;

- Private rooms are non-covered services. However, if the member has a condition that requires an isolation room or special care unit (ICU, CCU), those are reimbursable. All other accommodations are reimbursed at the semiprivate room rate.

Upon admission, members should be notified that private rooms are non-covered services. Members who request a private room after being informed of WellCare’s policy will be responsible for the difference between the hospital's semi-private and private room rates.

If the member has a condition that requires an isolation room or special care unit or if the hospital only offers private rooms or only has private rooms available, the member cannot be billed for the difference between the semi-private room rate paid by WellCare and the private room rate.

- Services which are not medically necessary to the patient's well-being; i.e., television, telephone, combs, brushes, guest meals, cots, etc.;

- Non-consumable multiple supply items; i.e., bath basins, admission kits, disposable pillows, etc.;

- Take-home prescription drugs, medical supplies, durable medical equipment and artificial limbs and appliances are non-covered;

- Cosmetic surgery or mammoplasties for aesthetic purposes;

- Infertility procedures and related services;

- Some situations concerning abortions, sterilizations and hysterectomies. See Limits to Abortions,
Sterilizations and Hysterectomy Coverage for details.

- Tubal reanastomosis procedures pertaining to sterilizations and vasectomies;

- Preventive health care; Members under age 21 may receive this care through the EPSDT screening process.

- The ICD-9-CM procedure codes listed below.
  - 08.9 Other operations on eyelids
  - 08.91 Electrosurgical epilation of eyelid
  - 08.92 Cryosurgical epilation of eyelid
  - 08.93 Other epilation of eyelid
  - 18.01 Piercing of ear lobe
  - 18.5 Surgical correction of prominent ear
  - 18.9 Other operations on external ear
  - 20.95 Implantation of electromagnetic hearing aid
  - 23.3 Restoration of tooth by inlay
  - 63.82 Reconstruction of surgically divided vas deferens
  - 63.84 Removal of ligature of vas deferens
  - 64.5 Operations for sex transformation, not elsewhere classified
  - 64.94 Fitting of external prosthesis of penis
  - 64.95 Insertion or replacement of non-inflatable penile prosthesis
  - 64.97 Insertion or replacement of inflatable penile prosthesis
  - 66.79 Other repair of fallopian tube
  - 83.92 Insertion or replacement of skeletal muscle stimulator
  - 85.5 Augmentation mammoplasty
  - 85.50 Augmentation mammoplasty, not otherwise specified
  - 85.51 Unilateral injection into breast for augmentation
  - 85.52 Bilateral injection into breast for augmentation
  - 85.53 Unilateral breast implant
  - 85.54 Bilateral breast implant
  - 85.99 Other
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- 86.64 Hair transplant
- 86.82 Facial rhytidectomy
- 86.92 Electrolysis and other epilation of skin

Non-Covered Emergency Room and Outpatient Services

Not all emergency room and outpatient services are covered benefits for WellCare members.

Those listed below as well as any services related to these services are non-covered:

- Services or procedures performed which are not in compliance with the policies and procedures contained in this handbook;

- Routine physical examinations;

- Investigational items and experimental services, drugs or procedures;

- Services provided free of charge to the public by the hospital, county health departments, state laboratory or other state agencies; i.e., immunizations, metabolic screens for members under one year of age, etc.;

- Any services and supplies which WellCare or an authorized agent deems as inappropriate or not medically necessary;

- Any services or items furnished for which the hospital does not normally charge;

- Services non-covered or denied by WellCare because they were provided on an inpatient basis;

- Non-acute levels of care;

- Separately billed equipment and supplies which are integral parts of hospital care and the area in which care is being provided, i.e., cardiac monitor in ICU, light source in or, call system, blood pressure cuffs and monitors, specimen collection devices and containers, etc.;
Late charges defined as a portion of the charges for a given service omitted from the original billing, which included some of the charges for that given service, are non-covered. If the total charges for a given service were omitted from the original billing, a positive adjustment may be requested;

Take-home prescription drugs, medical supplies, appliances and durable medical equipment are also non-covered;

Differential service charges; i.e., "STAT" or priority, after-hours or "call-back" fees;

Resuscitation, code, CPR (cardiopulmonary resuscitation), etc. are non-covered. However, supplies associated with this service will be reimbursed;

Service charges for individual areas within the hospital; i.e., pharmacy dispensing fee, IV admixture fee (except for hyper alimentation), cover charge for central supply, charges for handling and distribution of supplies, transportation within the hospital, equipment installation, specimen collection, venipuncture, standby equipment, staff time and evaluations;

Nursing services, including services traditionally accepted as nursing care even though provided by other ancillary departments;

Some situations concerning abortions, sterilizations and hysterectomies. See Limits to Abortions, Sterilizations and Hysterectomy Coverage for details;

Tubal reanastomosis procedures pertaining to sterilizations and vasectomies;

Infertility procedures and related services;
• Patient or family education or supplies; and
• Cosmetic surgery or mammoplasties for aesthetic purposes.

Out-of-State Providers and Service Limitations

Out-of-state hospital providers not contracted with WellCare will be reimbursed for covered services provided to eligible WellCare members while out-of-state if the claim is received within 180 days from the date of service, and if at least one of the following conditions is met:

• The hospital provider preauthorized the service through WellCare; or

• The service was provided to the WellCare member as a result of an emergency or life-endangering situation occurring out of state. If the out-of-state provider believes the medical record supports the existence of an emergency situation but the diagnosis does not justify an emergency, the claim must be submitted with a copy of the medical record.

While out-of-state providers are eligible for reimbursement, the Medicaid program does not reimburse providers located outside the continental United States.

Routine health care or elective surgery provided by out-of-state providers is not covered unless prior authorization is obtained from WellCare. In order to receive prior authorization, the referring in-state provider is required to request prior approval by documenting in writing the medical necessity of obtaining services out-of-state and providing the name and address of the out-of-state medical provider. Provider reimbursement and coverage of out-of-state services are determined in accordance with current policies and procedures of WellCare and are contingent upon the patient's eligibility at the time services are provided.

Requests for prior approval or questions regarding out-of-state services must be directed to WellCare’s Provider Hotline. See the Quick Reference Guide for contact information.
If services are pre-authorized, a copy of the authorization letter from WellCare must be attached to out-of-state claims submitted for reimbursement.

Services rendered due to an emergency or life-endangering situation do not have to be pre-authorized.

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
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- 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
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- 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
## Prior Authorization Requirements

For details on the notification, prior authorization, concurrent review and retrospective review process refer to the [Utilization Management and Care Coordination section](#).
Overview

The focus of WellCare’s Utilization Management (UM) Program is to provide members access to quality care and to monitor the appropriate utilization of services.

WellCare’s UM Program has five principal functions:

1. Admission and continued stay review;
2. Data gathering;
3. Retrospective assessment;
4. Case management; and
5. Discharge coordination.

Program Objectives

- To ensure that a WellCare member receives care in the most appropriate and cost-effective setting for the treatment of his/her medical condition;
- To ensure that participating WellCare providers render appropriate, cost-effective quality services;
- To appropriately treat the member’s medical condition through services determined to be medically necessary;
- To ensure that participating hospitals monitor patient care by establishing and administering effective utilization review plans;
- To ensure that members receive necessary services that meet currently accepted professional quality standards of medical practices;
- To track a member’s care to ensure he/she is not subject to over-utilization or under-utilization of medical services.

Activities and Services Encompassed by the Program

WellCare’s UM Program includes, but is not limited to:

- Plan of treatment;
- Discharge planning and coordination;
• Oversight of hospital utilization review committee monitoring activities;

• Authorization of need for acute care;

• Review of need for continued stay;

• Post payment review and assessment, including length of stay and ancillary service review;

• Data gathering; and

• Referral for educational services.

Review Functions for Authorized Hospitals

Hospitals must meet the federal and state requirements for control of utilization of inpatient services including:

• Authorization and re-authorization of the need for acute care;

• Treatment pursuant to a plan of care; and

• Operation of utilization review plans.

At the time a WellCare member is admitted into a hospital for inpatient services, the admitting physician must certify that the inpatient services are medically necessary. The authorization must be made at the time of admission, or in the case of pending eligibility, before Medicaid payment is authorized. This requirement can be met by a comprehensive note in the medical record at the time of admission.

The attending physician, or authorized representative, must re-certify that inpatient services continue to be medically necessary and appropriate to the acute care setting. This requirement can be met by a comprehensive progress note in the medical record at least every two days.

WellCare requires that a written plan of care be completed for each member prior to authorization for payment before
admission to a hospital for elective admissions, within 24 hours for emergency admissions or, for pending Medicaid eligibles. The plan should be multi-disciplinary and should include at least the attending physician and the nursing staff. The plan must include:

- Diagnoses, symptoms or complaints indicating the need for admission;
- A description of the functional level of the individual;
- Medication or treatment orders;
- Diet and activity level;
- Plans for hospital course; and
- Plans for discharge.

In order to provide the best care possible for members, the Plan requires that all planned inpatient hospital admissions/observations and all outpatient procedures be prior approved.

For services requiring prior authorization, and for the telephone number of the Utilization Management Department, refer to the Quick Reference Guide.

The goal of prior authorization is to ensure that medically necessary, cost-effective services are provided to eligible WellCare members. Prior authorization is necessary for reimbursement; however, it does not guarantee payment. In addition, the requirement for prior authorization pertains to medical necessity and appropriateness of setting. The member must be eligible with the Plan at the time the service is rendered. The hospital medical record must substantiate the medical necessity including the appropriateness of the setting for the services provided and billed to WellCare. All services are subject to review for medical necessity.
The Plan has up to 14 calendar days to determine whether a service requested is a medically appropriate and covered service. When possible, decisions on prior authorization will be rendered by the Plan within two business days after adequate medical information has been received to determine medical necessity and appropriate level of care.

FAILURE TO OBTAIN THE REQUIRED AUTHORIZATION WILL RESULT IN DENIAL OF THE CLAIM.

Procedures for Obtaining Prior Authorization for All Medical Services Except Dental Services and Liver Transplants

The attending physician or hospital staff is responsible for obtaining prior authorization from WellCare and for providing the prior authorization number to each WellCare provider associated with the case; i.e., assistant physician, hospital, etc. Failure to obtain prior authorization will result in denial of payment.

Requests for prior authorization should be submitted at least 10 business days prior to the planned admission or procedure. Once a procedure is approved, the approval is only valid for 90 days from the date of issuance.

In cases when prior authorization has been obtained for an outpatient procedure, and during the procedure it is determined that the member requires an additional or different procedure, that procedure will be considered an urgent procedure. The hospital's request for an update of the prior authorization will be considered timely if received within one business day of the date of the procedure.

When prior authorization has been obtained for an outpatient procedure, and after the procedure has been performed it is determined that the member requires inpatient services, the admission should be considered an emergency. The hospital should notify WellCare of the admission within 24 hours, and the request for an update of the prior authorization should be considered timely if received within one business day of the beginning date of the episode of care.
UTILIZATION MANAGEMENT
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Hospital requests for updates of prior authorization and retroactive authorizations of inpatient admissions following a procedure will be denied if it is determined that the procedure clearly required an inpatient level of care that should have been anticipated.

When it is determined that a member with outpatient observation status requires inpatient services, the request for authorization must be received within one business day of the beginning of the episode of care.

Procedures for Obtaining Prior Authorization for Dental Services Requiring Hospitalization

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 prior authorization number to the hospital. The failure of the attending dentist to obtain the correct prior 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 number listed on the Quick Reference Guide.

Procedures for Obtaining Prior Authorization for Transplants

In order to receive prior authorization for a transplant, a written request with medical records must be received by WellCare for review. This pertains to liver, bone marrow, kidney and cornea transplants as well as medically necessary heart, lung and heart/lung transplants for members under the age of 21. These records must include current medical history, pertinent laboratory findings, X-ray and scan reports, social history and test results that exclude viremia and other relevant information.

Transplant procedures and related services must be approved by WellCare prior to the transplant, regardless of the age of the member. Once a transplant procedure is approved, a prior authorization number will be assigned. The member must be eligible at the time services are provided, and these services cannot be approved retroactively.
For requests for approval of coverage of all transplant services, contact the Plan’s Utilization Management department at the telephone number listed on the Quick Reference Guide.

Procedures for Obtaining Prior Authorization for Observation Services

All observation services require prior authorization. Observation should be considered if the patient does not meet acute care criteria, and any of the following apply:

- Diagnosis, treatment, stabilization and discharge can reasonably be expected within 24 to 48 hours;
- Treatment and/or procedures will require more than six hours observation;
- The clinical condition is changing and a discharge decision is expected within 24 hours;
- Unsafe for patient to return home/caregiver unavailable (arrangements need to be made for a safe and appropriate discharge setting such as SAC/SNF, Home Care, etc.);
- Complications or extended observation post ambulatory surgery/procedure;
- Symptoms unresponsive to at least four hours emergency room treatment; or
- Psychiatric crisis intervention/stabilization with observation every 15 minutes;

At 24 hours, if the patient is not stable for discharge, acute care criteria will be applied, and observation will be extended up to 48 hours.

The decision to admit a patient continues to be the responsibility of the treating provider. If cases arise where the circumstances would pose a hazard to the patient's health and/or safety and the appropriate setting is in question, then the case should be referred to secondary review.
FAILURE TO OBTAIN THE REQUIRED AUTHORIZATION WILL RESULT IN DENIAL OF THE CLAIM.

Concurrent Review

The Plan’s concurrent review involves oversight of members admitted to hospitals, rehabilitation centers, skilled nursing facilities and other inpatient settings. The concurrent review nurse follows the clinical status of the member on an ongoing basis through telephonic or onsite chart review and communication with the physicians and/or other health care professionals involved in the member’s care. The concurrent review process incorporates the use of clinical guidelines developed from peer-reviewed, evidence-based literature to assess quality care and the appropriate level of care for continued medical treatment. Reviews are performed by licensed nurses under the direction of the Plan medical director.

Integral to the concurrent review process is notification by the hospital of unplanned (usually urgent or emergent) inpatient and observation status admissions.

- Hospitals must notify Wellcare by phone within 24 hours of the admission. No medical authorization will be made at this time, unless all clinical information is provided. Clinical information must be provided on the next business day if not already presented at the time of notification.

- WellCare has staff available 24 hours a day, seven days a week. If a hospital would like to have an immediate authorization decision rendered, and is able to provide clinical information at the time of notification, the call will be transferred to the nurse review staff (or on-call nurse) to provide a response within one hour.

- A WellCare nurse will review the clinical information, and will respond to the facility with an authorization status decision within one day after reviewing the information.
• If a member is admitted, and subsequently discharged before the next business day (i.e., over a weekend) the facility must still notify WellCare, and provide clinical information so that an authorization decision can be made.

• Facilities must notify WellCare of admissions for the delivery of newborn or stillborn babies. Notification should be by fax, using the Inpatient Authorization Form, within 24 hours of the birth. Baby clinical information (gender, weight, date of birth) must be provided no later than the next business day, if not included in the initial notification. WellCare will respond to the facility with an authorization number within two business days of the receipt of complete information.

Based on professionally generated criteria, WellCare will review all admissions to and services provided in an acute care setting. All participating hospital reviews must be in compliance with procedures outlined in the hospital’s utilization review plan. An entry must be made in the utilization review notes on the review date, indicate the name and title of the reviewer and be signed by the reviewer. This entry must also indicate the severity of illness/intensity of service (SI/IS) criteria that was met for medical necessity of the hospital stay. Failure to document the SI/IS criteria in the utilization review notes may result in the denial of reimbursement of your claim.

If the hospital utilizes an electronic entry system for utilization review, the entry must indicate a unique identifier with the name and title of the reviewer on file as well as the date the entry was made.

After-Hours Utilization Management

The Plan provides authorization of inpatient admissions 24 hours a day, seven days a week. Physicians requesting after-hours authorization for inpatient admission should refer to their Quick Reference Guide for the number to contact an after-hours nurse. Discharge planning needs that may occur after normal business hours will be handled by the Plan’s after-hours nurse.
Plan Criteria for Utilization Management Decisions

The Plan’s UM department utilizes various criteria, which may include the following, when making coverage determinations:

- Member benefits
- Local and federal statutes and laws
- InterQual
- Medicaid/Medicare guidelines
- Hayes Health Technology Assessment

Retrospective Review

Retrospective authorization 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 30 calendar days of receipt of necessary information. All services are subject to retrospective review. Prior authorization or concurrent review decisions will not be reversed unless the Plan receives information that contradicts the information given when the initial determination was made.

WellCare will also conduct retrospective medical record reviews. WellCare will request medical records, usually once per month, and perform a random audit of the records. The review will focus on identifying conflicts in the coded claims compared to the information documented in the medical record. Depending on the situation, WellCare will communicate via phone and letter outlining the specific coding errors. Additional follow-up will occur in the event the coding trends continue after education and review with the respective facility.

Expedited Organization Determination

The Plan has up to 14 calendar days to determine whether a service requested is a medically appropriate and covered service. In some cases, a member has the right to a decision within 24 hours of a request. Plan members can get an expedited decision if their health or ability to function could be seriously harmed by waiting 14 days for a standard decision.
If a member desires an expedited decision, the request for such must be submitted through a verbal or written request to the Plan, or requested by the referring provider. The receipt of the request will be documented by the Plan. If the member’s request is determined to be valid, and a delayed decision would negatively impact the member’s health, the Plan will deliver an expedited decision. If the member’s health is not likely to be impacted by a wait of up to 14 days for a decision, the request will be processed within 14 days. If any physician requests an expedited decision, it will be granted.

**Extension for Standard Organization Determination**

An extension of up to 14 calendar days for the Plan to render an authorization decision is permitted, if the extension of time benefits the member. For example, if the member requires additional time to obtain and provide the Plan with requested documents, the Plan could offer an extension on the decision for authorization.

**Case Management**

While the provision of health care services and the exercise of professional medical judgment is the purview of treating physicians and other health care providers, case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual’s health needs, using communication and available resources to promote quality, cost-effective outcomes. Case management emphasizes continuity of care for the members through the coordination of care among physicians and other providers. Case management is not an episode but occurs across a continuum of care, addressing ongoing individual needs rather than being restricted to a single practice setting.

- PCPs serve as principal case manager and coordinator of care. The Plan’s Case Management team serves a support capacity to the PCP and assists in coordinating care actively linking the member to providers, medical services and residential, social and other support services where needed.
• The Case Management team is comprised of specially qualified nurses who, through the case management process, assess the member’s risk factors, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the treatment plan.

• The Plan has incorporated Case Management programs that manage members with specific health care needs such as catastrophic diseases (adult and pediatric), transplants, wounds, HIV and obstetrics. The physician may call to request case management services for any of the Plan members.

• The Plan has adopted practice guidelines that are based on valid and reliable clinical evidence from the American College of Obstetrical and Gynecology (ACOG) for the OB program, the Case Management Society of America (CMSA) standards of care and the Agency for Health Care Research and Quality (AHRQ) for the wound care program.

**Discharge Coordination**

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 lower 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.

**Lock-In Members**

WellCare may “lock in” or restrict the number of providers from whom a member may receive services. Members who have demonstrated a pattern of utilization abuse are placed in the program once they have failed to correct the
behavior even after notification from WellCare and counseling.

In the “lock-in” program, a member who has consistently utilized services at a frequency or amount that is not medically necessary is locked in to a single physician and pharmacy provider selected by the Plan. The provider chosen will be geographically situated to give reasonable access to the member. The initial lock-in period will not exceed 12 months. Following the lock-in period, the member’s usage is re-evaluated to determine if continuation of the restriction is necessary. A member facing lock-in will be given notice of a hearing prior to the lock-in. A lock-in does not apply to emergency services or if a specialized provider is medically necessary.

The physician and pharmacy selected by WellCare to participate in the lock-in will be contacted by the Plan prior to the start of the lock-in period, and that physician and/or pharmacy may decline to participate.

Claims submitted for a lock-in member by providers other than those selected will be denied.

If a hospital suspects a member seeking services of a non-emergent nature is in the lock-in program, the hospital should contact the physician listed on the member’s Medicaid ID card. The physician listed on the ID card is to be considered the member’s attending physician and should be consulted prior to providing services of a non-emergent nature. Hospitals should be alert to possible abuse of emergency room services to prevent the hospital from incurring costs for non-reimbursable expenditures.

Further, hospitals are asked to identify and report emergency room abuse by Medicaid members who are not currently monitored by the "lock-in" program to WellCare. See the Quick Reference Guide for contact information.
PATIENT SAFETY PROGRAM

Overview

WellCare is committed to improving safety and reducing medical errors for patients within the hospital. Participating hospitals are required to have a Patient Safety Program (Program) to address concerns or complaints regarding clinical care.

Program Requirements

Each participating hospital must implement a Program with the following requirements:

- A system of classifying complaints according to severity;
- Uniform reporting standards and definitions for adverse patient events;
- A summary of incident(s), including the final disposition, included in the provider profile;
- A review by the medical director, physician advisor, chief of staff or department chairperson and a mechanism for determining which incidents will be forwarded to peer review and credentialing committees;
- Peer review protected infrastructure to promote reporting and sharing of information on patient safety and medical errors;
- Provider education to promote adoption of patient safety practices into their clinical practice guidelines and standards;
- Safety alerts for quick communication of strategies to prevent errors identified as the most frequently occurring types of sentinel events and other patient safety risk factors;
- The sharing of evidence-based best practices for reducing medical errors, improving patient safety and enhancing quality of care; and
PATIENT SAFETY PROGRAM

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- Participating agreements, which require the implementation of internal programs for corrective actions and continuous improvement.

The participating hospital shall:

- Develop and implement an ongoing, proactive program for defining, identifying and managing risks to patient safety and medical errors throughout the organization with defined executive responsibility for the program;

- Measure the effectiveness of process and system improvements;

- Establish data reporting systems for the collection of data on defined processes that affect patient safety; and

- Implement pertinent best practice for reducing medical errors and enhancing positive care outcomes.

Program Compliance

All network facilities accredited by the Joint Commission of the Accreditation of Healthcare Organizations (JCAHO), as a component of that accreditation, are expected to be actively working to comply with JCAHO National Patient Safety Goals, established in 2003.

WellCare will periodically assess the status of the facility’s efforts to improve patient safety through application of JCAHO standards and further communicate performance improvement findings to WellCare members and providers. WellCare will also seek out and publicize any best practices identified in the promotion of patient safety in the hospital setting.

If a hospital has not been accredited by JCAHO and has not implemented a Program, WellCare will require the hospital to submit a plan of action for Program creation. If the plan of action is approved, WellCare will permit the
hospital to become compliant with policy within a prescribed time period provided the plan of action is implemented.

In addition, on an annual basis, WellCare will define specific measures to be monitored as indicators of safe clinical care. These will be communicated through the provider newsletters.
ADMINISTRATIVE REVIEWS
AND GRIEVANCES

Overview
The Plan maintains distinct grievance and administrative review processes for members and providers, as well as access to the state’s hearing system. Providers have the right to participate in these processes on behalf of patients and to challenge failure by the Plan to cover a specific service. Members, or their representatives, can call the Customer Service department to file an administrative review request or a grievance.

Definitions
An *administrative review* is a request for review of an action taken by or on behalf of the Plan. A member, a member’s representative, or a provider acting on behalf of the member may file an administrative review. Examples of actions that can be administratively reviewed include, but are not limited to, the following:

- Denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the state.

A *grievance* is an expression of dissatisfaction about any matter other than an action that can be administratively reviewed. Specifically, a *grievance* is an expression of dissatisfaction with any aspect of the managed care Plan or provider’s operation, provision of health care services, activities or behaviors. A member or a member’s representative acting on behalf of the member and with the member’s written consent, may file a grievance within 90 days of the date the member became aware of the issue.
ADMINISTRATIVE REVIEWS
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Possible subjects for grievances include but are not limited to the following:

- Quality of care of services provided;
- Rudeness of the provider or staff; or
- Failure to respect the member’s rights.

The Plan ensures that decision-makers on grievances and administrative reviews were not involved in previous levels of review or decision-making. These decision-makers are health care professionals with clinical expertise in treating the member’s condition/disease, or have sought advise from providers with expertise in the field of medicine related to the request when deciding any of the following:

- An administrative review of a denial based on lack of medical necessity;
- A grievance regarding denial of expedited resolution of an administrative review;
- A grievance or administrative review involving clinical issues.

No health care provider may be penalized by a managed care plan for providing testimony, evidence, records or any other assistance to an enrollee who is disputing a denial, in whole or in part, of a health care treatment or service or claim thereof.

Submission of Member Administrative Reviews

Any party to an action appropriate for administrative review, including a member or a member’s authorized representative, may request that the action be reconsidered.

The member, member’s representative or provider may file a request for an expedited or standard administrative review determination. A provider may file a statement with the member’s administrative review request supporting the
need for an expedited resolution. The request must be a statement by the physician him/herself and not from an office staff member.

The Plan will not take, or threaten to take, any punitive action against any provider acting on behalf or in support of a member requesting a standard or expedited administrative review.

The Plan gives members reasonable assistance in completing forms and other procedural steps for an administrative review, including, but not limited to, providing interpreter services and TTY/TDD toll-free telephone numbers with interpreter capability. To arrange interpreter services, please contact Customer Service for assistance.

Members are provided reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. If the request for reconsideration is submitted after 30 calendar days, then good cause must be shown for the Plan to accept the late request. Examples of good cause include but are not limited to the following:

- The member did not personally receive the Notice of Action, or he/she received it late;
- The member was seriously ill, which prevented a timely administrative review;
- There was a death or serious illness in the member's immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limit;
- The member had incorrect or incomplete information concerning the administrative review process;
• The member lacked capacity to understand the time frame for filing a request for reconsideration.

Questions regarding the filing or status of an administrative review should be directed to Customer Service, which will coordinate with the Appeals department as appropriate. A member of the Customer Service or Appeals team will be in contact with the provider within two business days of the inquiry.

A member, a member’s representative or a provider acting on behalf of the member with a member’s written consent may file an administrative review request verbally or in writing within 30 calendar days of the date on the Notice of Proposed Action.

If filed verbally through Customer Service, the request must then be supplemented with a written, signed administrative review request to the Plan. For verbal filings, the time frame for resolution begins on the date the verbal request was called into Customer Service. The Plan will assist the member to ensure that a written administrative review is filed immediately by converting a verbal filing into a written record. If the member follows the verbal filing with a written administrative review, this administrative review will supersede the written record.

If the member wishes to use a representative, then he/she must complete an Appointment of Representative statement. The member and the person who will be representing the member must sign the statement. An Appointment of Representative form is available in the Forms section of this handbook.

An acknowledgement of receipt will be provided to the person filing the administrative review within ten business days.

The Plan must make a determination on an administrative review within the following time frames:

• Expedited Request: 72 hours
• Standard Pre-Service Request: **30 calendar days**
• Retrospective Request: **45 calendar days**

Members have the right to request continuation of benefits during an administrative review. The member may be liable for the cost of any continued benefits if the Plan’s action is upheld at the discretion of the Georgia Department of Community Health (DCH).

The Plan will continue the member’s benefits if:

The administrative review or hearing request is filed timely, meaning on or before the later of the following:

1. Within 10 calendar days of the date on the Notice of Action (add five calendar days if the notice is sent via U.S. mail); or

2. The intended effective date of the Plan’s proposed action.

• The administrative review involves the termination, suspension or reduction of a previously authorized course of treatment;

• The services were ordered by an authorized provider;

• The original period covered under the original authorization has not expired; and

• The member requests continuation of benefits.

If the Plan continues or reinstates member benefits while the administrative review is pending, the member’s benefits will be continued until one of following occurs:

• The member withdraws the administrative review;

• Ten calendar days pass from the date of the Plan’s Notice of an Adverse Administrative Review
Decision and the member has not requested a Hearing with continuation of benefits within the 10 calendar day time frame (add five calendar days if the notice is sent via U.S. mail);

- A Hearing or administrative review decision adverse to the member is made; or

- The authorization expires or authorized service limits are met.

This process shall also be available for dissatisfaction concerning the timeliness of services or the timeliness of grievance responses.

**Request for Member Administrative Review Determinations**

**Request for Expedited Determination**

A request for an expedited administrative review may be made verbally by calling Customer Service or in writing by mail to the Appeals department. A written administrative review is not required.

The plan has a responsibility to review all administrative reviews and expedite those that warrant quicker action. In order to meet criteria for expedited review, it must be shown that applying the standard procedure could seriously jeopardize the member’s life, health or ability to regain maximum function.

The Plan will make a determination on whether processing will be expedited or standard within one business day from the receipt of the request.

Administrative reviews selected for expedited processing will be determined within three business days from receipt of the request. The Plan will make reasonable efforts to notify the member of the disposition of their request verbally and also in writing.
A request for payment of a service already provided to a member is not eligible to be reviewed as an expedited reconsideration.

**Denial of Expedited Request**

If the Plan denies the request for the expedited determination, then the Plan will automatically transfer the request to the standard reconsideration process no later than 30 calendar days from the date the Plan received the request for expedited reconsideration. The Plan will then make its determination as expeditiously as the member’s health condition requires. The plan will also make reasonable efforts to give the member prompt verbal notice of the denial, and will follow-up within two calendar days with a written notice.

**Request for Standard Pre-Service Determination**

A request for a standard administrative review determination may be made verbally by calling Customer Service or in writing by mail to the Appeals department. The Plan will make a determination and provide notification within 30 calendar days from receipt of the standard request.

**Request for Retrospective Determination**

The provider and member must complete an Appointment of Representative statement, which can be found in the Forms section of this handbook to file a request for a retrospective determination.

The Plan will make a determination and provide notification within 30 calendar days from receipt of the retrospective request.

**14-Day Extension**

The Expedited and Standard Administrative Review determination periods noted above may be extended up to 14 calendar days if the member, member’s authorized
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representative, or a provider acting on behalf of the member with the member’s written consent requests an extension or if the Plan justifies a need for additional information and documents how an extension is in the best interest of the member. If an extension is not requested by the member, the Plan will obtain prior approval from DCH, and if approved, will provide the member with written notice of the reason for the delay and the date by which a decision must be made.

Affirmation of Denial

If the Plan upholds the action and/or denial, then the member, the member’s representative or the provider will be notified in writing of the decision, as well as any additional administrative review rights.

Reversal of Denial

If the Plan overturns the action, it will notify the member and provider verbally and in writing.

The Plan will authorize or provide the disputed services promptly and as expeditiously as the member’s health condition requires if the services were not furnished while the administrative review was pending and the decision is to reverse a decision to deny, limit or delay services.

The Plan also will pay for disputed services, in accordance with state policy and regulations if the services were furnished while the administrative review was pending and the disposition reverses a decision to deny, limit or delay services.

Member Administrative Law or DCH Hearing Rights

The member has the right to request an Administrative Law (Medicaid) or DCH (PeachCare for Kids) Hearing only after completing the Plan’s administrative review process.

Parties to the Administrative Law/DCH Hearing include the Plan, as well as the member and his/her representative or the representative of a deceased member’s estate.
A provider can be a representative or a witness in a hearing process.

The member or a member’s representative with written consent from the member, may request an Administrative Law/DCH Hearing within 30 calendar days of the date the Notice of Adverse Action is mailed by the Plan. A provider cannot request an Administrative Law Hearing on behalf of the member. The request must be sent to the following addresses:

**Medicaid**

GA Department of Community Health  
Legal Services Section, 40th Floor  
2 Peachtree Street NW  
Atlanta, GA 30303

**PeachCare for Kids**

PeachCare for Kids  
2 Peachtree Street, NW  
Atlanta, GA 30303-3159

The Plan will continue the member’s benefits while the Administrative Law/DCH Hearing is pending if:

- The Administrative Law/DCH Hearing is filed timely, meaning on or before the following:
  - Within 10 calendar days of the mailing date on the Administrative Law/DCH Hearing notice (add five calendar days if the notice is sent via U.S. mail); or
  - The intended effective date of the notice.
- The Administrative Law/DCH Hearing involves the termination, suspension or reduction of a previously authorized course of treatment.
- The Administrative Law/DCH Hearing involves the termination, suspension or reduction of a
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previously authorized course of treatment;

- The services were ordered by an authorized provider;

- The original period covered under the original authorization has not expired; and

- The member requests continuation of benefits.

If the Plan continues or reinstates the member's benefits while the Administrative Law/DCH Hearing is pending, the benefits will be continued until one of following occurs:

- The member withdraws the request for Administrative Law/DCH Hearing;

- Ten calendar days pass after the Plan mails the Notice of Adverse Action, unless the member, within the 10 calendar day time frame, has requested an Administrative Law Hearing with continuation of Benefits until an Administrative Law Hearing decision is reached.

- An Administrative Law/DCH Hearing judge issues a hearing decision adverse to the member; or

- The time period or service limits of a previously authorized service has been met.

The Plan will authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, if the services were not furnished while the Administrative Law/DCH Hearing was pending and reverses a decision to deny, limit or delay services.

The Plan will pay for disputed services, in accordance with state policy and regulations, if the services were furnished while the Administrative Law/DCH Hearing was pending and reverses a decision to deny, limit or delay services.
Administrative Reviews and Grievances

At the discretion of DCH, the member may be liable for the cost of continued benefits if the Plan’s action is upheld.

Submission of Provider Administrative Reviews

Providers have 90 days* from the original utilization management denial or claim denial to file a provider administrative review. Cases reviewed after that time will be denied for untimely filing. There is no second level consideration for cases denied for untimely filing. If the provider feels they have filed their case within the appropriate time frame, they may send proof. 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.

A provider may file an administrative review by submitting a letter stating this purpose and/or an administrative review form with supporting documentation such as medical records. An administrative review form may be found in the Forms section of this handbook.

- The Plan is not responsible for payment of medical records generated as a result of a provider inquiry. 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 has 30 business days to review the case for medical necessity and conformity to Plan guidelines. During this time, the Plan may request additional information from the provider in order to complete a review of the case. In the event the provider submits additional information, the Plan will have 30 business days from the receipt of the additional information to render a decision in writing.

* Subject to change
It is the responsibility of the provider to provide the requested documentation within 60 days of the denial to re-open the case. Records and documents received after that time frame will not be reviewed and the case will remain closed.

If it is determined that the provider has complied with Plan protocols and that the reviewed services were medically necessary, the denial will be overturned. The provider will be notified of this decision in writing.

The provider may file a claim for payment if they have not already done so. If a claim has been previously submitted and denied, it will be adjusted for payment after the decision to overturn the denial has been made. The Plan will ensure that claims are processed and comply with federal and state requirements.

Claim Reconsiderations

A Provider may file a Claim Reconsideration by submitting a letter to the Plan with supporting documentation such as medical records. The Claim Reconsideration must be submitted within 90 days of the Remittance Advice/Explanation of Benefits issue date. Claim Reconsideration requests 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 to the Plan.

For written requests, acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of the Plan, a similar receipt from other commercial delivery services or a fax confirmation.

- The Plan is not responsible for payment of medical records generated as a result of provider initiated claim reconsideration requests. Any invoices received by the Plan for such charges will be redirected to the provider.
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- Cases received without the necessary documentation will be denied for lack of information.

A decision on a claim reconsideration request will be made within 30 business days of receipt. If you do not agree with this decision, you have the right to request a Fair Hearing in front of an administrative law judge from the Department of Community Health. To schedule a hearing, you must make your request in writing within 30 calendar days of the date of the administrative review determination letter. Mail your request with a copy of the administrative review letter to:

WellCare Health Plans, Inc.
Administrative Law Hearing Request
PO Box 31580
Tampa, FL 33631-3580

Submission of Provider Administrative Review for a Termination Request

If a provider termination is initiated by the Plan, regardless of whether the termination is with cause or without cause, the Plan will notify the provider of the termination decision in writing, via certified mail, of the reason including, but not limited to, termination for business reasons.

Providers will be informed as to their right to appeal the action, the process and timing for reconsideration of the termination decision. The appeal request must be filed within 15 days of receipt of the Plan’s termination notice. The Plan will send an acknowledgement letter to the provider within three business days of receipt of the appeal request.

The Plan may request additional information from the provider in order to review the appeal. If this is the case, the provider has five business days to submit the required documentation. If not received within five business days, the Plan will continue to process the appeal.

A panel will review the appeal request and upon determination send an outcome letter to the provider stating that the appeal has been overturned or upheld.
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Termination Overturn

If the Plan overturns the termination of the provider, the Plan will ensure that there is no lapse in the period of the provider’s participation with the Plan.

Termination Upheld

If the Plan upholds its termination of the provider, the Plan will notify members 30 days prior to and no later than five business days after the termination effective date of their assigned PCP. Members will be requested to select a new PCP within 30 days. If the member does not respond, a new PCP will be selected for the member. The member will be notified in writing of their new PCP and given a choice to change their PCP by contacting Customer Service.

The Plan is obligated to notify all appropriate regulatory agencies of provider terminations in writing. The Plan will notify members who have been seen two or more times within the past six months, are in active, ongoing treatment or are under OB care, 30 days prior to and no later than five business days after the termination effective date of a specialist, a significant ancillary provider or a hospital.

Submission of Provider Complaints

The Plan encourages providers to contact Customer Service to informally resolve any concerns or issues. Refer to the Quick Reference Guide for telephone numbers. In the event an issue cannot be resolved, the Plan has established a provider complaint system that permits a provider to formally dispute the Plan’s policies, procedures or any aspect of the administrative functions.

Providers have 45 calendar days from the date he or she becomes aware of the issue to file a written complaint. Complaints 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 complaints, 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.

A Provider may file a complaint by submitting a letter with supporting documentation such as medical records.

- The Plan is not responsible for payment of medical records generated as a result of a provider complaint. 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 will respond to the complaint within 60 calendar days of receipt.

Customer Service has dedicated staff that may be reached via telephone or our Web site to answer provider questions, assist providers in filing a complaint and help resolve any issues.

During the complaint process, the Plan will thoroughly investigate each provider complaint using applicable statutory, regulatory and contractual provisions, collect all pertinent facts from all parties and apply the Plan’s written policies and procedures. Plan management members with the authority to implement corrective action are involved throughout the provider complaint process.

The Plan is required to submit a quarterly report to the state on all provider complaints filed and the resolution of each.

In the event a provider is not satisfied with the Plan’s complaint decision, the provider may request a review at an Administrative Law Hearing. However, providers must exhaust the Plan’s provider termination and/or provider complaint procedures before bringing action by way of arbitration or court action against WellCare.
Administrative Law Hearing

In the event the outcome of the review of the Provider complaint is adverse to the Provider, the Plan will provide a written notice of adverse action to the Provider. The notice of adverse action will state that a provider has 15 business days from receipt of the notice, to file a request for an administrative law hearing with the state.

To file a request for administrative law hearing, submit the request in writing to:

WellCare Health Plans, Inc.
Administrative Law Hearing Request
PO Box 31580
Tampa, FL 33631-3580

A request for an administrative law hearing must include the following information:

- A clear expression by the provider or authorized representative that he/she wishes to present his/her case to an administrative law judge;
- Identification of the adverse action being appealed and the issues that will be addressed at the hearing;
- A specific statement of why the provider believes the Plan’s adverse action is wrong; and
- A statement of the relief sought.

Submission of Member Grievances

A member or a member’s representative acting on behalf of the member, may file a grievance either verbally or in writing within 90 calendar days of the date that the member became aware of the issue. A verbal request may be followed up with a written request, but the time frame for resolution begins the date the Plan receives the verbal filing.
If the member wishes to appoint another person as their representative, he/she must complete an Appointment of Representative statement. The member and the person who will be representing the member must sign the statement. This form is available in the Forms section of this handbook.

The Plan will send an acknowledgement of receipt to the person filing the grievance within three business days. If the grievance is filed verbally, a verbal acknowledgement will be provided. If filed in writing, written acknowledgement will be provided. The Plan will make a determination on the grievance notification within the following time frames:

- Within two business days of receipt if the grievance is regarding access to Medicaid-covered services;
- Within 30 calendar days of receipt for non-claims related grievances; or
- Within 60 calendar days of receipt of claims-related grievances.

The Plan gives members reasonable assistance in completing forms and other procedural steps, including but not limited to the provision of interpreter services and TTY/TDD toll-free telephone numbers with interpreter capability. Refer to the Quick Reference Guide for the appropriate contact information.

Members will be provided reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing.

A member, a member representative or a provider acting on behalf of a member may file a request for an expedited grievance determination verbally or in writing. A verbal request can be filed by calling Customer Service. A written request can be mailed or faxed directly to the Grievance department.
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A determination on the expedited request will be made within 72 hours of receipt of the expedited request.

A request for an expedited grievance determination can be made for complaints related to Plan’s decisions to:

- A grievance regarding denial of expedited resolution of an administrative review; or
- A grievance or administrative review that involves clinical issues.

Request for Standard Member Grievance Determination

A grievance will be investigated, a determination made and a closure letter sent to the complainant (and DCH upon request), within 90 calendar days of receipt of the standard request.

The closure letter will include:

- The results and date of the grievance resolution;
- Notice of the right to request a second-level grievance to the Plan;
- The time limit to file a second-level request (standard is 30 calendar days from the date of the notice); and
- Information on how to present the case at the second-level Grievance Committee either in person or via teleconference.

14-Day Extension

The Plan may extend the time frames for a determination on a standard grievance by up to 14 calendar days if the member requests an extension or if the Plan shows that there is need for additional information (to the satisfaction of the state, upon its request) and includes how the delay is in the member’s interest.
Grievances Filed Against a Provider

If a member files a grievance against a provider in reference to the quality of care or service provided, the Plan will fax and mail a request to the provider for a response. The provider is given 10 business days to respond and submit medical records for review. If a provider has not responded within the 10 business days, a second fax and letter is sent giving an additional five business days to respond.

Continued failure to respond may result in the provider’s panel being closed to new patients and/or will be interpreted as the provider not in disagreement with the member’s issue.

The case is then forwarded to the Quality Improvement department for further investigation.

If the provider does respond, the case is referred to a Plan nurse who reviews the medical records to determine if a quality issue exists. If the nurse feels a quality issue may exist, the case is referred to a Plan medical director for review. If he/she determines a quality issue exists, the case is referred to the Quality Improvement department for further investigation. If no quality issue is identified, the case is entered into the Plan’s database for tracking and trending purposes.
Overview
WellCare’s Risk Management Program includes an overview of medical practice risk management, incident reporting and guidelines for the prevention, detection, investigation, reporting, corrective actions and education/training related to fraud and abuse.

Medical Practice Risk Management
The following recommendations regarding medical practice risk management are informational only. Providers should develop their own risk management policies and procedures to assist in reducing medical practice risks.

Patient Information
Physicians should remind members to be aware of the Plan’s covered benefits and requirements and teach them their role in the health care process:

- Inform their physician of changes in health history;
- Inform their physician of care and medications rendered by other providers;
- Keep appointments;
- Follow advice and instructions;
- Ask questions.

Receptionists should be required to ask members if any insurance, address or telephone information has changed and verify with the Plan that the individual still has coverage. During the exam, a health care professional should verify medications, allergies and changes in health history.

Staff Training
Provider support staff members should be educated on the Plan’s policies and procedures. The provider’s support staff is a reflection of the provider’s practice and is important in ensuring patient satisfaction. Support staff should be instructed to be courteous and respectful to all patients.
Exposures to Blood

Health care workers are at risk for occupational exposure to bloodborne pathogens, including hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV). Exposures occur through needle sticks or cuts from other sharp instruments contaminated with an infected patient's blood or through contact of the eye, nose, mouth or skin with a patient's blood. Important factors that may determine the overall risk for occupational transmission of a bloodborne pathogen include the number of infected individuals in the patient population, the chance of becoming infected after a single blood contact from an infected patient and the type and number of blood contacts.

Most exposures do not result in infection. Following a specific exposure, the risk of infection may vary with factors such as these:

- The pathogen involved;
- The type of exposure;
- The amount of blood involved in the exposure; and
- The amount of virus in the patient's blood at the time of exposure.

Physicians should have in place a system for reporting exposures in order to quickly evaluate the risk of infection, inform patients (and support staff) about treatments available to prevent infection, monitor patients for side effects and to determine if infection occurs. This may involve blood tests of the source patient and offering appropriate post-exposure treatment.

To Prevent Occupational Exposures

Many needle sticks and other cuts can be prevented by using safer techniques (i.e., not recapping needles by hand), disposing of used needles in appropriate sharps disposal containers and using medical devices with safety features designed to prevent injuries. Many exposures to the eyes, nose, mouth or skin can be prevented by using
appropriate barriers (i.e., gloves, eye and face protection gowns) when contact with blood is expected.

If An Exposure Occurs

No scientific evidence shows that using antiseptics or squeezing the wound will reduce the risk of transmission of a bloodborne pathogen. Using a caustic agent such as bleach is not recommended. Immediately following an exposure to blood:

• Wash needle sticks and cuts with soap and water;

• Flush splashes to the nose, mouth or skin with water; and

• Irrigate eyes with clean water, saline or sterile irrigants.

Following Any Blood Exposure

• Report the exposure to the appropriate authorities responsible for managing exposures. Prompt reporting is essential because, in some cases, post-exposure treatment may be recommended, and it should be started as soon as possible.

• Discuss the possible risks of acquiring HBV, HCV and HIV and the need for post-exposure treatment with the injured person. All health care personnel should have already received hepatitis B vaccine, which is extremely safe and effective in preventing HBV infection.

Other Sources Of Information

• HBV and HCV
  For additional information about hepatitis B and hepatitis C, call the hepatitis information line at 1-888-4-HEPCDC (1-888-443-7232) or

Anyone believing they have had a reaction or adverse event should report it to his/her health care provider. The Vaccine Adverse Event Reporting System (1-800-822-7967) receives reports from health care providers and others about vaccine side effects.

- HIV
Information specialists who staff the CDC National AIDS Hotline (1-800-342-2437) can answer questions or provide information on HIV infection and AIDS and as well as local resources. The HIV/AIDS Treatment Information Service (1-800-448-0440) can also be contacted for information on the clinical treatment of HIV/AIDS. For free copies of printed material on HIV infection and AIDS, please call or write the CDC National Prevention Information Network, P.O. Box 6003, Rockville, MD 20849-6003, Telephone: 1-800-458-5231, Web site: www.cdcnpin.org.

Additional information about occupational exposures to bloodborne pathogens is available on CDC’s Hospital Infections Program’s Web site at www.cdc.gov/ncidod/hip or on CDC’s National Institute of Occupational Safety and Health’s Web site at www.cdc.gov/niosh or call 1-800-35 NIOSH (1-800-356-4674).

Universal Precautions for Infection Control
Universal precautions are intended to supplement rather than replace recommendations for routine infection control, such as hand washing and using gloves to prevent gross microbial contamination of hands. Because specifying the types of barriers needed for every possible clinical situation is impractical, some judgment must be exercised.
The risk of nosocomial transmission of HIV, HBV and other bloodborne pathogens can be minimized if health care workers use the following general guidelines:

- Take care to prevent injuries when using needles, scalpels and other sharp instruments or devices; when handling sharp instruments after procedures; when cleaning used instruments; and when disposing of used needles. Do not recap used needles by hand; do not remove used needles from disposable syringes by hand; and do not bend, break or otherwise manipulate used needles by hand. Place used disposable syringes and needles, scalpels and other sharp items in puncture-resistant containers for disposal. Locate the puncture-resistant containers as close to the use area as is practical.

- Use protective barriers to prevent exposure to blood, body fluids containing visible blood and other fluids to which universal precautions apply. The type of protective barrier(s) should be appropriate for the procedure being performed and the type of exposure anticipated.

- Immediately and thoroughly wash hands and other skin surfaces that are contaminated with blood, body fluids containing visible blood, or other body fluids to which universal precautions apply.

**Glove Use for Phlebotomy**

Gloves should reduce the incidence of blood contamination of hands during phlebotomy (drawing blood samples), but they cannot prevent penetrating injuries caused by needles or other sharp instruments.
The likelihood of hand contamination with blood containing HIV, HBV or other bloodborne pathogens during phlebotomy depends on several factors:

- The skill and technique of the health care worker;

- The frequency with which the health care worker performs the procedure (other factors being equal, the cumulative risk of blood exposure is higher for a health care worker who performs more procedures);

- Whether the procedure occurs in a routine or emergency situation (where blood contact may be more likely); and

- The prevalence of infection with bloodborne pathogens in the patient population.

The likelihood of infection after skin exposure to blood containing HIV or HBV will depend on the concentration of virus (viral concentration is much higher for hepatitis B than for HIV), the duration of contact, the presence of skin lesions on the hands of the health care worker, and for HBV, the immune status of the health care worker.

Although not accurately quantified, the risk of HIV infection following intact skin contact with infective blood is certainly much less than the 0.5 percent risk following percutaneous needlestick exposures. In universal precautions, all blood is assumed to be potentially infective for bloodborne pathogens, but in certain settings (i.e., volunteer blood-donation centers) the prevalence of infection with some bloodborne pathogens (i.e., HIV, HBV) is known to be very low. Some institutions have relaxed recommendations for using gloves for phlebotomy procedures by skilled phlebotomists in settings where the prevalence of bloodborne pathogens is known to be very low.

Institutions that judge that routine gloving for all phlebotomies is not necessary should periodically...
reevaluate their policy. Gloves should always be available to health care workers who wish to use them for phlebotomy. In addition, the following general guidelines apply:

- Use gloves for performing phlebotomy when the health care worker has cuts, scratches or other breaks in his/her skin.

- Use gloves in situations where the health care worker judges that hand contamination with blood may occur, for example, when performing phlebotomy on an uncooperative patient.

- Use gloves for performing finger and/or heel sticks on infants and children.

- Use gloves when persons are receiving training in phlebotomy.

**Selection of Gloves**

The Center for Devices and Radiological Health, FDA, has responsibility for regulating the medical glove industry. Medical gloves include those marketed as sterile surgical or nonsterile examination gloves made of vinyl or latex. General purpose utility ("rubber") gloves are also used in the health care setting, but they are not regulated by FDA since they are not promoted for medical use. There are no reported differences in barrier effectiveness between intact latex and intact vinyl used to manufacture gloves. Thus, the type of gloves selected should be appropriate for the task being performed. The following general guidelines are recommended:

- Use sterile gloves for procedures involving contact with normally sterile areas of the body.

- Use examination gloves for procedures involving contact with mucous membranes, unless otherwise indicated, and for other
patient care or diagnostic procedures that do not require the use of sterile gloves.

- Change gloves between patient contacts.

- Do not wash or disinfect surgical or examination gloves for reuse. Washing with surfactants may cause "wicking," i.e., the enhanced penetration of liquids through undetected holes in the glove. Disinfecting agents may cause deterioration.

- Use general-purpose utility gloves (i.e., rubber household gloves) for housekeeping chores involving potential blood contact and for instrument cleaning and decontamination procedures. Utility gloves may be decontaminated and reused but should be discarded if they are peeling, cracked, or discolored, or if they have punctures, tears or other evidence of deterioration.

**Waste Management**

Universal precautions are not intended to change waste management programs previously recommended by CDC for health care settings. Policies for defining, collecting, storing, decontaminating and disposing of infective waste are generally determined by institutions in accordance with state and local regulations. Information regarding waste management regulations in health care settings may be obtained from state or local health departments or agencies responsible for waste management.

From the Department of Health and Human Services and Centers for Disease Control (CDC)

**Incident Reporting**

Any injury, regardless of degree, or any adverse or unexpected occurrence incurred by a provider or member should be reported to the Plan.
Incidents are statutorily defined as any untoward or adverse event that results in death, serious impairment of bodily function or any other result that requires medical intervention other than minimal first aid treatment. Serious incidents involving Plan members shall be reported to the Plan’s risk manager immediately as these incidents must be reported within 48 hours. The Risk Management department phone number can be found on the Quick Reference Guide.

Examples of such incidents are death, fetal death, brain damage, spinal damage, surgical procedure performed on the wrong patient or wrong site or wrong surgical procedure performed.

Other incidents involving Plan members which are required to be communicated to the Plan include: a slip or fall, medication error, reaction requiring treatment, abusive patient or family member, a theft or loss from provider’s office, malfunction or damage of equipment during treatment, accusations of malpractice by a patient or family member, non-compliance which may potentially be considered life-threatening. An Incident Report form, included in the Forms section, should be used to report all incidents to the Plan’s risk manager.

Further reporting to the Plan’s insurance carrier and governmental agencies, as appropriate, shall be arranged within the prescribed time frames by the Plan’s risk manager. Physicians are reminded that serious negative events or incidents which occur in a provider’s office or facility must be reported to the appropriate regulatory agency directly by the provider.

Fraud and Abuse

The Plan is committed to the prevention, detection and reporting of health care fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements. The Plan has developed an aggressive, proactive fraud and abuse program designed to collect, analyze and evaluate data in order to identify suspected fraud and abuse. Effective detection tools have been developed to identify patterns of health care
service use, including over utilization, unbundling, up-coding, misuse of modifiers and other common schemes.

Federal and state regulatory agencies, law enforcement and the Plan vigorously investigate incidents of suspected fraud and abuse. Service providers are cautioned that unbundling, fragmenting, up-coding and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD), Physicians’ Current Procedural Terminology (CPT), the Health care Common Procedure Coding System (HCPCS), and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement, may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

In addition, providers are reminded that medical records and other documentation must be legible and support the level of care and service indicated on claims. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized provider, loss of licensure, and/or civil and/or criminal prosecution, fines and other penalties.

To report suspected fraud and abuse, please refer to the Quick Reference Guide of this handbook and call our confidential Trust Program hotline.

Fraud and Abuse Definitions

*Fraud* is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit or financial gain to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Some examples of health care fraud include, but are not limited to the following:
• Falsifying any medical record, note, diagnostic test result, report, claim, financial, administrative or clinical documents used to validate services.

• Billing for services, supplies or equipment not actually furnished to any health plan member.

• Providing false and intentionally misleading information regarding health plan coverage, limitations and exclusions to any health plan member.

• Misrepresentation of date of service, frequency, duration, description of service, the identity of the recipient of such services or the identity of the service provider.

• Billing for non-covered or non-chargeable services, supplies or equipment disguised as any covered or chargeable service.

• Duplicate billings (i.e., billing more than once for the same service, multiple providers billing for the same service for the same member on the same day, billing the health plan and the member for the same services or submitting claims to both the health plan and other third parties without making full disclosure of relevant facts to all parties).

• Providing payment or other inducement to any health plan member in exchange for the use of their identification card or other member information with or without the permission of the health plan member for the purpose of obtaining wrongful payment.

• Receipt or offering of any unlawful kickback, gratuity or other inducement made with the intent to increase referrals.
• Reciprocal billing (i.e., billing or claiming services furnished by another provider or furnished by the billing provider in a capacity other than claimed).

• Practicing medicine or other health care without a valid license, with an expired or revoked license or without proper credentials, or while excluded from participation in any federal or state health care program.

• Any agreement or other arrangement between a provider and a health plan member that results in claims for unnecessary costs or charges to the health plan (i.e., providing health care services, supplies or equipment to an ineligible person that is in possession of a health plan member’s identification card, or any fraudulent scheme involving the use of member information to submit false claims).

• Any other intentional misrepresentation of a material fact regarding the provision of health care services for the purpose of obtaining wrongful payment.

Abuse is defined as provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medicaid program.

Some examples of health care abuse include, but are not limited to the following:

• Unauthorized waiver or reduction of applicable member co-payment or deductible.

• Billing for services, supplies or equipment in any amount in excess of the applicable federal and/or state fee schedules, negotiated or contract rates.
- Direct or balance billing of health plan members where prohibited.

- Billing for services that are not medically necessary, or if medically necessary, not to the extent actually provided.

- Providing health care services of an inferior quality (i.e., services that do not meet generally accepted standards of care), or in an inappropriate setting, or at a level of care that is in excess to medical necessity.

- Failure to fully document services according to generally accepted standards (i.e., records must be legible, clearly document the services provided, etc.) and maintain adequate clinical, financial and other records substantiating claims.

**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 corporate 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;
RISK MANAGEMENT

Education and Training

The Provider Relations department is responsible for distributing provider handbooks and other information, as well as conducting provider education and training. Providers may contact the Provider Relations department to arrange education and training, or answer questions regarding health plan benefits, coverage, limitations and exclusions, policies and procedures, provider rates and contracting issues, claims, fraud and abuse awareness or other information.

Business and Medical Records

Providers are required to maintain books, records, documents and other evidence pertaining to the costs and expenses to the extent and in such detail as will properly reflect all services for which claim payments are made.

Providers are required to preserve and make available all of its records pertaining to services rendered to Plan members for a period of seven years from the date of final payment under their provider agreement, and for such period, if any, as is required by applicable statute. If a provider agreement is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for period of seven years from the date of termination or of any resulting final settlement.
Inspection and Release of Business and Medical Records

Pursuant to the requirements of 42 CFR 434.6(a)(5) and 42 CFR 434.38, providers are required to make all books, documents, papers, provider records, medical records, financial records, data, surveys and computer databases available for examination and audit by the Plan, the Georgia Department of Community Health (DCH), the State Attorney General, the State Health Care Fraud Control Unit, the State Department of Audits or authorized state or federal personnel.

Providers are required to release medical records (i.e., the complete, comprehensive records of a member including, but not limited to, X-rays, laboratory tests, results, examinations and notes, accessible at the site of the member’s participating primary care physician or provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary and emergency care, prepared in accordance with all applicable DCH rules and regulations, and signed by the medical professional rendering the services) as may be authorized by the member, or as may be directed by the Plan, appropriate agencies of the state, or the United States government.

Any records requested hereunder shall be produced immediately for onsite review or sent to the requesting authority by mail within 14 calendar days following a request. All records shall be provided at the sole cost and expense of the provider.
## Overview

The Quality Improvement Program (Program) is an ongoing, comprehensive and integrated system designed to actively initiate, monitor and evaluate standards of health care practice and infrastructures essential to the delivery of quality clinical care and service to Georgia Medicaid and PeachCare for Kids members.

## Quality Improvement Program

The goals of the Program are:

- To develop and maintain a well-integrated system that continuously measures clinical and operational performance, identifies the need for and initiates meaningful corrective action when appropriate and evaluates the result of actions taken to improve quality of care outcomes and service levels.

- To establish a mechanism for the safe, culturally-sensitive delivery of health care that not only promotes efficient, appropriate and effective use of resources, but also supports the physician-patient relationship.

- To ensure access to and availability of qualified and competent providers.

- To engage members in managing, maintaining or improving their current state of health.

- To provide a forum for members, providers and various health care associations and community agencies to provide suggestions regarding the implementation of the Program.

- To ensure compliance with standards as required by contract, regulatory statutes and accreditation agencies.

The Quality Improvement Program includes initiatives to ensure that members are receiving age-appropriate preventive health screenings and interventions to optimize health.
QUALITY IMPROVEMENT

Quality Improvement Participation

The Quality Improvement Committee is charged by the Plan’s Board of Directors with monitoring and evaluating the results of Program initiatives and initiating corrective action when the results are less than desired or when areas needing improvement are identified.

Current Program activities which involve network-contracted providers include, but are not limited to:

- Review of member medical records focusing on patient safety, continuity and coordination of care practices;
- Review of physician office site;
- Review of member quality complaints and adverse, unexpected events;
- Review of office site accessibility and availability;
- Participation in quality improvement and utilization management activities. Within the scope of the program, providers are required to:
  - Cooperate with QI Activities;
  - Allow WellCare, or its representative, access to medical records without a fee, to the extent permitted by state and federal law; and
  - Maintain the confidentiality of medical records.
- Participation on focused performance improvement initiatives, such as improvement of well child visit rates, immunizations and lead screenings, as appropriate. Studies will also be conducted on the accessibility, availability, efficiency, safety, efficacy, appropriateness, effectiveness and continuity of the patient care and services; and
QUALITY IMPROVEMENT

- Completion of the re-credentialing process.

The results of all reviews are maintained in a centralized database for reference during physician re-credentialing and/or provider re-contracting.

Physician Involvement

The Program seeks out and invites input from the physician community regarding Program implementation. Georgia licensed physicians are members of the following Program committees:

- Medical Advisory Committee
- Credentialing Committee
- Utilization Management Committee

Provider input is also integral to the development of Preventive Health Guidelines, Clinical Practice Guidelines, Performance Improvement Projects and Disease Management Programs.

Medical Record Review

The Program incorporates periodic screening of the medical record to assure compliance with medical record documentation standards and also clinical practice guidelines for health screening and high-risk diagnoses such as diabetes and asthma. A Plan representative will make an appointment to assess for these items in the physician’s office.

Upon completion of the review, a summary of findings will be created and shared with the physician. If opportunities to improve guideline compliance or record documentation are identified, a plan of action will be instituted. A corrective action plan is required for all deficiencies.

Regulatory and Accreditation Agency Review of Medical Records

Providers contracted with the Plan are required to participate in all quality improvement functions and tasks as may be required by regulatory and accreditation agencies, including the Georgia Department of Community Health (DCH), the Georgia Department of Human Resources (DHR) and the
External Quality Review Organization (EQRO). These activities may include, but are not limited to:

- Compliance with request for medical record review for quality improvement studies and audits;
- Cooperation with quality improvement initiatives related to collaborative projects;
- Cooperation with efforts to improve care for chronic disease and/or preventive care measures;
- Compliance with requests for information and recommendations formulated by DCH and EQRO in the process of reviewing or resolving beneficiary and/or provider complaints.

These agencies may also perform annual audits. Providers will need to copy office records for these audits. It is very important that any time a copy of a record is requested the entire record is sent.

**Patient Safety Program**

WellCare is committed to offer network of providers that ensure the safe delivery of clinical care to its members. WellCare’s Patient Safety Plan exists to establish the framework for demonstrating this commitment. Through execution of standardized internal processes and collaborative participation of providers, WellCare seeks to promote improvement in network clinical safety.

In support of safe clinical practices, WellCare’s policies and procedures define and provide for the monitoring of widely accepted quality of care indicators. Through tracking and trending of relevant Patient Safety Plan metrics, WellCare can identify opportunities for improvement and facilitate education of a specific practitioner and/or the provider community at large in order to reduce the potential for patient safety incidents.

The Patient Safety Plan addresses key elements of patient safety, such as the extent of coordination of care...
QUALITY IMPROVEMENT

Section 12

between providers, office site visit review results, medical record review findings, clinical practice guideline compliance, adverse event and quality of care grievance tracking/trending, disease management program participation, pharmaceutical management practices and member interactions.

Annually, WellCare will define the specific areas of patient safety to be monitored, which may include, but not be limited to the following metrics as indicators of safe clinical care:

- Number of member quality of care complaints per 1,000 members;
- Number of adverse events reported per 1,000 members;
- Percent of reviewed physician medical records compliant to standard: drug allergies or "NKA" recorded;
- Number of providers contacted quarterly regarding prescribed, but duplicate, drug therapies; and
- Number of providers contacted quarterly regarding potential drug interactions between prescribed drug therapies.

Following the objectives as outlined, WellCare will utilize both the member and provider newsletters to periodically communicate the results of patient safety activities, including network patient safety performance data, and also any provider best practices identified in the promotion of patient safety.

Quality of Care Issues

Defined as quality complaints and adverse outcomes, quality of care referrals may be generated by the Administrative Review, Grievance, Risk Management and/or Utilization Management department or may be identified through routine record review. Issue types include items such as unplanned readmission for a
same or similar diagnosis in less than 30 days, patient fall, serious complication of anesthesia, transfusion error or serious transfusion reaction, medication error or adverse drug reaction with serious potential for harm, care or lack of care which could have resulted in a potentially serious complication, etc.

Record review identifying possible quality of care issues will be referred for peer review. In the event the peer reviewer/panel feels there is a possible quality of care issue, the physician will be asked, in writing, to provide additional information to address the issue. The response is reviewed and a final determination is rendered.

Peer review is categorized in the following manner:

- **Substantiated** – there is evidence of a deviation in the standard of care.

- **Unsubstantiated** – there is no evidence of a deviation from the standard of care.

Once that determination is made, the outcome is classified as either **adverse event** or **no adverse event**. Results of peer review activity will be reported to state and regulatory agencies as appropriate.

**Clinical Practice Guidelines**

Clinical Practice Guidelines have been adopted that are based on the health care needs of the member population and also opportunities for improvement as have been identified as part of the quality improvement program. Addressing both preventive and chronic care conditions, they are reviewed for need of revision on an annual basis, utilizing nationally-recognized evidenced based sources. The review process includes:

- A consistency check, assessing linkage with member educational materials, benefit plans, and coverage parameters;

- Input from community physicians via the WellCare Medical Advisory Committee.
Approval occurs through the Quality Improvement Committee.

**Disease Management Initiatives**

The Disease Case Management program offers members with chronic medical conditions, (including but not limited to asthma, congestive heart failure and diabetes), awareness of their condition, direction and education. The Disease Case Management program has been designed to assist the physician in the educational process for the member and to promote a healthy lifestyle.
CULTURAL COMPETENCY

Purpose

The purpose of the Cultural Competency program is to ensure that the Plan meets the unique diverse needs of all members in the population; to ensure that the associates of the Plan value diversity within the organization and to make certain members in need of linguistic services have adequate communication support. In addition, the Plan is committed to ensuring our Providers fully recognize and care for the culturally diverse needs of the members they serve.

At the national level, WellCare is a member of the National Alliance for Hispanic Health, an organization with ties to the federal government that fosters the development of resources to improve Hispanics’ access to, and quality of, health care. One of the Alliance’s projects is the National Hispanic Family Health Helpline, (866) 783-2645. The Alliance also sponsored the report, “Genes, Culture and Medicines: Bridging Gaps in Treatment for Hispanic Americans,” which WellCare will start using in 2005 in educating providers about ways to reduce health disparities.

Objectives

The objectives of the Cultural Competency program are to:

- Identify members that have potential cultural or linguistic barriers for which alternative communication methods are needed;

- Utilize culturally sensitive and appropriate educational materials based on the member’s race, ethnicity and primary language spoken;

- Ensure resources are available to meet the unique language barriers and communication barriers that exist in the population;

- Ensure providers care for and recognize the culturally diverse needs of the population; and
CULTURAL COMPETENCY

• Ensure associates are educated and value the diverse cultural and linguistic differences in the organization and the populations served.

Goals

The goals of the Cultural Competency program are to:

• Improve communication to members for whom cultural and/or linguistic barriers exist;

• Decrease health care disparities in the minority populations we serve; and

• Improve associates’ understanding and sensitivity to cultural diversity within the organization and the members served.

The delivery of culturally competent health care and services requires health care providers and/or employees to possess a set of attitudes, skills, behaviors and policies which enable the organization and staff to work effectively in cross-cultural situations.

Culturally and linguistically appropriate services (CLAS): Health care services that are respectful of, and responsive to, cultural and linguistic needs.1

The Plan endorses the view, promulgated by the federal government,2 that achieving cultural competence will help the health Plan to:

• Improve services, care and health outcomes for current members (improved understanding leads to better adherence and satisfaction);

• Increase market penetration by appealing to potential culturally and linguistically diverse members;

CULTURAL COMPETENCY

Section 13

- Enhance the cost-effectiveness of service provision; and
- Reduce potential liability from medical errors and Title VI (Civil Rights Act) violations. 3

The Components of the Plan’s Cultural Competency program include:

**Data Analysis**

- Needs assessment in the areas served, utilizing the state-supplied data for Medicaid and S-CCHIP populations;
- Analysis of claims and encounter data to identify the health care needs of the population; and
- Collection of data on race, ethnicity and language spoken for members.

**Community-based support**

Outreaches to community-based organizations which support minorities and the disabled to be sure that the existing resources for members are being utilized to their full potential.

**Diversity of Health Plan Associates**

- The Plan does not discriminate with regards to race, religion or ethnic background when hiring associates.
- The Plan recruits diverse talented associates in

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3 Title VI of the Civil Rights Act specifically requires that managed care organizations provide assistance to persons with limited English proficiency, where a significant number of the eligible population is affected. Department of Justice regulations (28 CFR Section 42.405(d)(1)) state: “Where a significant number or proportion of the population eligible to be served or likely to be directly affected by a federally assisted program … needs service or information in a language other than English in order effectively to be informed of or to participate in the program, the recipient shall take reasonable steps, considering the scope of the program and the size and concentration of such population, to provide information in appropriate languages to such persons. This requirement applies with regard to written material of the type which is ordinarily distributed to the public.”
CULTURAL COMPETENCY

all levels of management.

- The Plan ensures that bilingual associates are hired for areas that have direct contact with members to meet the needs identified.

Diversity of Provider Network

- Providers are inventoried for their language abilities and this information is housed in the Diamond system and printed in the Provider Directory, so that members can choose a provider that speaks their primary language.

- Providers are recruited to ensure a diverse selection of providers to care for the population served.

Linguistic Services

- Providers will identify members that have potential linguistic barriers for which alternative communication methods are needed and contact the Plan to arrange appropriate assistance.

- Members may receive interpreter services at no cost when necessary to access covered services through a vendor, as arranged by the Customer Services department.

- Interpreter services available include oral translation, oral interpretation for those with limited English proficiency and sign language for the hearing impaired. These services will be provided by vendors with such expertise and are coordinated by the Plan’s Customer Services department.

- Written materials are available for members in large print format and the prevalent non-English languages of the Plan’s service areas.
Electronic Media

- Telephone system adaptations – members have access to the TTY/TDD line for hearing impaired services. The Customer Service Representatives have responsibility for any necessary follow-up phone calls to the member.

Provider Education

- Educated regarding the Cultural Competency program through the Provider Manual; and
- Receive a Cultural Competency Checklist to assess their Cultural Competency in their office.

Determination of Performance Improvement Projects

- Focused assessments to identify opportunities for improvement
- Setting priorities and assignments

Cultural Competency Survey

Promoting Cultural and Linguistic Competency: Self-Assessment Checklist for Personnel Providing Primary Health care Services.

Developed by: Tawara D. Goode, National Center for Cultural Competence, Georgetown University

Target Group

Health care workers

Purpose

1. To increase individual awareness of practices, beliefs, attitudes and values that promote and hinder cultural and linguistic competence in the delivery of health care.

2. To identify training needs.
CULTURAL COMPETENCY

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Length of Survey
30-item list

Distinguishing Characteristics

Divided into 3 categories:

1. Physical Environment, Materials and Resources
2. Communication Styles
3. Values and Attitudes

Each item is rated on a 3-point scale.

Self-Assessment Checklist for Personnel Providing Primary Health Care Services

Georgetown University Center for Child and Human Development - National Center for Cultural Competence

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic cultural competence in health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values and practices, which foster cultural and linguistic competence at the individual or practitioner level.

DIRECTIONS: Select A, B or C for each item listed below.

A = Things I do frequently
B = Things I do occasionally
C = Things I do rarely or never

Physical Environment, Materials & Resources

____ 1. I display pictures, posters, artwork and other décor that reflect the cultures and ethnic backgrounds of clients served by my program or agency.

____ 2. I ensure that magazines, brochures and other printed materials in reception areas are of interest to and reflect the different cultures of individuals and families served by my program or agency.
3. When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures and ethnic background of individuals and families served by my program or agency.

4. I ensure that printed information disseminated by my agency or program takes into account the average literacy levels of individuals and families receiving services.

Communication Styles

5. When interacting with individuals and families who have limited English proficiency I always keep in mind that:
   - Limitation in English proficiency is in no way a reflection of their level of intellectual functioning
   - Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin
   - They may or may not be literate in their language of origin or English

6. I use bilingual/bi-cultural staff and/or personnel and volunteers skilled or certified in the provision of medical interpretation during treatment, interventions, meetings or other events for individuals and families who need or prefer this level of assistance.

7. For individuals and families who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.

8. I attempt to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment or other interventions.
9. When possible, I insure that all notices and communiqués to individuals and families are written in their language of origin.

10. I understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method.

Values & Attitudes

11. I avoid imposing values which may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

12. I screen books, movies and other media resources for negative cultural, ethnic or racial stereotypes before sharing them with individuals and families served by my program or agency.

13. I intervene in an appropriate manner when I observe other staff or clients within my program or agency engaging in behaviors which show cultural insensitivity, racial biases and prejudice.

14. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

15. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).

16. I accept and respect that male-female roles may vary significantly among different cultures and ethnic groups (e.g. who makes major decisions for the family).

17. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decision of elders, the role of eldest male or female in families or roles and expectation of children within the family).
18. Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.

19. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

20. I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease and death.

21. I understand that the perception of health, wellness and preventive health services have different meanings to different cultural or ethnic groups.

22. I recognize and accept that folk and religious beliefs may influence an individual’s or family’s reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic disorder or special health care needs.

23. I understand that grief and bereavement are influenced by culture.

24. I seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by my program or agency.

25. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to the culturally and ethnically diverse groups served by my program or agency.

26. I keep abreast of the major health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my program or agency.
27. I am aware of the socio-economic and environmental risk factors that contribute to the major health problems of culturally, ethnically and racially diverse populations served by my program or agency.

28. I am well versed in the most current and proven practices, treatments and interventions for major health problems among ethnically and racially diverse groups within the geographic locale served by my agency or program.

29. I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, ethnically, racially and linguistically diverse groups.

30. I advocate for the review of my program or agency mission statement, goals, policies and procedures to insure that they incorporate principles and practices that promote cultural and linguistic competence.

There is no answer key with correct responses. However, if you frequently responded “C”, you may not necessarily demonstrate beliefs, attitudes, values and practices that promote cultural and linguistic competence within health care delivery programs.

National Center for Cultural Competence
3300 Whitehaven Street, NW, Suite 300,
Washington, DC 20057
Voice: (800) 788-2066 or (202)687-5387
Fax: (202) 687-8899
E-mail: cultural@georgetown.edu
The Plan will, at a minimum, provide medically necessary services and benefits as outlined below and pursuant to the Georgia State Medical Plan and the Georgia Medicaid Policies and Procedures Manual.

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Surgical Services</td>
<td></td>
</tr>
<tr>
<td>Audiology Services</td>
<td>Not covered for members age 21 and older. Available under EPSDT as part of a written service plan.</td>
</tr>
<tr>
<td>Childbirth Education Services</td>
<td></td>
</tr>
<tr>
<td>Dental Services</td>
<td>Preventive, diagnostic and treatment services provided to members under age 21. Emergency Services only for members age 21 and older.</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td></td>
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<tr>
<td>Early and Periodic Screening, Diagnostic, and Treatment Services</td>
<td></td>
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<tr>
<td>Emergency Transportation Services</td>
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<tr>
<td>Emergency Services</td>
<td></td>
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<tr>
<td>Family Planning Services and Supplies</td>
<td></td>
</tr>
<tr>
<td>Federally Qualified Health Center Services</td>
<td>Ambulatory services such as dental services are subject to any limitations applicable to the specific ambulatory service.</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Not covered: social services, chore services, meals on wheels, audiology services.</td>
</tr>
<tr>
<td>Hospice Services</td>
<td>Available to members certified as being terminally ill and having a medical prognosis of life expectancy of six months or less.</td>
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<tr>
<td>Inpatient Hospital Services</td>
<td></td>
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<tr>
<td>Covered Services</td>
<td>Details</td>
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<td>-------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Laboratory and Radiological Services</td>
<td>Not covered: portable X-ray services; services provided in facilities not meeting the definition of an independent laboratory or X-ray facility; services or procedures referred to another testing facility; services furnished by a State or public laboratory; services or procedures performed by a facility not certified to perform them.</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>Community Mental Health Rehabilitation services are only available as part of a written service plan.</td>
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<tr>
<td>Nurse Midwife Services</td>
<td></td>
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<tr>
<td>Nurse Practitioner Services</td>
<td></td>
</tr>
<tr>
<td>Nursing Facility Services</td>
<td>Not covered: Long-term nursing facility stays (over 30 days)</td>
</tr>
<tr>
<td>Obstetrical Services</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy Services</td>
<td>Not covered for members age 21 and older. Available under EPSDT as part of a written service plan.</td>
</tr>
<tr>
<td>Optometric Services</td>
<td>Not covered for members age 21 and older: routine refractive services and optical devices.</td>
</tr>
<tr>
<td>Orthotic and Prosthetic Services</td>
<td>Not covered for members age 21 and older: orthopedic shoes and supportive devices for the feet which are not an integral part of a leg brace; hearing aids and accessories.</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital Services</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>Not covered: certain outpatient drugs pursuant to Section 1927(d) of the Social</td>
</tr>
<tr>
<td>Service Type</td>
<td>Coverage Details</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Physical Therapy Services</td>
<td>Not covered for members age 21 and older. Available under EPSDT as part of a written service plan.</td>
</tr>
<tr>
<td>Physician Services</td>
<td></td>
</tr>
<tr>
<td>Podiatric Services</td>
<td>Not covered: services for flatfoot; subluxation; routine foot care, supportive devices; vitamin B-12 injections.</td>
</tr>
<tr>
<td>Pregnancy-Related Services</td>
<td></td>
</tr>
<tr>
<td>Private Duty Nursing Services</td>
<td>Not covered</td>
</tr>
<tr>
<td>Rural Health Clinic Services</td>
<td></td>
</tr>
<tr>
<td>Speech Therapy Services</td>
<td>Not covered for members age 21 and older; available under EPSDT as part of a written service plan.</td>
</tr>
<tr>
<td>Substance Abuse Treatment Services (Inpatient)</td>
<td>Substance abuse treatment, inpatient and rehabilitative, are covered as part of a written service plan.</td>
</tr>
<tr>
<td>Swing Bed Services</td>
<td></td>
</tr>
<tr>
<td>Targeted Case Management</td>
<td>Covered for pregnant women under age 21 and other pregnant women at risk for adverse outcomes; infants and toddlers with established risk for developmental delay.</td>
</tr>
<tr>
<td>Transplants</td>
<td>Not covered for members age 21 and older: heart, lung, and heart/lung transplants.</td>
</tr>
</tbody>
</table>
**Quick Reference Guide**  
**Georgia Families**  
February 2008

<table>
<thead>
<tr>
<th>Important Telephone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider Hotline/Customer Service</strong></td>
</tr>
<tr>
<td>Language services including on-site verbal interpretation in the provider’s office are available for those with limited English skills.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacy Services</th>
<th>Authorization Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Evaluation Review Fax Number</td>
<td>- Drugs not listed on the Preferred Drug List</td>
</tr>
<tr>
<td>Pharmacy After Hours/Weekends (WHI) Group Number 726257</td>
<td>- Some PDL drugs which require a DER</td>
</tr>
<tr>
<td>For areas with no 24-hour pharmacies, members can call WHI</td>
<td>- Duplication of drug therapy</td>
</tr>
<tr>
<td>Web-Based Information</td>
<td>- Dosing that exceeds the FDA daily or monthly quantity maximum</td>
</tr>
<tr>
<td>- Pharmacy Services Overview</td>
<td>- Most self-injectable and infusion drugs</td>
</tr>
<tr>
<td>- Preferred Drug List (PDL)</td>
<td>- Prescriptions that exceed $1000/prescription (some exceptions apply), and/or plan limitations</td>
</tr>
<tr>
<td>- Drug Evaluation Review (DER) Forms</td>
<td>- Brand name request when a generic exists</td>
</tr>
<tr>
<td>- Participating Pharmacies</td>
<td>- Drug that has a step edit and the first line therapy is inappropriate</td>
</tr>
<tr>
<td>- Pharmacy Updates</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Administrative Reviews (Appeals) &amp; Grievances</th>
</tr>
</thead>
<tbody>
<tr>
<td>A provider may file an appeal on behalf of the member with the member’s written consent. A provider may also seek an appeal through the Appeals Department when a claim is denied for lack of prior authorization, the service exceeds authorization, insufficient supporting documentation or late notification.</td>
</tr>
</tbody>
</table>

| Mail or fax an appeal with supporting clinical documentation to: |
| WellCare Health Plans, Inc. |
| Attn: Appeals Department |
| P.O. Box 31368 |
| Tampa, FL 33631-3368 |
| Fax: (866) 201-0657 |

| Grievances may be initiated by a call to the Customer Service department. |
| WellCare Health Plans, Inc. |
| Attn: Grievance Department |
| P.O. Box 31384 |
| Tampa, Florida 33631 |
| Fax: (866) 388-1769 |

<table>
<thead>
<tr>
<th>Risk Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trust Program - Fraud &amp; Abuse Hotline</strong></td>
</tr>
<tr>
<td>Georgia Medicaid Integrity Hotline – Report Fraud &amp; Abuse</td>
</tr>
<tr>
<td>(866) 678-8355</td>
</tr>
<tr>
<td>(800) 533-0686 or (404) 463-7590</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related to any administrative issue such as WellCare’s policies and procedures or authorization/referral process must be submitted within 45 calendar days of the event giving rise to the complaint. You may submit your complaint in writing by mail or fax to:</td>
</tr>
<tr>
<td>WellCare Health Plans, Inc.</td>
</tr>
<tr>
<td>Attn: Customer Service</td>
</tr>
<tr>
<td>P.O. Box 31370</td>
</tr>
<tr>
<td>Tampa, FL 33631-3370</td>
</tr>
<tr>
<td>Fax (813) 262-2802</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claims Department</strong></td>
</tr>
<tr>
<td>(800) 278-5155</td>
</tr>
</tbody>
</table>

| Mail medical paper claim submissions to: |
| WellCare Health Plans, Inc. |
| Attn: GA Claims Department |
| P.O. Box 31224 |
| Tampa, FL 33631-3224 |

<table>
<thead>
<tr>
<th>EDI Partners</th>
<th>EDI Payer ID</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACS EDI Gateway, Inc.</td>
<td>77004</td>
<td>(800) 987-6720</td>
</tr>
<tr>
<td>Avaluity</td>
<td>14163</td>
<td>(800) 282-4548</td>
</tr>
<tr>
<td>Emdeon (former WebMD®)</td>
<td>14163</td>
<td>(804) 855-6592</td>
</tr>
<tr>
<td>RelayHealth (McKesson)</td>
<td>14163</td>
<td>(800) 522-6562</td>
</tr>
<tr>
<td>SSI Group</td>
<td>14163</td>
<td>(800) 880-3032</td>
</tr>
<tr>
<td>ZirMed</td>
<td>14163</td>
<td>(877) 494-7633</td>
</tr>
<tr>
<td><strong>Encounter Data Submissions</strong></td>
<td>59354</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claim Appeals</strong></td>
</tr>
<tr>
<td>(800) 278-5155</td>
</tr>
<tr>
<td>The Claims Appeal process is designed to address claim denials for issues related to untimely filing, incidental procedures, bundling, unbundling, non-covered codes, etc. Claim appeals must be submitted to WellCare, in writing, within 90 days of the date of denial on the EOB. To initiate this process, please mail written Claim Appeals and documentation to:</td>
</tr>
<tr>
<td>WellCare Health Plans, Inc.</td>
</tr>
<tr>
<td>Attn: GA Claim Appeals</td>
</tr>
<tr>
<td>P.O. Box 31224</td>
</tr>
<tr>
<td>Tampa, FL 33631-3224</td>
</tr>
</tbody>
</table>

| Claim Appeals Fax | (813) 262-2802 |
|--------------------|
| Providers may also fax written Claim Appeals and documentation to the number listed above, attention of **GA Claim Appeals**. |

There is a separate and distinct appeals process available for medical necessity/authorization related claim denials. Please reference the Administrative Review section on this guide for instructions.

**NOTE:** This guide is not intended to be an all-inclusive list of covered services under WellCare Health Plans, Inc., but it substantially provides current referral and prior authorization instructions. Authorization does not guarantee claims payment. All services/procedures are subject to benefit coverage, limitations and exclusions as described in the applicable plan coverage guidelines.  
WCPC-GMD-033 Revised 2/01/08  
Page 1 of 2
Utilization Management

**URGENT Requests and Admission Notifications** - Call (866) 231-1821 and follow the prompts.
- To notify the Plan of unplanned inpatient hospital admissions and observations within 24 hours of admission. A telephone authorization must be followed by a fax submission of clinical information -- on the next business day.
- You may also call to request outpatient authorizations for urgent and time sensitive services when warranted by the patient's condition. Please include CPT and ICD-9 codes with your authorization request.

**Standard Authorization Requests**
Fax your request to the numbers listed below. Note that Place of Service codes (POS) are specified for some services. Please include CPT and ICD-9 codes with your authorization request.
- All services by non-participating providers require authorization (ALL POS) - fax to appropriate numbers below.

**Ancillary Services Request Form - Fax: (877) 431-8859**
- All durable medical equipment rentals
- Durable medical equipment purchases, with net reimbursement amount of $200 or more
- Hearing aids and devices
- Home Health Care Services
- Occupational, Physical and Speech Therapy
- Respiratory therapy services
- Transition of Care

**Inpatient Authorization Form – Fax: (877) 431-8860**
- All planned hospital admissions
- Clinical updates for medical review by nurses
- Newborn deliveries by the next business day
- Transition of Care

**Outpatient Authorization Form – Fax: (866) 455-6487**
- All services performed in an outpatient hospital or ambulatory surgery setting
- All subsequent specialist visits
- All diagnostic services performed at non-participating facilities
- Cardiac/Pulmonary Rehabilitation programs
- Court-ordered services
- Dialysis
- Domiciliary, rest home and custodial care admissions
- Hospice care services
- Laboratory Tests - Cytogenetic, Reproductive, Molecular
- *MRI, CAT, PET scans and other radiology services
- New technology and experimental procedures
- Nutritional counseling
- OB ultrasounds (2 per pregnancy without authorization; CPT 76801 or 76805 for routine pregnancies as appropriate)
- Pain Management Program
- *Plain X-rays in outpatient hospital settings
- Rehabilitation facility admissions
- Skilled nursing facility admissions
- Transition of care

**Prenatal Notification Form – Fax: (877) 647-7475**
- Submit notification of expectant mothers within 30 days of first prenatal visit.

**No Authorization Required**

**Emergency/Urgent Care**
- Emergent transportation services
- Urgent or emergent care services rendered in emergency rooms and urgent care centers

**Primary Care**
- Primary care provider office visits and minor procedures, including EPSDT (Early and Periodic Screening Diagnostics Treatment Health Check)
- *Certain diagnostic tests and procedures that are considered by the health plan to be routinely part of an office visit.

**Maternity/OB**
- Annual wellness exam, including pap-smear
- Labor checks
- Normal deliveries (notification required)
- OB Ultrasounds, up to two for routine pregnancies

**Specialists**
- Referrals for an initial consultation by participating specialists for the following CPT codes: 99201-99205, 99241-99245
- *Certain diagnostic tests and procedures that are considered by the health plan to be routinely part of an office visit.

**Laboratory**
- Routine Laboratory tests consistent with CLIA guidelines

**Radiology**
- *Plain X-rays in a free-standing imaging center, provider office, or clinic
- *Plain X-rays in rural hospitals

**Other**
- Family Planning Services
- Hearing evaluations
- *CPT code must be included with request and claim submission. A complete list of approved CPT Codes not requiring an authorization is available on our website (http://georgia.wellcare.com) in the Provider Resources area, under Forms and Documents. For a copy, click here.

PLEASE NOTE: Failure to obtain the required prior approval/pre-certification from WellCare will result in a denied claim. This guide is not intended to be an all-inclusive list of covered services but it substantially provides current referral and prior authorization instructions. All services/procedures are subject to benefit coverage, limitations and exclusions as described in applicable plan coverage guidelines.

**Contracted Networks**
For authorizations and customer service related to services provided by contracted networks, please contact the following:

**Behavioral Health** [Magellan Health](800) 424-5412
(包括 Inpatient/Outpatient Mental Health Alcohol/Substance abuse)

**Dental** [Doral](800) 516-9615
(866) 522-5923
(Vision [Avesis](866) 522-5923
(Routine vision checks, glasses and contacts)

**Place of Service Codes (POS)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Office</td>
</tr>
<tr>
<td>20</td>
<td>Urgent Care Facility</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient Hospital</td>
</tr>
<tr>
<td>23</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory Surgery Center</td>
</tr>
<tr>
<td>31</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>32</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>50</td>
<td>FQHC</td>
</tr>
<tr>
<td>61</td>
<td>Inpatient Rehab</td>
</tr>
<tr>
<td>62</td>
<td>Outpatient Rehab</td>
</tr>
<tr>
<td>65</td>
<td>ESRD</td>
</tr>
<tr>
<td>71</td>
<td>Public Health Clinic</td>
</tr>
<tr>
<td>72</td>
<td>Rural Health Clinic</td>
</tr>
<tr>
<td>81</td>
<td>Laboratory</td>
</tr>
</tbody>
</table>

NOTE: This guide is not intended to be an all-inclusive list of covered services under WellCare Health Plans, Inc., but it substantially provides current referral and prior authorization instructions. Authorization does not guarantee claims payment. All services/procedures are subject to benefit coverage, limitations and exclusions as described in the applicable plan coverage guidelines. WCPC-GMD-033 Revised 2/01/08
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- Abortion Certificate of Necessity Form (DMA-311)
- Administrative Review Request Form - Member
- Administrative Review Form - Provider
- Applicable Co-payments
- Appointment of Representative Statement
- Case Management Referral Form
- CMS 1500 Submission Sample
- Complaint Request Form - Provider
- Grievance Form - Member
- Hysterectomy Form Patient Acknowledgement (DMA-276)
- Hysterectomy Information
- Incident Report
- Informed Consent for Voluntary Sterilization (DMA-69)
- Request for Referral/Certification
- UB-04 Submission Sample
CERTIFICATE OF NECESSITY FOR ABORTION (DMA-311)

This is a federal mandated form that must be completed and attached to all invoices containing claim lines submitted for reimbursement for abortion procedures and abortion-related procedures.

The Department will reimburse only for abortion which meet the criteria established in Part II, Chapter 900 of the Policies and Procedures for Physician Services manual.

GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE
CERTIFICATION OF NECESSITY FOR ABORTION

THE INFORMATION PROVIDED ON THIS FORM IS CONFIDENTIAL UNDER FEDERAL LAW AND REGULATIONS AND CANNOT BE DISCLOSED WITHOUT THE INFORMED CONSENT OF THE MEMBER.

MEMBER INFORMATION

NAME ____________________________

MEDICAID # ____________________________

ADDRESS ______________________________________

______________________________________________

STATEMENT OF MEDICAL NECESSITY

This is to certify that I am a duly licensed physician and that in my professional judgment, an abortion is medically necessary for the reason indicated below:

☐ This patient suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place this woman in danger of death unless an abortion is performed.

☐ The pregnancy is the result of rape.

☐ The pregnancy is the result of incest.

_________________________________________, M.D.

(Print Name)

_________________________________________, M.D.

(Signature of Physician)

DMA-311 (Rev. 3/03)

746:311 (ATT 12)
Non-Medicare Member Administrative Review Request Form

Please use this form to submit your administrative review in writing. You may attach additional sheets, if necessary. If you have filed a standard administrative review verbally, you must send this form back to the Plan prior to our completion time frame of your verbal request. If the form or written request is not received, no decision will be returned to you.

☐ Medicaid  
Request Date: _____________

☐ PeachCare for Kids  
Has the service been provided yet? __Yes __No

Expedited Request: ___ Yes ___No * See Below

Requestor (Appellant) Information

Name: ________________________________________________
Address: __________________________________________________________________
City: ________________________________________________
Telephone: ________________________________
Contact Person: _________________________________

Relationship to Member:

☐ Self  ☐ Appointed Representative  ☐ Power of Attorney  ☐ Parent/Guardian
☐ Provider (must have written consent from member to file on member’s behalf)

Member Information

Name: ________________________________________________
Address: __________________________________________________________________
City: ________________________________________________
ID Number: _____________________________
Date of Birth: ______________________________
Telephone: ________________________________

SERVICES PLANNED INFORMATION (Pre-service Request)

Who are you requesting to provide the service?

Name: __________________________________________________________________
Address: __________________________________________________________________
City: ___________________________________________________________________
Telephone: ________________________________
Contact Person: _________________________________

What date is the service planned to begin? ______________________________
Why do you feel the planned service should be authorized?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

If your denial received was for a request for an out-of-network provider, why do you feel we should authorize the request?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

SERVICES PROVIDED INFORMATION (Retrospective request)

Who provided the service(s) or who are you being billed by?

Name: __________________________________________________________________
Address: ________________________________________________________________
City: ______________________________________________
Telephone: _________________________________________
Contact Person: _____________________________________
Date(s) of Service: ___________________________________

Please state why the services were not authorized prior to services being rendered:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

I hereby request an administrative review described in this document and understand that in order for the administrative review to be considered, WellCare of Georgia, Inc. (the Health Plan), may need medical records and other records or other information related to my appeal. I authorize persons or entities that have any medical or other records, or knowledge of me or my dependants, to release such information to WellCare of Georgia, Inc. (the Health Plan). Those persons or entities may include any: 1) licensed physician; 2) medical practitioner; 3) hospital, 4) clinic or other medical or medically-related provider; 5) insurer; 6) employer; or 7) other organization, institution, or person. I specifically authorize the release of the following records or information if needed for the review of my administrative review: any and all medical records and information about, associated with, or with reference to: 1) a positive test result for HIV infection; 2) ARC; 3) AIDS; 4) alcohol or drug dependency; and 5) mental and nervous disorders.

Member or Authorized Representative’s Signature .................................................. Date ..........................
You may fax to (866) 201-0657 or mail to:

WellCare of Georgia, Inc.
Attn: Appeals Department
P.O. Box 31368
Tampa, Florida 33631-3368

If you have any further questions or concerns regarding this form, or about your administrative review and grievance rights, please contact Customer Service at (866) 231-1821, or you may also access TTY/TDD (877) 247-6272, if hearing impaired. Our hours of operation are Monday - Friday 7:00 a.m. – 7:00 p.m. ET, except for holidays.

* Expedited Administrative Review:

An administrative review for a service that has not already been rendered and which taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function.

- A request for expedited administrative review submitted by your treating physician or with support from your treating physician will automatically be processed as an expedited administrative review.

- If either of these are lacking, the Plan will review your request and determine if your request should be processed as expedited. If we do not agree with your request, we will notify you and provide you with grievance rights to grieve our decision not to expedite your grievance. Your request will then be transferred to the Standard Administrative Review process and a decision will be issued within 45-calendar days.

**Administrative Review Timeframes**

Standard request: 30 calendar days from receipt
Expeditied request: 72 hours from receipt
Provider Administrative Review Request Form

Harmony Health Plan
HealthEase
Healthy Kids
Staywell
WellCare Choice
WellCare Commercial

Request Date: __________
Has the service been provided yet? ☐ Yes ☐ No
Expedited Request? ☐ Yes ☐ No
(See reverse side for definition of Expedited Request)

Provider/Appellant Information

Name: ____________________________________
Address: __________________________________
City: _____________________________________
Telephone: ________________________________
Fax: _____________________________________
Contact Person: ____________________________

Patient Information

Name: ________________________________
ID Number: _____________________
Date of Birth: ________________________
Date(s) of Service: __________________
Place of Service: _________________________

Service Provided Information

√ Reason Given for Denial (from EOB or denial letter)

☐ Medical Necessity
☐ Lack of Information
☐ Not Prior Authorized
☐ Benefits Exhausted
☐ Out of Network
☐ Not a Covered Benefit
☐ Untimely Filing
☐ Invalid Code
☐ Inclusive
☐ Exclusive
☐ Incidental
☐ Medicare Payment In Full
☐ Claim Not Billed as Authorized
☐ Exceeds Authorization
☐ Other: ________________________________

Reason for Request:
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Unless your contract allows otherwise, WellCare will pay the Medicare or Medicaid allowable, depending on member’s plan, for the service performed if we overturn our previous decision. By signing this form, you agree to these terms and will not bill the member, except for applicable co-pays.

Signature: ________________________________ Date: __________________________

This form is to be used when you want to appeal a claim or authorization denial. Fill out the form completely and keep a copy for your records. Send this form with all pertinent medical documentation to support the request to WellCare Health Plans, Inc., Attn: Appeals Department, P.O. Box 31368 Tampa, FL 33631-3368. You may also fax the request if fewer than 10 pages to (866) 201-0657. Your appeal will be processed once all necessary documentation is received and you will be notified of the outcome.

See other side for additional information.
**Filing on Member’s Behalf**
Member appeals for medical necessity, out-of-network services benefit denials or services for which the member can be held financially liable must be accompanied by an Appointment of Representation form or other office documentation signed and dated by the member you are appealing on behalf of, unless you are an attorney, power of attorney, court appointed guardian or health care proxy agent with associated documentation.

**Expedited Request**
Applies when the standard 30-calendar-day time frame could jeopardize the life or health of the member or the member’s ability to regain maximum function. A decision will be made within 72 hours of receipt.

**Documentation needed:** All Medical Information Needed to Determine Medical Necessity. Examples:
- **Inpatient or observation stays**—doctor orders, progress notes, ER notes, medication record, lab reports, nurses notes, consultation reports, PT/OT/ST notes (if applicable)
- **Procedures**—procedure report, supporting consultation reports, PCP progress notes, referring MD script
- **Consultations**—consultation report, referring MD script
- **PT, OT, ST**—progress notes, evaluations, summaries, Referring MD script
- **Radiology**—reports, referring MD script
- **Timely filing**—billing notes, fax confirmation, certified, signed mail card
Children under the age of 21, pregnant women, nursing facility residents and hospice care members are exempt from co-payments. There are no co-payments for family planning or emergency services except as defined below. Services may not be denied to anyone based on the inability to pay these co-payments.

<table>
<thead>
<tr>
<th>Service</th>
<th>Additional Exceptions</th>
<th>Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Surgical Centers</td>
<td></td>
<td>A $3 co-payment to be deducted from the surgical procedure code billed. In the case of multiple surgical procedures, only one $3 amount will be deducted per date of service.</td>
</tr>
<tr>
<td>FQHC/RHCs</td>
<td></td>
<td>A $2 co-payment on all FQHC and RHC.</td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td>A $3 co-payment is required on all non-emergency outpatient hospital visits.</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Members who are admitted from an emergency department or following the receipt of urgent care or are transferred from a different hospital, from a skilled nursing facility, or from another health facility are exempted from the inpatient co-payment.</td>
<td>A co-payment of $12.50 will be imposed on hospital inpatient services.</td>
</tr>
<tr>
<td>Emergency Department</td>
<td></td>
<td>A $6 co-payment will be imposed if the condition is not an emergency medical condition.</td>
</tr>
<tr>
<td>Oral Maxiofacial Surgery</td>
<td></td>
<td>A $2 co-payment will be imposed on all evaluation and management procedure codes (99201-99499) billed by oral surgeons.</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
<td>Drug Cost / Co-pay Amount&lt;br&gt;Less than $10.01 / $.50&lt;br&gt;$10.01 - $25.00 / $1.00&lt;br&gt;$25.01 - $50.00 / $2.00&lt;br&gt;More than $50.01 / $3.00</td>
</tr>
</tbody>
</table>
Non-Medicare Member Appointment of Representative Statement

SECTION I
APPOINTMENT OF REPRESENTATIVE

________________________________          _____________________________
Member Name                                   Member ID Number

________________________________         _____________________________
Name of Provider in Question                               Dates of Service

$_______________________________               ______________________ _____________
Amount of Charges                                             Requested Service (Pre-Service)

I do hereby swear that I am the above-mentioned member or have the legal authority to appoint a representative for the above-mentioned member. I do hereby appoint the following individual to act as my representative in requesting a reconsideration from the above-referenced health plan and for the services for which the above-referenced health plan has denied payment or authorization.

______________________________________      ______________________
Member’s Signature                                                          Date

SECTION II
ACCEPTANCE OF APPOINTMENT

I, __________________________________________ hereby accept the above appointment.

(Appointed Representative)

______________________________________                 ___________________
Signature of Appointed Representative                                           Date
Fax to: 1-866-287-3286

Please print or type requested information below.

<table>
<thead>
<tr>
<th>Date:</th>
<th>Referral Date:</th>
</tr>
</thead>
</table>

**CHECK ONE OF THE FOLLOWING:**

- [ ] Case Management
- [ ] Disease Management

**PATIENT INFORMATION**

*Please verify with patients that all demographic information is correct for timely and effective processing.*

<table>
<thead>
<tr>
<th>County</th>
<th>Member Phone #:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member Name (Last, First, MI):</th>
<th>Member DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

| Member Address (Full Address): | |
|--------------------------------||
|                                 | |

| Subscriber ID #: | |
|-----------------||
|                 | |

<table>
<thead>
<tr>
<th>PCP Name:</th>
<th>PCP Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital Name:</th>
<th>Hospital Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**REFERRAL INFORMATION**

**Name of Referring PCP or Specialist (Full Name):**

<table>
<thead>
<tr>
<th>Phone Number: (Include Area Code)</th>
<th>Fax Number: (Include Area Code)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**REASON FOR REFERRAL:** (Include CLINICAL INFORMATION below)

**DIAGNOSIS:** (Include CLINICAL INFORMATION below)

**CASE MANAGEMENT USE ONLY**

<table>
<thead>
<tr>
<th>CM STATUS</th>
<th>Accepted</th>
<th>Rejected</th>
<th>CM Screening Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Screened by:</th>
<th>Assigned to CM:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fill in if different from reviewer name</td>
</tr>
</tbody>
</table>

Reason for REJECTION:
Provider Complaint Form

Request Date: _____________

Provider Information

Name: ____________________________________
Address: ________________________________
City: ____________________________________
Telephone: ______________________________
Fax: ___________________________________
Contact Person: _________________________

Patient Information

Name: ____________________________________
ID Number: ______________________________
Date of Birth: ____________________________

Information on Service Provided

Date(s) of Service: _______________________
Place of Service: _________________________

Complaint Reason

☑ WellCare Administration
☐ Provider Reimbursement
☐ Member Behavior
☐ Contracting
☐ Health Care Delivery

Explanation of Issue(s)

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Fill out the form completely and keep a copy for your records. Send this form with all documentation to support the complaint to WellCare of Georgia, Inc. Attn: Grievance Department at P.O. Box 31384 Tampa, FL 33631-3384. Your request will be processed once all necessary documentation is received and you will be notified of the outcome.

*Failure to submit supporting documentation may delay our response to your complaint.
NON-MEDICARE MEMBER FORMAL GRIEVANCE FORM

Please use this form or a separate letter for information needed for the review of your grievance. Be as complete and detailed as possible. If the grievance is about a physician(s), be sure to list the name(s) of the doctor(s). If medication is the issue, list all the names of the medications. If the grievance is about a balance billing, please attach the billing statement from the provider.

Member Name: __________________________ Member Phone: __________________________

Member ID#: __________________________

Relationship to Member:  ○ Self ○ Appointed Representative ○ Power of Attorney ○ Parent/Guardian

Type of Coverage:  ○ Medicaid ○ PeachCare for Kids

Type of Grievance

| ______ | Physician Related | ______ | Enrollment/Disenrollment Related |
| ______ | Hospital Related | ______ | Provider- Poor Customer Service |
| ______ | Delay in Getting Physician Care | ______ | Telephone Problems |
| ______ | Delay in Getting Hospital Care | ______ | Transfer of Centers |
| ______ | Plan–Poor Customer Service | ______ | Other: ________________________ |

Date of occurrence that caused grievance: __________________________ (month, day, year)

Nature of Complaint:
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

I would like my grievance to be handled as:  ○ Expedited/Urgent: 72 hours ○ Standard: 45 calendar days

If you feel should be handled as Expedited, explain why:
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

How would you like your grievance resolved?
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
What date(s) was the service provided? ______________________________________________________

Name of physician or hospital who provided the service: _________________________________________

Have you discussed this grievance with any company staff/personnel? ☐ Yes ☐ No

If yes, with whom?

1. ______________________________________________________
2. ______________________________________________________
3. ______________________________________________________

What did they say?

1. ______________________________________________________
2. ______________________________________________________
3. ______________________________________________________

If your grievance involves balance billing, have you paid the bill you are referencing? ☐ Yes ☐ No

Where did you receive the service?  _________________________________________________________

When? _______________________   By whom?  ___________________________________________

Other comments:
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

I HEREBY request a review of the Grievance described in this document and understand that in order for the
Grievance to be reviewed, WellCare of Georgia, Inc., (the Health Plan), may need medical records and other
records or other information related to my grievance. I authorize persons or entities that have any medical or
other records, or knowledge of me or my dependants, to release such information to WellCare of Georgia,
Inc., (the Health Plan). Those persons or entities may include any: 1) licensed physician; 2) medical
practitioner; 3) hospital, 4) clinic or other medical or medically-related provider; 5) insurer; 6) employer; or 7)
other organization, institution, or person. I specifically authorize the release of the following records or
information if need for the review of my Grievance: any and all medical records and information about,
associated with, or with reference to: 1) a positive test result for HIV infection; 2) ARC; 3) AIDS; 4) alcohol or
drug dependency; and 5) mental and nervous disorders.

I also understand that if the Grievance described in this form is not resolved to my satisfaction, I may request
a Second-Level review to the Corporate Appeals and Grievance Committee.

_______________________________________  ____________________________
Member Name (please print)    Date

_______________________________________  
Member’s or Representative’s Signature

Please fax this form to (866) 388-1769, or mail to:

WellCare Health Plans, Inc.
Attn: Grievance Department
P.O. Box 31384
Tampa, FL 33631-3384
GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

Medicaid Program

RECIPIENT INFORMATION

RECIPIENT NAME: LAST          FIRST                                                           INITIAL               SUFFIX

RECIPIENT MEDICAID CASE NO.

PATIENT'S ACKNOWLEDGEMENT OF PRIOR RECEIPT OF HYSTERECTOMY INFORMATION

Section 1—Recipient’s Statement

I have been told and I understand that this hysterectomy (operation to remove my womb uterus) will cause/has caused me to be permanently sterile (unable to bear children).

Signature of Medicaid Recipient                                  Date

OR

Signature of Recipient                                                     Date

STATEMENT OF MEDICAL NECESSITY

Section II – Physician’s Statement

The above mentioned hysterectomy will be/has been performed for medical necessity, not for sterilization, hygiene purposes or mental retardation.

Check one of the below if applicable. – (Recipient’s signature not required if number 1 or 2 is applicable.)

1. Recipient was sterile prior to hysterectomy. The recipient was sterile because _________________________________
   ____________________________________________________________________________________________________
   ____________________________________________________________________________________________________

2. Emergency Hysterectomy: (Attach a copy of the discharge summary and operative record to validate the emergency hysterectomy.)

   Physician’s Name (Please print)                                      Date
   Physician’s Signature

DMA 276 (Rev. 4/03)
Hysterectomy Information

WellCare reimburses for those hysterectomy procedures outlined in the Scope of Services section of the Georgia Medicaid Hospital Services Handbook.

A copy of the "Patient's Acknowledgement of Prior Receipt of Hysterectomy Information" (DMA-276) is attached. This form must be signed either before or after the hysterectomy, as follows, and must be attached to the claim form submitted to WellCare for payment.

Claims submitted to WellCare for payment without the required documentation or with incomplete or inaccurate documentation will be denied. WellCare does not accept documentation meant to satisfy informed consent requirements which has been completed or altered after the service was performed.

Reference the attachment:

- Section I - Member's Statement

The member or her representative must sign and date this form in the spaces provided unless the member was sterile prior to the hysterectomy or the hysterectomy was an emergency.

- Section II - Physician's Statement

The physician must sign and date this form on all hysterectomies performed. If the member was sterile prior to the hysterectomy, the physician must indicate this condition beside #1 and state the reason for prior sterility. If the hysterectomy was an emergency, the physician must indicate this condition beside #2 and attach the discharge summary and operative record.
# Incident Report

**CONFIDENTIAL**

**WellCare Health Plans, Inc.**

The WellCare Group of Companies

**INSTRUCTIONS:** This Incident Report Form is used to report adverse incidents or injuries that occur to members, visitors, or associates. Complete this report in full and submit the original to HR immediately after the incident. Do NOT make copies of this report. Fax the completed report to 800-873-5292.

## PERSON INJURED

<table>
<thead>
<tr>
<th>Last Name, First Middle Initial</th>
<th>Date of Birth</th>
<th>☐ Male</th>
<th>☐ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Associate</td>
<td>☐ Visitor</td>
<td>☐ Member</td>
<td></td>
</tr>
<tr>
<td>Street Address</td>
<td></td>
<td>Member ID #</td>
<td></td>
</tr>
<tr>
<td>City, State, Zip Code</td>
<td></td>
<td>Contact Number</td>
<td></td>
</tr>
</tbody>
</table>

## DETAILS OF INCIDENT

<table>
<thead>
<tr>
<th>Date of Incident:</th>
<th>Time of Incident:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location (Be specific and include facility name, street address, building number, floor, direction such as NE corner, etc.)</td>
<td></td>
</tr>
<tr>
<td>Diagnosis and diagnosis codes</td>
<td></td>
</tr>
<tr>
<td>Is additional information attached?</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>Clear and concise description of incident.</td>
<td></td>
</tr>
</tbody>
</table>

## WITNESS(ES)

<table>
<thead>
<tr>
<th>Last Name, First Middle Initial</th>
<th>Street Address</th>
<th>City, State, Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## PHYSICIAN INFORMATION

<table>
<thead>
<tr>
<th>Physician notified?</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalized?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

If yes, complete the following:

Name of Physician or Facility
Street Address
City, State, Zip
Summary of physician’s recommendation, if applicable.

## PERSON COMPLETING REPORT

<table>
<thead>
<tr>
<th>Last Name, First Middle Initial</th>
<th>Department</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td>Date</td>
<td>Time</td>
</tr>
</tbody>
</table>

## HUMAN RESOURCES

Summary and Disposition:

<table>
<thead>
<tr>
<th>Last Name, First Middle Initial</th>
<th>Title</th>
<th>Date:</th>
</tr>
</thead>
</table>

## RISK MANAGER

<table>
<thead>
<tr>
<th>Last Name, First Middle Initial</th>
<th>Title</th>
<th>Date:</th>
</tr>
</thead>
</table>
INFORMED CONSENT FOR VOLUNTARY STERILIZATION

CONSENT TO STERILIZATION

1. I have asked for and received information about sterilization from ________ Provision or Clinic ________

2. I had asked for the sterilization, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment and I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid, that I am not getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN, OR FATHER CHILDREN.

3. I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father children in the future. I have rejected these alternatives and chosen to be sterilized.

4. I understand that I will be sterilized by an operation known as a ________ Sterilization Procedure ________ The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

5. I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits from programs receiving Federal funds.

6. I am at least 21 years of age and was born on ________ Month ________ Day ________ Year ________

7. I ________ Print name of Member ________ hereby consent of my own free will to be sterilized
by ________ Print name of Physician ________ by a method called ________ Sterilization Procedure ________ My consent expires ________ days from the date of my signature below ________

8. I also consent to the release of this form and other medical records about the operation to Representatives of the Department of Health, Education, and Welfare or Employees of programs funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form ________

Signature of Medicaid Recipient ________ Date Signed ________ Month ________ Day ________ Year ________

You are requested to supply the following information, but it is not required: Race and ethnicity designation (please check)
Black (not Hispanic descent) ________
Hispanic ________
Asian or Pacific Islander ________
American Indian or Alaskan Native ________
White (not of Hispanic origin) ________

INTERPRETER’S STATEMENT

I have translated the information and advice presented orally to the individual to be sterilized by the individual obtaining this consent. I have also read the consent form to ________ Name of Member ________ in ________ language and explained its contents to him/her ________

To the best of my knowledge and belief he/she understood this situation ________

Signature of Interpreter ________ Date ________ Month ________ Day ________ Year ________

IN ORDER FOR THIS FORM TO BE VALID BOTH SIDES MUST BE COMPLETED ________

(Refer to Reverse Side) ________

DMA-85 (8443) ________
STATEMENT OF PERSON OBTAINING CONSENT

Before _______________________________ Name Of Member ___________________________ signed this consent form, I explained to him/her the nature of the sterilization operation, _______________________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

______________________________
Signature Of Person Obtaining Consent

______________________________
Date

______________________________
Facility

______________________________
Address

__________________________________________________________________________________________________________

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _______________________________ Name of Member ___________________________ on _______________________________, I explained to him/her the nature of the sterilization operation _______________________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

SELECT THE APPROPRIATE PARAGRAPH: NUMBER (1) OR NUMBER (2)
(Cross out the paragraph which is not used.)

Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual’s signature on the consent form. In those cases, the second paragraph below must be used.

(1) At least 30 days have passed between the date of the individual’s signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual’s signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery
  Individual’s date of expected delivery _______________________________

☐ Emergency abdominal surgery (describe circumstances): _______________________________

__________________________________________________________________________________________________________

______________________________
Physician’s Signature

______________________________
Date

DMA-69 (04/03)
REQUEST FOR REFERRAL/CERTIFICATION

Fax to: ____________________________ (based on the member’s county of residence – see attached)

MEMBER INFORMATION, DIAGNOSIS (ICD-9 CODE) & TREATMENT (HCPCS/CPT CODE)

* Request Type: Routine_____ Stat_____ Expedited_____

Request Date: __________________ Request for Hospital Admission or Observation? Yes _____ No _____

Member Name: _________________________________
Member ID #: __________________________________
Diagnosis: _____________________________________
Requested days/visits: ____________________________
Start/Service Date: _______________________________
Service Requested:_______________________________
Member Date of Birth: ________________________
Member Telephone #: _________________________
ICD-9 Code: ________________________________
Expiration Date:   ____________________________
HCPCS/CPT Code: __________________________

REQUESTED BY

Physician: ______________________________________
WellCare Provider #: _____________________________
TIN# _________________________________________
Address: ___________________________________
City: _____________    State: _____    Zip: _______
Telephone #: ____________  Fax #: _____________

REFERRED TO

Physician/Provider: ______________________________
WellCare Provider #: _____________________________
Facility Name: __________________________________
Facility Address: __________________________________
City: ____________ State: _____ Zip: _______
Telephone #: ____________  Fax #: _____________

RESPIRATORY EQUIPMENT

Oxygen: _______ Concentrator: _______ Liter Flow: _______ (Requires 02 Sat% +/-Date)
C Pap/B Pap: _______ Settings: _______ (Studies req.) Nebulizer: _______ Masks/Kits: _______
Trach Supplies (specify) __________

DME

Member Weight: _______ Height: _______ (Required to ensure appropriate size) W/C: ______
Hospital Bed: _____ Walker: _____ Quad Cane: _____ BSC: _____ Special equipment needs: _________________

Clinical Information: _________________________________________________________________

_____________________________________________________________________________________

Delivery Address: __________________________________ City: _____________ State: _____ Zip: _______
Phone # 1: ___________________________ Phone # 2: ______________________

* See Provider Manual for definition of routine, stat and expedited.

Authorizations are not a guarantee of payment. Payment of claims is subject to a member’s eligibility, covered benefits, limitations and exclusions on the date of service and to any other contractual provision of the plan.

Physician’s Signature ____________________________________________
**Billing Provider’s Name, Address, State & Zip**

Matching vendor information on contract.

**Pay to:** Name, Address, State & Zip if different from field 1.

- **Field 56 NPI**
  - MUST include TAX ID Number

- **Field 76 NPI**
  - Billing Provider ID
  - Not to be reported, effective 5/23/08

- **Field 77 NPI**
  - Operating Provider NPI

- **Field 78-79 NPIs**
  - Other Provider NPIs

- **Field 71 PPS Code**
  - Enter DRG Code

81 CC Taxonomy Codes corresponding to fields 76-79.

Ensure use of correct form.