WellCare® of Kentucky

2025–2026

Kentucky Medicaid Provider Manual

wellcareky.com

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Partners in Quality Care

Dear Provider Partner:

At WellCare we value everything you do to deliver quality care to our enrollees – your patients. Through our combined efforts we ensure that our enrollees continue to trust us to help them in their quest to lead longer and more satisfying lives.

We're committed to quality. That pledge demands the highest standards of care and service. We are constantly investing in people and programs, innovating, and working hard to remove barriers to care.

WellCare's dedication to quality means that we are also committed to supporting you. We want to make sure that you have the tools you need to succeed. We will work with you and your staff to identify enrollees with outstanding care gaps.

The enclosed provider manual is your guide to working with us. We hope you find it a useful resource, and the areas highlighted to the right are sections of the manual that directly address our mutual goal of delivering quality care.

Thank you again for being a trusted WellCare provider partner!

Sincerely,

WellCare

Quality Highlights

Section 2

- Responsibilities of All Providers
- Access Standards
- Cultural Competency Program and Plan
- Enrollee Rights and Responsibilities

Section 3

- Quality Improvement

Section 4

- Criteria for Utilization Management Decisions
- Prior Authorization
- Access to Care and Disease Management Programs

Section 7

- Appeals and Grievances

Section 10

- Continuity and Coordination of Care Between Medical and Behavioral Healthcare

Section 11

- Preferred Drug List

2025 WellCare of Kentucky Provider Manual Table of Revisions

Date	Section	Comments	Change
2/25/2024	Section 3: Quality Improvement	Diamond Designation™ Program	Updated content description
9/20/2024	Section 3: Quality Improvement	Provider Participation in the Quality Improvement Program verbiage	Updated to comply with 2024 NCQA Accreditation Standards
9/20/2024	Section 2: Provider and Enrollee Administrative Guidelines	Healthy People verbiage and link	Updated to reflect current 2030
9/20/2024	Section 2: Provider and Enrollee Administrative Guidelines	Cultural Competency Section	Updated verbiage
9/20/2024	Section 2: Provider and Enrollee Administrative Guidelines	Dental Home	Section Added
9/20/2024	Section 2: Provider and Enrollee Administrative Guidelines	Specialists Provider Section	Section Added
9/20/2024	Section 2: Provider and Enrollee Administrative Guidelines	Smoking Cessation	Resources added
9/20/2024	Section 2: Provider and Enrollee Administrative Guidelines	Changing PCP	Updated verbiage
9/20/2024	Section 4: Utilization Management (UM), Care Management (CM) and Disease Management (DM)	Criteria for UM decisions	Updated to comply with 2024 NCQA Accreditation Standards
9/20/2024	Section 11: Pharmacy	PDL	Updated to comply with 2024 NCQA Accreditation Standards
9/20/2024	Section 4: Utilization Management (UM), Care Management (CM) and Disease Management (DM)	Chronic Care Management	Section added to comply with 2024 NCQA Accreditation Standards

Date	Section	Comments	Change
9/20/2024	Section 6: Credentialing	Updated verbiage	Updated to comply with 2024 NCQA Accreditation Standards
9/20/2024	Section 2: Provider and Enrollee Administrative Guidelines	Enrollee rights and responsibilities updated verbiage	Updated verbiage to reflect NCQA 2024 Accreditation Standards
9/20/2024	Section 3: Quality Improvement	Clinical Practice Guidelines updated	Updated verbiage to reflect NCQA 2024 Accreditation Standards
9/20/2024	Section 2: Provider and Enrollee Administrative Guidelines	Responsibilities of Primary Care Providers	Updated verbiage to reflect NCQA 2024 Accreditation Standards
9/20/24	Section 8: Compliance	Confidentiality of Enrollee Information and Release of Records	Updated verbiage to reflect NCQA 2024 Accreditation Standards
9/20/24	Section 8: Compliance	Sections added: Medical Records Audits, Access to Records and Audits, EMR Access	Updated to comply with 2024 NCQA Accreditation Standards
9/20/24	Section 4: Utilization Management (UM), Care Management (CM) and Disease Management (DM)	UM Affirmation	Updated verbiage to reflect NCQA 2024 Accreditation Standards
9/23/24	Section 1: Overview	My Health Pays	Updated verbiage
9/25/24	Section 1: Overview	Free Benefits for Enrollees	Updated verbiage
9/26/24	Section 2: Provider and Enrollee Administrative Guidelines	Smoking Cessation	Quit now information and CDC resources added
11/6/2024	Section 2: Provider and Enrollee Administrative Guidelines	Submission of NOP form	Verbiage updated
9/9/2025	Section 5: Claims	Claims Payment Appeals	New mailing address for administrative hearings
9/15/2025	Section 7: Appeals and Grievances	Provider Appeals Process	New mailing address for administrative hearings
9/15/2025	Section 3: Quality Improvement	Diamond Designation Program	Updated language

Date	Section	Comments	Change
	Section 7: Appeals and Grievances	*State Fair Hearing for Enrollees*	*New mailing address*

Section 1: Welcome to WellCare

Overview
WellCare of Kentucky is a wholly owned subsidiary of Centene Corporation, a leading multi-line healthcare enterprise offering both core Medicaid and specialty services. WellCare provides managed care services targeted exclusively to government-sponsored healthcare programs. It focuses on Medicare, Medicaid and Children's Health Insurance Programs, including prescription drug plans and health plans for families, and the aged, blind and disabled. Centene's experience and commitment to government-sponsored healthcare programs enables WellCare to serve its Enrollees and Providers, as well as manage its operations effectively and efficiently.

Mission
Our Enrollees are our reason for being. WellCare helps those eligible for government-sponsored healthcare plans live better, healthier lives.

Vision
To be a leader in government-sponsored healthcare programs in collaboration with our Enrollees, Providers, and government partners. WellCare fosters a rewarding and enriching culture to inspire our associates to do well for others and themselves.

Core Values

- *Partnership – WellCare delivers excellent service to our Enrollee, Provider, and government partners. Enrollees are the reason we are in business; Providers are our partners in serving our Enrollees; and government partners are the stewards of the public's resources and trust.*
- *Integrity – WellCare does the right thing to keep the trust of those we serve and with whom we work.*
- *Accountability – WellCare is responsible for the commitments we make and the results we deliver, both internally and externally.*
- *One Team – WellCare demonstrates a collaborative "One Team" approach across all areas and puts Enrollees first in all we do.*

Purpose of this Provider Manual
This Provider Manual is intended for Medicaid Providers that are contracted with WellCare and provide healthcare service(s) to WellCare members enrolled in a WellCare Medicaid managed care plan. This Manual serves as a guide to the policies and procedures governing the administration of WellCare's Medicaid plans and is an extension of and supplements the Provider Contract between WellCare and healthcare Providers who include, without limitation: physicians, hospitals, and ancillary Providers (collectively, Providers).

***This Manual replaces and supersedes any previous versions prior to September 15, 2025, and is available at wellcareky.com**. A paper copy may be obtained, at no charge, upon request by contacting Provider Services or a Provider Relations representative.*

In accordance with the Policies and Procedures clause of the Provider Contract, participating WellCare Medicaid Providers must abide by all applicable provisions contained in this Manual. Revisions to this Manual reflect changes made to WellCare's Policies and Procedures. Revisions shall become binding 30 days after notice is provided by mail or electronic means, or such other

period of time as necessary for WellCare to comply with any statutory, regulatory, contractual and/or accreditation requirements. As the Policies and Procedures change, updates will be issued by WellCare in the form of Provider Bulletins and will be incorporated into subsequent versions of this Manual.

WellCare's Medicaid Managed Care Plans

WellCare provides Medicaid and CHIP managed care services in the Commonwealth of Kentucky (Commonwealth). These products are offered in select markets to allow flexibility and offer a distinct set of benefits to fit Enrollee needs in each area. For product information, please refer to the Quick Reference Guide at ***wellcareky.com****.*

Eligibility

Eligibility for Kentucky's Medicaid program is solely determined by the Department. Upon determination of eligibility, Kentucky Medicaid recipients will be enrolled with a Medicaid managed care plan, provided the following conditions are met:

- *The individual must reside within a Medicaid managed care region; and*
- *The individual must qualify to receive Medicaid assistance under one of the aid categories defined by the Department.*

Individuals eligible for Kentucky Medicaid can be categorized into:

- *Families and children, including children enrolled in the Kentucky Children's Health Insurance Program (KCHIP);*
- *Aged, Blind or Disabled (ABD);*
- *Adults aged 19 to 64 with income under 138% of the Federal Poverty Level; and*
- *Former Foster Care Children up to age 26.*

The families and children population is comprised of children, pregnant women and caretaker relatives. The ABD population is comprised mostly of individuals with disabilities or those who are 65 years old or older.

Certain Enrollees who are eligible for Medicaid, including those eligible for both Medicaid and Medicare, children in foster care and children with disabilities, may be voluntarily enrolled into a Medicaid MCO, but may not be enrolled on a mandatory basis without a waiver from the Centers for Medicare & Medicaid Services (CMS).

For more information on Medicaid assistance, refer to the Kentucky Department for Medicaid Services website at ***chfs.ky.gov/agencies/dms****.*

Core Benefits and Services

The following Covered Services are provided as Medically Necessary to WellCare's Kentucky Medicaid Enrollees:

Benefit/Services	Co-pay	Description/More Information
Allergy services	**$0**	• Covers both adult and children
Ambulatory surgical centers	**$0**	• Per visit • Does not cover cosmetic surgery (except for post-mastectomy reconstructive surgery)

Benefit/Services	Co-pay	Description/More Information
Behavioral health services	***$0***	• *Treatment for mental health (MH) disorders* • *Treatment for substance use (SU) disorders* • *Treatment for co-occurring MH and SU disorder*
Cervical and vaginal cancer screening (Pap tests, pelvic exams)	***$0***	• *Per screening* • *1 each year unless more are needed and as ordered by the Provider*
Chiropractic care (restrictions may apply)	***$0***	• *Per visit* • *26 visits per 12-month period*
Dental services	***$0***	• *Per visit* • *Preventive services* • *Diagnostic services* • *1 oral exam each 12-month period* • *2 oral exams for Enrollees younger than 21 if in conjunction with a cleaning* • *1 cleaning each 12-month period for Enrollees 21 and older* • *2 cleanings each 12-month period for Enrollees younger than 21* • *1 set of X-rays each 12-month period* • *Extractions and fillings* • *Oral surgery* • *Orthodontic and prosthodontic services*
Durable medical equipment	***$0***	• *Per item*
Dialysis End-Stage Renal Disease (ESRD)	***$0***	• *Per visit* • *Services and procedures that promote and maintain the functioning of the kidneys and related organs*
Early & Periodic Screening, Diagnosis and Treatment (EPSDT) services – health checks for children under age 21	***$0***	• *1 neonatal exam (right after the baby is born)* • *1 exam at 1, 2, 4, 6, 9, 12, 15, 18 and 24 months* • *1 exam each year for children ages 3 to 20*
Emergency room	***$0*** ***$0 nonemergency***	• *Per emergency visit* • *Per nonemergency visit*
Emergency ambulance and air	***$0***	• *Per service* • *Basic life support (BLS)*

Benefit/Services	Co-pay	Description/More Information
transportation		• *Advanced life support (ALS) ambulance services*
Family planning	***$0***	• *Per visit* • *Enrollees of child-bearing age* • *Provided through routine physician visits or family planning clinics*
Habilitation services	***$0***	• *Up to 20 visits per calendar year*
Hearing services	***$0***	• *1 complete hearing evaluation per calendar year*
Hearing evaluation and testing by audiologist (no age limit) with referral from physician	***$0***	• *Per visit*
HIV screening	***$0***	• *Per screening includes:* - *Pregnant women* - *Those who have an increased risk for the infection* - *Anyone who asks for the test*
Home healthcare services	***$0***	• *Per visit* • *20 limited visits per calendar year* • *Limits may be "exceeded" if Medically Necessary* • *Includes:* - *Skilled nursing* - *Home health aide* - *Physical, speech and occupational therapy* -
Inpatient Hospital Services	***$0***	• *Per admission*
Inpatient Mental Health / Substance Use Services	***$0***	• *Per admission*
Immunizations	***$0***	• *Per immunization* • *Includes:* - *Adults and children* - *Flu* - *Pneumonia* - *Hepatitis B*
Laboratory diagnostic and radiology services (by physician or lab)	***$0***	• *Per visit*
Maternity services	***$0***	• *Per visit*

Benefit/Services	Co-pay	Description/More Information
Meals and lodging	***$0***	• *For appropriate escorts who help an Enrollee get covered medical services*
Non-emergency ambulance stretcher services	***$0***	• *When other means of transportation could endanger an Enrollee's health*
Nursing facility services	***$0***	• *Per visit* • *Includes physician services*
Nutritional counseling	***$0***	• *Per session*
OB ultrasounds	***$0***	• *2 each 9-month period unless more are ordered by the Provider (family planning)*
Outpatient hospital services	***$0***	• *Per visit* • *Does not cover cosmetic surgery (except for post-mastectomy reconstructive surgery)*
Outpatient mental health/substance use services	***$0***	• *Per visit*
Prescription drugs (for Enrollees who do NOT have Medicare) (exceptions/restrictions may apply)**	***$0Brand Name Drugs $0Generic Drugs $0Brand Name Drugs Preferred Over Generic***	• *Unlimited prescriptions per month*
Physician services (PCPs, specialists, physician assistants, nurse practitioners, nurse midwives)	***$0***	• *Per visit* • *Includes:* - *Specialists* - *Physician assistants* - *Nurse practitioners* - *Nurse midwives* - *Office visits* - *Medical/surgical care and consultation* - *Diagnosis and treatment*
Podiatry services	***$0***	• *Per visit* • *Routine foot care not covered except for certain conditions that require professional supervision*
Preventive care	***$0***	• *Wellness visits*
Private duty nursing	***$0***	• *96 units per recipient per 24-hour period* • *35,040 units per 12 consecutive month period per recipient*
Prosthetic & orthotic devices	***$0***	• *Per item*

Benefit/Services	Co-pay	Description/More Information
Psychiatric residential treatment facilities (PRTFs) (children ages 6 through 21)	***$0***	• *Services are covered for residents ages 6 to 21 who need intensive care and a more highly structured setting than they can get in family and other community-based alternatives to hospitalization*
Rural health clinic (RHC), federally qualified health center (FQHC) & primary care center (PCC)	***$0***	• *Per visit*
Second opinion	***$0***	• *Per visit*
Specialized children's services clinics	***$0***	• *Per visit* • *Sexual abuse medical exams are covered if Medically Necessary and Enrollee is under age 18*
Targeted case management services	***$0***	• *For severe mental illness (SMI)/serious emotional disability (SED)* • *For substance use disorder (SUD)* • *For combination of SME/SED/SUD plus chronic complex physical health problems* •
Telehealth	***$0***	• *Per service* *Use of phones and other technology to access health services from a distance*
Therapeutic group residential services	***$0***	• *Per service* • *Services in a therapeutic environment with 24-hour supervision and treatment in a group residential facility*
Therapy – physical, speech, occupational	***PT – $0 per visit*** ***ST – $0 per visit*** ***OT – $0 per visit***	• *Up to 20 visits per calendar year (may be exceeded if medically necessary)*
Tobacco cessation	***$0***	• *Per visit (doctor)*
Transplant services	***$0***	• *Per service*
Urgent care center	***$0***	• *Per visit* •
Vision (adults 21 and over)	***$0***	• *Eye exam every 12 months* • *Enrollees age 21 and over are eligible to receive an annual*

Benefit/Services	Co-pay	Description/More Information
		allowance of $150 to purchase eyeglasses or contacts every 12 months.
Vision (children under 21)	***$0***	• *1 eye exam every 12 months* • *Limit of 1 pair of eyeglasses per year, or a 2nd pair if 1st pair is broken or prescription changes*

***Prescriptions in these classes are subject to exceptions or exemptions from the brand/generic rules:*

- *Certain antipsychotics: $0*
- *Contraceptives for family planning: $0*
- *Tobacco cessation: $0*
- *Diabetes supplies:*
  - *Blood glucose meters: $0*
  - *All other covered diabetic supplies: $0 for 1st fill; $0 for 2nd fill and beyond*

For the most up-to-date information on Covered Services, please refer to Title 907 of the Kentucky Administrative Regulations available on the web at apps.legislature.ky.gov/law.

Non-emergency Medical Transportation Benefit for Enrollees

The Department for Medicaid Services contracts with the Kentucky Transportation Cabinet, Office of Transportation Delivery to provide non-emergency medical transportation (NEMT) services to select Medicaid Enrollees. Through the NEMT program, certain eligible Enrollees receive safe and reliable transportation to Medicaid Covered Services. This benefit is paid for by the Department for Medicaid Services. NEMT services do not include emergency ambulance and non-emergency ambulance stretcher services. The Department for Medicaid Services website addressing NEMT instructs Enrollees to request NEMT as follows:

- *Non-emergency medical transportation services are available through the Human Service Transportation Delivery (HSTD) program a regional brokerage system. Depending on an Enrollee's medical needs, transportation is provided by taxi, van, bus or public transit. Ambulance stretcher service is covered to obtain covered benefits if it is documented that the Enrollee's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. Wheelchair service is also provided if required by Medical Necessity. To find your regional broker, please click on the HSTD Brokerage Listing. For program policies and complaints, contact the Office of Transportation Delivery at **1-888-941-7433**. The HSTD Broker Listing website is **transportation.ky.gov/TransportationDelivery**.*

Extra FREE Benefits for Enrollees

WellCare offers extra benefits to enrollees at no cost. These include:
Adult Vision — Enrollees ages 21 and older are eligible to receive an annual allowance of $150 to purchase eyeglasses or contacts every 12 months. One eye exam every 12 months.

- *Health and Wellness Items – Each head-of-household is eligible to receive FREE Health and Wellness Items each month that are mailed directly to their home—with no shipping costs. No prescription is required. The Health and Wellness allowance amount*

is based on the Kentucky enrollees household size. Only WellCare of Kentucky Medicaid plan enrollees residing in the same home will be counted as part of the household.

- *1 person household – $10 per month*
- *2 person household – $20 per month*
- *3+ person household – $25 per month*

- *Enrollees can choose from a variety of items, including diapers, dental care items, first-aid items, laundry detergent, and more.*
- *My Health Pays Program – Enrollees earn valuable rewards for taking steps that help them live a healthy life (completing annual wellness visits, including well child visits, having annual screenings and getting childhood and adolescent immunizations.*

  Rewards include:
  - *Enrollees can earn points online that can be redeemed for merchandise. Rewards and products may be different online and/or by phone.*
  - *$75 Nike gift card for Enrollees ages 3 to 20 who complete an annual check-up and dental cleaning*
  - *Bonus Reward – Pregnant enrollees who complete three prenatal visits have the option to choose between a stroller, pack-n-play, car seat, or diapers.*
  - *For complete My Health Pays Program details visit wellcareky.com or call the My Health Pays Customer Service Center at **1-888-392-1185 (TTY: 711).***

- *Healthy Weight Program — WellCare offers a FREE six-month membership benefit for Enrollees. The goal of the program is to support a healthy lifestyle and improve health outcomes.*
  - *Requirements:*
    - *BMI must be greater or equal to 25 for adults 18 years or older*
    - *Completion of baseline form by physician*
- *Good Measures® — WellCare offers health coaching to help support Enrollees with a diagnosis of diabetes. For more information, please call the Case Management team.*
- *Assurance Wireless – WellCare Enrollees 18 years or older are eligible for cell phone service. This service includes 4.5 GB of data, 3,000 minutes, and unlimited texts each month. Calls made to WellCare of Kentucky do not count against the monthly total. Enrollees can bring their own phone or pay a one-time $20 fee for a new phone.*
  WellCare BabySteps Maternity Care Management Program:
  - *Eligibility: Pregnant Enrollees ages 12 and up who have WellCare of Kentucky as their primary payer.*
  - *Pregnant Enrollees ages 12 and up who complete three prenatal visits can choose 1 item from our My Health Pays Program such as a stroller, a portable playpen, a car seat, or diapers. One visit must occur during the first trimester or within 42 days of enrollment.*
  - *Enrollees ages 12 and up who attend one postpartum visit seven to 84 days after the birth of their child can chose between select products or 750 points from our My Health Pays Program.*
  - *If you have any questions about this program and for complete program details, please go online at wellcareky.com or call the Case Management team at **1-844-901-3780.***
- *Cellphones for high-risk pregnancies and Enrollees with chronic conditions– WellCare provides a FREE cellphone to Enrollees with high-risk pregnancies and/or chronic conditions engaged in a care management program who do not have a telephone.*

Cellphone includes unlimited text messaging, and programmed numbers for the enrollees' doctor, case manager, and social worker.

- *Food Allergen Program -- Decrease the risk of food allergies for infants with supplements for milk and formula*

Tutoring

  - *Twelve free one-hour tutoring sessions for Enrollees ages 8-18. Sessions available in-person or virtually. Applications are available online or call Enrollee Services for more information.*

Internet Hot Spot

  - *Get free internet service for 12 months and a hot spot for Enrollees ages 8-18. Available in limited rural areas.*

College/Trade School Scholarships – Enrollees have a chance to win one of 50 scholarships available at $1,000 per winner. Scholarships are for Enrollees ages 18 and up who have been accepted to attend a college, university, or trade school. Applications are available online or call Enrollee Services for more information.

- *Sports physical – One FREE sports physical per year, provided by a PCP, for children ages 6 to 18.*
- *Boy Scouts of America – FREE annual membership for Enrollees ages 5 to 18. Enrollees will also receive $25 toward a uniform.*
- *Girl Scouts – FREE annual membership for Enrollees ages 5 to18. Also covers the cost of an annual adult membership, which would allow guardian to be troop leader and/or participate in other activities. Enrollees will also receive $25 toward a uniform.*
- *Steps2Success Program – WellCare wants to help Enrollees take steps to be successful in reaching their employment and financial goals. WellCare will offer the following programs for Enrollees:*
  - *WellCare Works Training: FREE job training and financial education referral classes at no cost for enrollee to address educational, employment and economic advancement barriers. WellCare will help Enrollees to locate job training and financial education resources.*
  - *GED® exam – Enrollees ages 16 and older with no high school diploma can take the GED test for FREE.*

State Issued ID Card

  - *Free State issued ID Card. New or replacement (not driver's licenses or Real IDs).*

Meals Program

  - *Enrollees discharged from inpatient hospital, rehabilitation or skilled nursing facility or a Behavioral Health Facility are eligible to receive FREE meals. Meal deliveries must begin within 14 days after discharge. Ten meals per authorization with no annual limit. Community Connections Help Line – Enrollees can connect to FREE community services such as utility assistance, food banks and transportation. Please see "**Help with Problems beyond Medical Care**" to learn more or call **1-866-775-2192** (TTY: **711**).*

- *Personal care and disease managers – Enrollees are offered FREE support for conditions such as diabetes and asthma, etc.*
- *24-Hour Nurse Advice Line – WellCare's Nurse Advice Line is available to enrollees for FREE. Enrollees can call the line 24 hours a day, seven days a week to speak to a nurse and get answers to their health questions. Our trained nurses can give Enrollees information on how to treat medical symptoms at home. They can also tell them if they*

should wait to see their PCP, if they should go to an urgent care center, or if they should go to the ER.

- *24-hour crisis line – Enrollees can find FREE help with drug and alcohol abuse and behavioral health concerns.*
- *XtraSavings Program – Allows enrollees to receive FREE monthly discounts beyond what is available to the general public.*
    - *OTC4Me: Get discounts on more than 500 over-the-counter items used every day. Save on vitamins, toothpaste, diapers and much more. Get a 20% discount on the first order, then a 10% discount on each order after that.*

Services Not Covered by WellCare of Kentucky

- *Any lab service performed by a Provider without current certification in accordance with the Clinical Laboratory Improvement Amendment (CLIA) (this requirement applies to all facilities and individual Providers of any lab service)*
- *Cosmetic procedures or services performed only to improve appearance*
- *Hysterectomy procedures, if performed only to prevent pregnancy*
- *Medical or surgical treatment of infertility (for example, the reversal of sterilization, in vitro fertilization, etc.)*
- *Induced abortion and miscarriage services that go against federal and Kentucky laws and judicial opinions*
- *Paternity testing*
- *Personal service or comfort items*
- *Post-mortem services*
- *Services including but not limited to drugs that are investigational or experimental*
- *Gender reassignment services*
- *Sterilization of a mentally incompetent or institutionalized enrollee*
- *Services provided outside of the United States, unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services*
- *Services or supplies greater than what's allowed by federal or state laws, judicial opinions and the Kentucky Medicaid program*
- *Services for which an enrollee is not required to pay and for which no other person has a legal responsibility to pay*

Provider Services

WellCare's Provider Services Department is comprised of two teams – Provider Relations and Provider Operations. The Provider Relations team is responsible for Provider education, recruitment, contracting, new Provider orientation, monitoring of quality and regulatory standards such as Healthcare Effectiveness Data and Information Set (HEDIS®) and investigation of enrollee complaints. The Provider Operations team consists of Contract Operations, collection of credentialing and re-credentialing documents, and claims research and resolution.

WellCare offers an array of Provider services, which includes initial orientation and education – either one-on-one or in a group setting – for all Providers. These sessions are hosted by WellCare's Provider Relations representatives.

Provider Relations representatives are available to assist in many requests for Providers. Providers may contact their local market offices for assistance. To request that a Provider

Relations representative contact them, Providers may call the Provider Services number located on the Quick Reference Guide.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

WellCare Self-Service Tools for Providers

For faster results and more efficient customer service, WellCare offers technology options to save Providers time using the secure web portal, Chat and IVR (Interactive Voice Response System) self-service tools. These self-service tools help Providers do business with WellCare. We want your interactions with us to be as easy, convenient and efficient as possible. Giving Providers and their staff self-service tools and access helps us accomplish this goal. Providers can access this information below or at ***wellcareky.com****.*

Secure Provider Portal: Key Features and Benefits of Registering

WellCare's secure online provider portal offers immediate access to what Providers need most. All participating Providers who create an account and are assigned the appropriate role/permissions can use the following features:

- ***Claims Submission, Status, Appeal, Dispute** – Submit a claim, check status, appeal or dispute claims, and download reports;*
- ***Enrollee Eligibility and More** – Verify enrollee eligibility, and view benefit information, demographic information, care gaps, health conditions, and more;*
- ***Authorization Requests** – Submit authorization requests, attach clinical documentation, check authorization status and submit appeals. Providers may also print and/or save copies of the authorization;*
- ***Pharmacy Services and Utilization** – View and download a copy of the Kentucky Medicaid Pharmacy Program Single Preferred Drug List (PDL), view Enrollee prescription history, and access pharmacy utilization reports;*
- ***Visit Checklist/Appointment Agenda** – Download and print a checklist for enrollee appointments, then submit online to get credit for Partnership for Quality (P4Q);*
- ***Secure Inbox** – View the latest announcements for Providers and receive important messages from WellCare.*

Provider Registration Advantage

The secure provider portal lets Providers have one username and password for multiple practitioners/offices. Administrators can easily manage users and permissions. Once registered for the secure portal, Providers should retain username and password information for future reference.

How to Register

To create an account, please refer to the Provider Resource Guide at ***wellcareky.com****. For more information about WellCare's web capabilities, please call Provider Services or contact Provider Relations to schedule a website in-service training.*

Additional Resources

The following resources are at ***wellcareky.com****. To access them, select Overview under the Providers drop-down menu:*

- *The* ***Provider Resource Guide*** *contains information about the secure online provider portal, enrollee eligibility, authorizations, filing paper and electronic claims, appeals,*

and more. For more specific instructions on how to complete day-to-day administrative tasks, please see the Provider Resource Guide.

- *The **Quick Reference Guide** contains important addresses, phone/fax numbers and authorization requirements.*

Website Resources

*WellCare's website, **wellcareky.com**, offers a variety of tools to assist Providers and their staff. Available resources include:*

- *Provider Manuals*
- *Quick Reference Guides*
- *Clinical Practice Guidelines*
- *Clinical Coverage Guidelines*
- *Claim Payment Policies*
- *WellCare Companion Guide*
- *Forms and documents*
- *Pharmacy and Provider lookup (directories)*
- *Training materials and job aids*
- *Medicaid Provider Bulletins*
- *Newsletters*
- *Enrollee rights and responsibilities*
- *Privacy statement and notice of privacy practices*

Using Chat: Get to Know the Benefits of Chat

Faster than email and easier than phone calls, Chat is a convenient way to ask simple questions and receive real-time support. Providers now have the ability to use our Chat application as an alternative to calling and speaking with agents. Our Chat support can help you and your staff with web support assistance and real-time claim adjustments. Explore the benefits of using live Chat!

Convenience

- *Live Chat offers the convenience of getting real-time help and answers*

Documentation of Interaction

- *Unlike phone support, live Chat software gives you the option of receiving a transcription of the conversation.*

You can access Chat through the portal

- *The Chat Support Icon is on our secure provider portal. From there, you can:*
  - *Log on to the provider portal at **provider.wellcare.com***
  - *Access the "Help" section*
  - *Select the desired Chat topic*
  - *If the Chat agent is unable to resolve the issue, the issue will be routed to the right team for further assistance*

Interactive Voice Response (IVR) System

IVR system

- *Technology to expedite Provider verification and authentication within the IVR*
- *Provider/Enrollee account information is sent directly to the agent's desktop from the IVR validation process, so Providers do not have to re-enter information*
- *Full speech capability, allowing Providers to speak their information or use the touchtone keypad*

Self-Service features

- *Ability to receive enrollee co-pay information*
- *Ability to receive enrollee eligibility information*
- *Ability to request authorization and/or status information*
- *Unlimited claims information on full or partial payments*
- *Receive status for multiple lines of claim denials*
- *Automatic routing to the provider claims support (PCS) claims adjustment team to dispute a denied claim*
- *Rejected claims information*

TIPS for using IVR

Providers should have the following information available with each call:

- *WellCare Provider ID number*
- *NPI or tax ID for validation, if Providers do not have their WellCare ID*
- *For claims inquiries – provide the Enrollee's ID number, date of birth, date of service and dollar amount*
- *For authorization and eligibility inquiries – provide the enrollee's ID number and date of birth*

Benefits of using self-service

- *24/7 data*
- *No hold times*
- *Providers may work at their own pace*
- *Access information in real time*
- *Unlimited number of Enrollee claim status inquiries*
- *Direct access to provider claims support (PCS) – no transfers*

*The Phone Access Guide is at **wellcareky.com** under "Overview & Resources."*

*Providers may contact the appropriate departments at WellCare by referring to the Quick Reference Guides at **wellcareky.com**.*

In addition, WellCare Provider Relations representatives are available to help Providers. Please contact the local market office for assistance.

*The Provider Services phone number is **1-877-389-9457**.*

Section 2: Provider and Enrollee Administrative Guidelines

Provider Administrative Overview

This section is an overview of guidelines for which all participating WellCare Medicaid managed care Providers are accountable. Please refer to the Provider Contract or contact your WellCare Provider Relations representative for clarification of any of the following.

Participating WellCare Medicaid Providers must, in accordance with generally accepted professional standards:

- *Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act and the Rehabilitation Act of 1973;*
- *Agree to cooperate with WellCare in its efforts to monitor compliance with its Medicaid contract(s) and/or Department rules and regulations, and assist WellCare in complying with corrective action plans necessary for WellCare to comply with such rules and regulations;*
- *Comply with the Mental Health Parity and Addiction Equity Act of 2008 and 42 C.F.R. 438 Subpart K, including the requirements that treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by WellCare and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.*
- *Retain all agreements, books, documents, papers and medical records related to the provision of services to WellCare Enrollees for a minimum of ten (10) years, or longer, as required by state and federal laws;*
- *Provide Covered Services in a manner consistent with professionally recognized standards of healthcare 42 C.F.R. § 422.504(a)(3)(iii);*
- *Use physician extenders appropriately. Physician assistants (PAs) and advanced practice registered nurses (APRNs) should provide direct Enrollee care within the scope or practice established by the rules and regulations of the Commonwealth and WellCare guidelines;*
- *Assume full responsibility to the extent of the law when supervising PAs and APRNs whose scope of practice should not extend beyond statutory limitations;*
- *Clearly identify physician and extender titles (examples: M.D., D.O., APRN, PA) to Enrollees and to other healthcare professionals;*
- *Honor at all times any Enrollee's request to be seen by a physician rather than a physician extender;*
- *Administer, within the scope of practice, treatment for any Enrollee in need of healthcare services;*
- *Cooperate with all quality improvement (QI) activities;*
- *Maintain the confidentiality of Enrollee information and records;*
- *Allow WellCare to use Provider performance data for quality improvement activities;*
- *Respond promptly to WellCare's request(s) for medical records in order to comply with regulatory requirements and maintain the confidentiality of Enrollee information and records;*
- *Ensure that:*

    - *All employed physicians and other healthcare practitioners and Providers comply with the terms and conditions of the Provider Contract between the Provider and WellCare;*
    - *To the extent the physician maintains written agreements with employed physicians and other healthcare practitioners and Providers, such agreements contain similar provisions to the Provider Contract; and*
    - *The physician maintains written agreements with all contracted physicians or other healthcare practitioners and Providers, which agreements contain similar provisions to the Provider Contract.*
- *Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene;*
- *Communicate timely clinical information between Providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to WellCare, the Enrollee or the requesting party at no charge, unless otherwise agreed;*
- *Preserve enrollee dignity and observe the rights of Enrollees to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen;*
- *Not discriminate in any manner between WellCare Medicaid enrollees and non-WellCare Medicaid enrollees;*
- *Ensure that the hours of operation offered to WellCare enrollees is not fewer than those offered to commercial enrollees;*
- *Not deny, limit or condition the furnishing of treatment to any WellCare Medicaid enrollee on the basis of any factor that is related to health status including, but not limited to, the following:*
    - *Medical condition, including mental as well as physical illness;*
    - *Claims experience;*
    - *Receipt of healthcare;*
    - *Medical history;*
    - *Genetic information;*
    - *Evidence of insurability, including conditions arising out of acts of domestic violence; or*
    - *Disability.*
- *Freely communicate with and advise enrollees regarding the diagnosis of the enrollee's condition and advocate on the enrollee's behalf for the enrollee's health status, medical care and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services;*
- *Identify enrollees who need services related to children's health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation or substance abuse. If indicated, Providers must refer enrollees to WellCare-sponsored or community-based programs; and*
- *Must document the referral to WellCare-sponsored or community-based programs in the enrollee's medical record and provide the appropriate follow-up to ensure the enrollee accessed the services.*

Excluded or Prohibited Services

Providers must verify patient eligibility and enrollment prior to service delivery. WellCare is not financially responsible for non-covered benefits or for services rendered to ineligible recipients.

Certain covered benefits, such as non-emergency transportation, are administered outside of the managed care program.

Excluded services are defined as those services that enrollees may obtain under the Kentucky Medicaid plan and for which WellCare is not financially responsible. These services may be paid for by the Department on a fee-for-service or other basis. Providers are required to determine eligibility for Covered Services prior to rendering services. In the event the service(s) is (are) excluded, Providers must submit reimbursement for services directly to the Department. If the service(s) is (are) prohibited, neither WellCare nor the Department is financially responsible. For more information on prohibited services, refer to the Department's website at ***chfs.ky.gov/agencies****.*

School-based services provided by schools are excluded from coverage by WellCare and are paid by the Department through fee-for-service Medicaid. Any service provided under a child's Individualized Education Program (IEP) should not be duplicated. However, the Preventive Health Package pursuant to 907 KAR 1:360 is covered when supervised by appropriate medical personnel.

Responsibilities of All Providers

The following is a summary of responsibilities of all Providers who render services to WellCare enrollees. These are intended to supplement the terms of the Provider Contract, not replace them.

Provider Identifiers

All participating Providers are required to have a unique and active Kentucky Medicaid Provider number and a National Provider Identifier (NPI). For more information on NPI requirements, refer to Section 5: Claims. A current Medicaid Provider number is an important Medicaid program integrity control. WellCare verifies current Kentucky Medicaid Provider status by reference to data provided to it periodically by the Department. It is a Provider's responsibility to maintain a current Kentucky Medicaid Provider number with the Department. WellCare may deny reimbursement for claims for Covered Services if it determines that the Provider does not have an active Kentucky Medicaid Provider number at the time it adjudicates the claim.

Living Will and Advance Directive

Enrollees have the right to control decisions relating to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their lives. Living will and advance directive rights may differ between states. Kentucky Providers should follow the applicable KRS Section 311.621 – 311.643. Providers must comply with the advance directive requirements for hospitals, nursing facilities, Providers of home and healthcare hospices and health maintenance organizations (HMOs) specified in 42 CFR Part 49, subpart I, and 42 CFR Section 417.436(d).

Each WellCare enrollee (age 18 years or older and of sound mind), should receive information regarding living wills and advance directives. This allows enrollees to designate another person to make a decision should they become mentally or physically unable to do so.

Information regarding living wills and advance directives should be made available in Provider offices. Providers are also required to discuss living wills and advance directives with enrollees during their first primary care visit. Completed forms should be documented and filed in enrollees' medical records.

A Provider shall not, as a condition of treatment, require an enrollee to execute or waive an advance directive.

Provider Billing and Address Changes

Prior notice to a Provider Relations representative or WellCare's Provider Data Management team is required for any of the following changes:

- *1099 mailing address;*
- *Tax Identification Number (TIN) or Entity Affiliation (W-9 required);*
- *Group name or affiliation;*
- *Physical or billing address;*
- *Telephone and fax number;*
- *Panel changes; and/or*
- *Directory listing.*

Provider Termination

In addition to the Provider termination information included in the Provider Contract, the Provider must adhere to the following terms:

- *Any contracted Provider must give at least 90 days' prior written notice (180 days for a hospital) to WellCare before terminating their relationship with WellCare "without cause," unless otherwise agreed to in writing. This ensures that adequate notice may be given to WellCare enrollees regarding the Provider's participation status with WellCare. Please refer to the Provider Contract for details regarding the specific required days for providing termination notice as the Provider may be required by contract to give more notice than listed above; and*
- *Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month.*

Please refer to Section 6: Credentialing of this Manual for specific guidelines regarding rights to appeal plan termination (if any).

WellCare will notify in writing all appropriate agencies and/or enrollees prior to the termination effective date of a participating Primary Care Provider (PCP), hospital, specialist or significant ancillary Provider within the service area as required by Kentucky Medicaid Program requirements and/or regulations and statutes.

Out-of-Area Enrollee Transfers

Providers should assist WellCare in arranging and accepting the transfer of enrollees receiving care out of the service area if the transfer is considered medically acceptable by the WellCare Provider and the out-of-network attending physician/provider.

Enrollees with Special Health Care Needs

Individuals with Special Health Care Needs (ISHCN) include Enrollees with the following conditions:

- *Intellectual disabilities or related conditions;*
- *Serious chronic illnesses such as HIV, schizophrenia or degenerative neurological disorders;*

- *Disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes;*
- *Children and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care; and*
- *Related populations eligible for Supplemental Security Income (SSI).*

The following is a summary of responsibilities specific to Providers who render services to WellCare Enrollees who have been identified with Special Health Care Needs:

- *Assess enrollees and develop plans of care for those enrollees determined to need courses of treatment or regular care;*
- *Coordinate treatment plans with enrollees, family and/or specialists caring for enrollees;*
- *The plan of care should adhere to community standards and any applicable sponsoring government agency quality assurance and utilization review standards;*
- *Allow enrollees needing courses of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as appropriate for the enrollees' conditions or needs;*
- *Coordinate with WellCare, if appropriate, to ensure that each enrollee has an ongoing source of primary care appropriate to their needs, and a person or entity formally designated as primarily responsible for coordinating the healthcare services furnished;*
- *Coordinate services with other third-party organizations to prevent duplication of services and share the results on identification and assessment of the enrollee's needs; and*
- *Ensure the enrollee's privacy is protected as appropriate during the coordination process.*

For more information regarding utilization management for ISHCN, refer to Section 4: Utilization Management, Care Management and Disease Management.

Access Standards

All Providers must adhere to standards of timeliness for appointments and in-office waiting times. These standards take into consideration the immediacy of the enrollee's needs.

WellCare shall monitor Providers against these standards to ensure enrollees can obtain needed health services within the acceptable appointment time frames, in-office waiting times and after-hours standards. Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare.

Type of Appointment	Access Standard
PCP – Urgent	< 48 hours
PCP – Routine Care	< 30 days
Specialist – Routine	< 30 days
Specialist – Urgent	< 48 hours
Vision – Regular	< 30 days
Vision – Urgent	< 48 hours
Lab and X-ray – Regular	< 30 days
Lab and X-ray – Urgent	< 48 hours

Type of Appointment	Access Standard
Dental – Regular	< 30 days
Dental – Urgent	< 48 hours
Voluntary family planning, counseling and medical services	As soon as possible within a maximum of 30 days. If not possible to provide complete medical services to Enrollees younger than 18 years of age on short notice, counseling and a medical appointment as immediately as possible and within 10 days

In-office waiting times for primary care visits, specialty and urgent care, optometry services and lab and X-ray services shall not exceed 30 minutes.

PCPs must provide or arrange for coverage of services, consultation or approval for referrals 24 hours a day, seven days a week (both in and out of network, if such services are not available within WellCare's network). To ensure accessibility and availability, PCPs must provide one of the following:

- *Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of 30 minutes;*
- *Office phone is answered after hours by a recording directing the enrollee to call another number to reach the PCP or another medical practitioner whom the Provider has designated to return the call within a maximum of 30 minutes; or*
- *Office phone is transferred after office hours to another location where someone shall answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of 30 minutes.*

Unacceptable practices include:

- *Office phone is only answered during office hours;*
- *Office phone is answered after hours by a recording that tells enrollees to leave a message;*
- *Office phone is answered after hours by a recording that directs enrollees to go to the emergency room for any services needed; and*
- *Returning after-hours calls outside of 30 minutes.*

See Section 10: Behavioral Health for mental health and substance use access standards.

Secret Shopper Language

WellCare will monitor appointment wait time compliance through Secret Shopper surveys. Secret Shopper is a research technique used to evaluate the quality of service or compliance with appointment availability and after-hours access standards. It involves having an individual pose as a customer or client and interact with a provider to assess the quality of service.

Responsibilities of Primary Care Providers

The following is a summary of responsibilities specific to PCPs who render services to WellCare enrollees. These are intended to supplement the terms of the Provider Contract, not replace them:

- *See enrollees for an initial office visit and assessment within the first 90 days of enrollment in WellCare;*

- *Maintaining continuity of the enrollee's healthcare;*
  Coordinate, monitor and supervise the delivery of Medically Necessary primary and preventive care services to each enrollee, including EPSDT services for enrollees younger than the age of 21;
- *Coordinate, monitor and supervise the delivery of primary care services to each enrollee;*
- *Making referrals for Specialty Care and other Medically Necessary services. If such services are not available within the WellCare network, referrals can be made to an out of network provider;*
- *Provide appropriate referrals of potentially eligible women, infants and children to the Women, Infants and Children (WIC) Program for nutritional assistance;*
- *Screen all newborn enrollees for those disorders specific in the Commonwealth's metabolic screen;*
- *Arranging and referring enrollees when clinically appropriate, to behavioral health Providers;*
- *Assure enrollees are aware of the availability of public transportation where available;*
- *Provide access to WellCare or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity. A related organization or entity is defined as having influence, ownership or control and either a financial relationship or a relationship for rendering services to the primary care office;*
- *Submit an encounter for each visit where the Provider sees the enrollee or the enrollee receives a HEDIS service;*
- *Submit encounters. For more information on encounters, refer to Section 5: Claims;*
- *Ensure enrollees utilize network Providers. If unable to locate a participating WellCare Provider for services required, contact Provider Services for assistance. Refer to the Quick Reference Guide at* ***wellcareky.com****; and*
- *Comply with and participate in corrective action and performance improvement plan(s);*
- *Discuss Advance Medical Directives with all enrollees as appropriate;*
- *Documenting all care rendered in a complete and accurate medical record for each enrollee and maintaining a current medical record for each Enrollee, including documentation of all PCP and specialty care services;*
- *PCP's must have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders; and*
- *Maintaining formalized relationships with other PCPs to refer their enrollees for after-hours care, during certain days, for certain services, or other reasons to extend the hours of service of their practice.*

PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice.

Medical Records

WellCare Practitioners and Providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to enrollees. They will also enable WellCare to review the quality and appropriateness of the services rendered.

Medical records means the complete, comprehensive enrollee records including, but not limited to, x- rays, laboratory tests, results, examinations and notes, accessible at the site of the enrollee's participating primary care physician or provider, that document all medical services

received by the enrollee, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

To ensure the enrollee's privacy, medical records should be kept in a secure location. WellCare requires providers to maintain all records for Enrollees for at least 5 years. Only authorized personnel have access to records. Staff receive periodic training in Enrollee information confidentiality. See the enrollee Rights section of this handbook for policies on enrollee access to medical records.

PCPs shall maintain a primary medical record for each enrollee, which contains sufficient medical information from all providers involved in the enrollee's care, to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:

- *Enrollee/patient identification information, name, and/or medical record number, on each page;*
- *Personal/biographical data, including date of birth, age, gender, marital status, spouse, next of kin, race or ethnicity, primary language, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, and guardianship information;*
- *Date of data entry and date of encounter;*
- *All entries must be dated and signed, or dictated by the provider rendering the care;*
- *Provider identification by name;*
- *Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented ;*
- *Past medical history (for Enrollees seen three or more times) is easily identified and includes, serious accidents, operations and/or illnesses and discharge summaries. For children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses (for example, documentation of chickenpox), ER encounters;*
- *Identification of current problems - Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses;*
- *Appropriate subjective and objective information pertinent to the enrollee's presenting complaints is documented in the history and physical*
- *Consultation, laboratory, and radiology reports;*
- *An up-to-date immunization record is established for pediatric Enrollees or an appropriate history is made in chart for adults - documentation of immunizations pursuant to 902 KAR 2:060;*
- *For Enrollees 10 years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for Enrollees seen three or more times substance abuse history should be queried)*
- *Evidence that preventive screening and services are offered in accordance with practice guidelines*
- *Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020;*
- *Follow-up visits provided secondary to reports of emergency room care;*

- *Hospital discharge summaries;*
- *Advanced Medical Directives, for adults and evidence that an advance directive has been offered to adults 18 years of age and older;*
- *All written denials of service and the reason for the denial; and*
- *Record legibility to at least a peer of the writer. Any record judged illegible by one reviewer shall be evaluated by another reviewer.*
- *Working diagnosis is consistent with findings*
- *Treatment plan is appropriate for diagnosis*
- *Documented treatment prescribed, therapy prescribed and drug administered or dispensed including instructions to the Enrollee*
- *Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns*
- *Signed and dated required consent forms*
- *Unresolved problems from previous visits are addressed in subsequent visits*
- *Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases*
- *Health teaching and/or counseling is documented*
- *Providers are encouraged to document in the Enrollee's medical record any denial of professional interpreters and the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.*
- *Documentation of failure to keep an appointment*
- *Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed*
- *Evidence that the Enrollee is not placed at inappropriate risk by a diagnostic or therapeutic problem*
- *Confidentiality of Enrollee information and records protected*

An enrollee's medical record shall include the following minimal detail for individual clinical encounters:

A. *History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;*
B. *Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits;*
C. *Plan of treatment including:*
    1. *Medication history, medications prescribed, including the strength, amount, directions for use and refills;*
    2. *Therapies and other prescribed regimens; and*
    3. *Follow-up plans including consultation and referrals and directions, including time to return.*

An enrollee's medical record shall include at a minimum for hospitals and mental hospitals:

A. *Identification of the beneficiary*
B. *Physician name*

C. *Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission; the plan of care (as required under 42 CFR 456.170 (mental hospitals) or 42 CFR 456.50 (hospitals). Initial and subsequent continued stay review dates (described under 42 CFR 456.233 and 42 CFR 465.234 (for mental hospitals) and 42 CFR 456.128 and 42 CFR 456.133 (for hospitals)*
D. *Reasons and plan for continued stay if applicable*
E. *Other supporting material appropriate to include*
F. *For non-mental hospitals only:*
    1. *Date of operating room reservation*
    2. *Justification of emergency admission if applicable*

Early and Periodic Screening, Diagnosis and Treatment

Any Provider, including physicians, nurse practitioners, registered nurses, physician assistants and medical residents who provide EPSDT screening services are responsible for:

- *Providing all needed initial, periodic and interperiodic EPSDT health assessments, diagnosis and treatment to all eligible enrollees in accordance with Kentucky Medicaid administrative regulation 907 KAR 11:034 and the periodicity schedule provided by the American Academy of Pediatrics (AAP);*
- *Referring the enrollee to an out-of-network provider for treatment if the service is not available within WellCare's network;*
- *Providing vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines;*
- *Providing vaccinations in conjunction with EPSDT/Well Child visits. Providers have the option to use vaccines available without charge under the Vaccines for Children (VFC) Program for Medicaid children 18-years-old and younger;*
- *Addressing unresolved problems, referrals and results from diagnostic tests, including results from previous EPSDT visits;*
- *Requesting a Prior Authorization for Medically Necessary EPSDT special services in the event other healthcare, diagnostic, preventive or rehabilitative services, treatment or other measures described in 42 U.S.C. 1396d(a) are not otherwise covered under the Kentucky Medicaid Program;*
- *Monitoring, tracking and following up with Enrollees:*
    - *Who have not had a health assessment screening; and*
    - *Who miss appointments to assist them in obtaining appointments.*
- *Ensuring enrollees receive the proper referrals to treat any conditions or problems identified during the health assessment including tracking, monitoring and following up with enrollees to ensure they receive the necessary medical services; and*
- *Assisting enrollees with transition to other appropriate care for children who age out of EPSDT services at age 21.*

Except as otherwise noted by WellCare or in 907 KAR Chapter 1 or 3, an EPSDT diagnosis or treatment or an EPSDT special service which is not otherwise covered by the Kentucky Medicaid Program shall be covered subject to Prior Authorization if the requirements of subsections (1) and (2) of Section 9 of 907 KAR 11:034 are met. Requests for services will be reviewed to determine Medical Necessity without regard to whether the screen was performed by a Kentucky Medicaid Provider or a non-Medicaid Provider.

Providers will be sent a monthly gap in care list that specifies the health assessment-eligible children who have not had an encounter within 120 days of joining WellCare or who are not in compliance with the EPSDT Program.

The Provider's compliance with enrollee monitoring, tracking and follow-up will be assessed through random medical record review audits conducted by the WellCare Quality Improvement Department. Corrective action plans will be required for Providers who are below 80% compliance with all elements of the review.

*For more information regarding the Kentucky Medicaid EPSDT periodicity schedule and/or the Kentucky Medicaid administrative regulation 907 KAR 11:034, refer to the Department's website at **chfs.ky.gov/agencies/dms**. For more information on the periodicity schedule based on the AAP guidelines, refer to the AAP website at **aap.org/immunization/IZSchedule**.*

Primary Care Offices

PCPs provide comprehensive primary care services to WellCare enrollees. Primary care offices participating in WellCare's Provider network have access to the following services:

- *Support of the Provider Relations, Enrollee Services, Health Services and Marketing and Sales Departments;*
- *The tools and resources available at **wellcareky.com**; and*
- *Information on WellCare network Providers for the purposes of referral management and discharge planning.*

Closing of Provider Panel

When requesting closure of a panel to new and/or transferring WellCare enrollees, PCPs must:

- *Submit the request in writing at least 60 days (or such other period of time provided in the Provider Contract) prior to the effective date of closing the panel;*
- *Maintain the panel to all WellCare enrollees who were provided services before the closing of the panel; and*
- *Submit written notice of the reopening of the panel, including a specific effective date.*

Covering Physicians/Providers

If participating Providers are temporarily unavailable to provide care or referral services to WellCare enrollees, Providers should make arrangements with another WellCare-contracted, Medicaid-participating and credentialed Provider to deliver services on their behalf, unless there is an emergency.

Covering Providers should be credentialed by WellCare and are required to sign an agreement accepting the negotiated rate and agreeing not to balance bill WellCare Enrollees. For additional information, please refer to Section 6: Credentialing.

*In non-emergency cases, should a Provider have a covering Physician/Provider who is not contracted and credentialed with WellCare, contact WellCare for approval. For contact information, refer to the Quick Reference Guide at **wellcareky.com**.*

Termination of an Enrollee

A WellCare Provider may not seek or request to terminate their relationship with a Enrollee or transfer an enrollee to another Provider based upon the enrollee's medical condition, amount or variety of care required or the cost of Covered Services required by WellCare's enrollee.

Reasonable efforts should always be made to establish a satisfactory provider and Enrollee relationship in accordance with practice standards. If a participating Provider desires to terminate their relationship with a WellCare enrollee, the provider should submit adequate documentation to support that, although they have attempted to maintain a satisfactory provider and enrollee relationship, the Enrollee's noncompliance with treatment or uncooperative behavior is impairing the ability to care for and treat the enrollee effectively. If a satisfactory relationship cannot be established or maintained, the provider shall continue to provide medical care for the WellCare Enrollee until such time that written notification is received from WellCare stating that the enrollee has been transferred from the provider's practice, and such transfer has occurred.

A provider shall not have the right to request a transfer from their practice for the following: a change in the Enrollee's health status or need for treatment; an Enrollee's utilization of medical services; an enrollee's diminished mental capacity; or, disruptive behavior that results from the enrollee's special healthcare needs unless the behavior impairs the ability of the provider to furnish services to the Enrollee or others. Transfer requests shall not be based on race, color, national origin, handicap, age or gender. WellCare shall have authority to approve all transfers.

*The provider should complete a PCP Request for Transfer of Enrollee form, attach supporting documentation and fax the form to WellCare's Provider Services Department. A copy of the form is available at **wellcareky.com**. Request for Transfer of enrollees may also be submitted via WellCare's secure provider portal by users who have Administrator rights for their contract or sub-group. After logging in, providers should access the My Patients area, search for the enrollee, select Request enrollee Transfer from the Select Action menu, then complete and submit the form.*

The initial PCP must serve until the new PCP begins serving the enrollee, barring ethical or legal issues. The enrollee has the right to file a grievance regarding such a transfer.

Domestic Violence and Substance Abuse Screening

*PCPs should identify indicators of substance abuse or domestic violence. Sample screening tools for domestic violence and substance abuse are at **samhsa.gov** and **getdomesticviolencehelp.com**.*

Smoking Cessation

PCPs should direct enrollees who wish to quit smoking to call WellCare's Customer Service and ask to speak to the Care Management Department. A Care Manager will educate the enrollee on national and community resources that offer assistance, as well as smoking cessation options available to the enrollee through WellCare.

*Adults ages 18 and older may call **1-800-QUIT-NOW (784-8669)** or text **QUITNOW** to **333888**, and enrollees ages 17 and younger can call My Life, My Quit at **1-855-891-9989** or Text **START MY QUIT** to **36072** once per calendar year.*

CDC Smoking Cessation Recommendations

The CDC provides several evidence-based recommendations for smoking cessation. Here are the key points:

1. ***Counseling and Support**: Engage patients in behavioral counseling which can significantly increase the chances of quitting. Options include individual, group, or telephone counseling.*
2. ***Medications**: The CDC recommends using FDA-approved medications to aid in cessation. Remember to discuss with your patients the available medication therapy such as:*
    - ***Nicotine Replacement Therapies (NRTs)**: Patches, gum, lozenges, inhalers, and nasal sprays.*
    - ***Prescription Medications**: Bupropion (Zyban) and varenicline (Chantix).*
3. ***Combination Therapy**: Remember to us both counseling and medication which together tends to be more effective than using either alone.*
4. ***Tailored Programs**: Create patient centered smoking cessation care plans that consider individual needs and preferences can enhance success rates.*
5. ***Follow-Up Support**: Ensure access to ongoing support and follow-up which can help maintain long-term abstinence.*
6. ***Quitline Services**: Refer Enrollees to National and state guideline to offer free support and resources.*
7. ***Community Programs**: encourage patients to participation in community-based programs which can provide additional support.*
8. ***Prevent Relapse**: Implement patient centered strategies to cope with cravings and triggers which are essential for preventing relapse.*

For the most current guidelines and resources, visiting the CDC's official website is recommended cdc.gov/tobacco.

Adult Health Screening

An adult health screening, including screening for behavioral health conditions, should be performed to assess the health status of all WellCare Medicaid enrollees, as applicable. The adult enrollee should receive an appropriate assessment and intervention as indicated or upon request.

Hospital/Facility Responsibilities

Coverage is provided for eligible Enrollees for preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. Care must be rendered under the direction of a doctor or by an institution that 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 the recommendation of a licensed doctor and is receiving room, board and professional services in the hospital on a continuous 24 hours-per-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 Section 4: Utilization Management, Care Management and Disease Management 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-hours-per-day basis. Observation services are also considered outpatient. Observation services usually do not exceed 24 hours.

However, some patients may require 72 hours of outpatient observation services. Refer to Section 4: Utilization Management, Care Management and Disease Management 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 that 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 Section 4: Utilization Management, Care Management and Disease Management for more information.

Level of care determinations will be based on InterQual® criteria and Medical Director review.

Value-Based Payment Models

WellCare of Kentucky offers several value-based payment models (VBP) to our providers. Examples of these VBP models include:

- *An upside bonus agreement inclusive of a quality gate that allows Primary Care Physicians to share in savings generated by managing their Enrollees' care while ensuring quality outcomes;*
- *Hospital per diem rates tied to a withhold requiring achievement of specific quality measures;*
- *Hospital per diem rates tied to a withhold requiring achievement of specific quality measures, along with opportunity for enhanced reimbursement if specific quality measure thresholds are surpassed and;*
- *All-inclusive monthly case rates that are retrospectively adjusted based on achievement of specific quality metrics.*

These payment models are available to those providers who qualify and can be successful in such models.

Cultural Competency Program and Plan

Overview

The purpose of the Cultural Competency Program is:

- *To ensure that WellCare meets the unique diverse needs of all enrollees*
- *To ensure that the associates of WellCare value diversity within the organization*
- *To see that enrollees in need of linguistic services receive adequate communication support.*
- *To ensure its providers fully recognize and care for the culturally diverse needs of the enrollees they serve.*

WellCare views cultural competency as the measure of a person or organization's willingness and ability to learn about, understand, and provide excellent customer service across all segments of the population. It is the active implementation of a system-wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of health care delivery, Cultural Competency is the promotion of sensitivity to the needs of patients and incorporates cultural considerations that include, but are not limited to the following: race, ethnicity, primary language, age, geographic location, gender identity, sexual orientation, English proficiency, physical abilities/limitations, spiritual beliefs and practices, economic status, family roles, literacy, diverse populations. It accommodates the patient's culturally based attitudes, beliefs and needs within the framework of access to health care services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions, and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

The objectives of the Cultural Competency Program are to:

- *Identify enrollees that may have cultural, linguistic or disability-related barriers for which alternative communication methods are needed;*
- *Utilize culturally sensitive and appropriate educational materials based on the enrollee's race, ethnicity, condition of disability and/or primary language spoken;*
- *Ensure that resources are available to overcome the language and communication barriers that exist in the enrollee population;*
- *Make certain that providers care for and recognize the culturally diverse needs of the population;*
- *Teach staff to value the diversity of both their coworkers inside the organization and the population served, and to behave accordingly; and*
- *Provide cultural competency and disability training to all staff Enrollees and ensure training is provided both orally and in written format.*

Cultural competence in healthcare *describes a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enable effective work in cross-cultural situations. Healthcare services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.*

In particular, it is the promotion of quality services to understand racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

WellCare is committed to the development, strengthening, and sustaining of healthy provider/Enrollee relationships. Enrollees are entitled to dignified, appropriate, and quality care. Provider services should meet the unique needs of every Enrollee regardless of race, ethnicity, culture, language proficiency, or disability. In all interactions, providers are expected to act in a manner that is sensitive to the ways in which the Enrollee experiences the world. When healthcare services are delivered without regard for cultural differences, Enrollees are at risk for sub-optimal care. Enrollees may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

WellCare considers mainstreaming of Enrollees an important component of the delivery of care and expects providers to treat Enrollees without regard to race, color, creed, sex, gender identity, religion, age, national origin ancestry, marital status, sexual orientation, health status, income status, program Membership, physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- *Denying an Enrollee a covered service or availability of a facility; and*
- *Providing WellCare Enrollees a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay Enrollees (examples: separate waiting rooms, delayed appointment times*
- *Subjecting an Enrollee to segregation or separate treatment in any manner related to the receipt of any covered service; or restricting a Enrollee in any way in his/her enjoyment of any advantage or privilege enjoyed by others receiving any covered service.*
- *Assigning times or places for provision of services based on the race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual orientation, gender identity, income status, Medicaid Membership, or physical or mental illnesses of the participants served.*

Providers should note that the experience of an enrollee begins at the front door. Failure to use culturally competent and linguistically competent practices could result in the following:

- *Feelings of being insulted or treated rudely*
- *Reluctance and fear of making future contact with the office*
- *Confusion and misunderstanding*
- *Treatment Non-compliance*
- *Feelings of being uncared for, looked down on, and devalued*
- *Parents resisting to seek help for their children*
- *Unfilled prescriptions*
- *Missed appointments*
- *Misdiagnosis due to lack of information sharing*
- *Wasted time*
- *Increased grievances or complaints*

As part of WellCare's Cultural Competency Program, providers must:

- *Facilitate Enrollee access to Cultural and Linguistic Services, including informing Enrollees of their right to access free, quality medical interpreters and signers, accessible transportation, and TDD/TTY services.*
    - *To support informing Enrollees of their right to access free language services, it is recommended that providers post nondiscrimination notices and language assistance taglines in lobbies and on websites. Language assistance taglines notify individuals of the availability of language assistance the top 15 languages utilized in Kentucky as identified by Section 1557 of the ACA.*
- *Provide medical care with consideration of the Enrollees' primary language, race ethnicity and culture;*
- *Participate in cultural competency training annually and ensure that office staff routinely interacting with Enrollees have also been given the opportunity to participate in, and have participated in, cultural competency training;*
- *Ensure that treatment plans are developed with consideration of the Enrollee's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, gender identity, sexual orientation, and other characteristics that may influence the Enrollee's perspective on health care;*
- *Ensure an appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act including that all facilities providing services to Enrollees must be accessible to persons with disabilities. Additionally, no Enrollee with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public facility, or be subjected to discrimination by any such facility.*

***Culturally and linguistically appropriate services (CLAS)**: The collective set of culturally and linguistically appropriate services (CLAS) mandates guidelines and recommendations intended to inform, guide and facilitate required and recommended practices related to culturally and linguistically appropriate health services. The U.S. Department of Health and Human Services, Office of Minority Health, has issued national CLAS standards. WellCare is committed to a continuous effort to perform according to those standards.*

The components of WellCare's Cultural Competency Program include:

- *WellCare analyzes data on the populations in each region it serves quarterly and as needed to learn their cultural and linguistic needs as well as any health disparities they may suffer. Such analyses are performed at the time WellCare enters a new market and regularly thereafter, depending on the frequency with which new data become available. Data sources and analysis methods include the following:*
    - *State-supplied data for Medicaid and CHIP populations;*
    - *Demographic data available from the U.S. Census and any special studies done locally;*

- *Claims and encounter data to identify the healthcare needs of the population by identifying the diagnostic categories that are the most prevalent;*
- *Enrollee requests for assistance, plus complaints and grievances, to identify areas of opportunity to improve service to enrollees from a cultural and linguistic angle; and*
- *Data on race, ethnicity and language spoken for enrollees can be collected both electronically from the state data received and through voluntary self-identification by the enrollee during enrollment/intake or during encounters with network providers.*

- *Community-Based Support – WellCare's success requires linking with other groups having the same goals.*
  - *WellCare reaches out to community-based organizations that support racial and ethnic minorities and disabled people to ensure that the community's existing resources for enrollees who have special needs are utilized to their full potential. The goal is to coordinate the deployment of both community and health plan resources, as well as to take full advantage of the bonds that may exist between the community-based entities and the covered population.*
  - *WellCare will develop and maintain grassroots sponsorships that will enhance WellCare's effort to reach low-income communities and provide opportunity for building meaningful relationships that benefit all enrollees of the communities. These sponsorships will be coordinated with providers, community health fairs and public events.*

- *Management Accountability for Cultural Competency – The Quality Improvement Committee maintains ultimate responsibility for the activities carried out by the health plan related to cultural competency. The committee oversees the day-to-day operations of the quality program in the health plan including the Cultural Competency Program and improvement activities undertaken by the individual WellCare plans.*
  - *WellCare's Director of Quality Improvement is the principal executive in charge of the company's efforts to meet its internal cultural competency objectives and any externally set rules and guidelines on the subject. The Director of Quality Improvement collaborates with the heads of all of WellCare's functional units in making certain that the Cultural Competency Program plan is fully and properly executed.*
  - *The Senior Management team, comprised of the unit leaders of all major functional departments of WellCare Health Plans and the heads of the state operations, is responsible for ensuring that culturally sensitive training occurs in their respective areas.*

- *Diversity and Language Abilities of WellCare – WellCare recruits diverse, talented staff Enrollees to work in all levels of the organization. WellCare does not discriminate with regard to race, religion or ethnic background when hiring staff.*
  - *WellCare ensures that bilingual staff Enrollees are hired for functional units that have direct contact with enrollees to meet the needs identified. Today, approximately 10 % of WellCare's Customer Service representatives are*

bilingual. Spanish is the most common translation required. Whenever possible, WellCare will also distinguish place of origin of its Spanish-speaking staff to ensure sensitivity to differences in cultural backgrounds, language idioms and accents.

- *Where WellCare enrolls significant numbers of enrollees who speak languages other than English or Spanish, WellCare seeks to recruit staff who are bilingual in English plus one of those other languages. WellCare does this even if the particular population is not of a size that triggers state agency mandates.*

- *Diversity of Provider Network*
  - *Providers are inventoried for their language abilities and this information is made available in the provider directory so that Enrollees 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.*
  - *It is recommended that providers report their demographic race and ethnicity information so that WellCare can assess meeting the membership's diversity needs.*

- *Linguistic Services*
  - *In accordance with Title VI of the Civil Rights Act, Prohibition Against National Origin Discriminations, the President's Executive Order 131166, Section 1557 of the Patient Protection and Affordable Care Act, the Health Plan and its providers must make language assistance available to persons with Limited English Proficiency (LEP) at all points of contact during all hours of operation. Language services are available at no cost to WellCare Enrollees and providers without unreasonable delay at all medical points of contact. The Enrollee has the right to file a grievance if cultural and linguistic needs are not met.*
  - *Providers will identify enrollees who have potential linguistic barriers for which alternative communication methods are needed and will contact WellCare to arrange appropriate assistance.*
  - *Enrollees may receive interpreter services at no cost when necessary to access Covered Services through a vendor, as arranged by the Customer Service Department.*
  - *Interpreter services available include verbal translation, verbal 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 WellCare's Customer Service Department.*
  - *Written materials are available for enrollees in large print format and certain non-English languages prevalent in WellCare's service areas.*
  - *Language services include:*
    - *Telephonic interpretation*

- *Oral translation (reading of English material in a Enrollee's preferred language)*
- *Face-to-face non-English interpretation*
- *American Sign Language*
- *Auxiliary aids, including alternate formats such as large print and braille*
- *Written translations for materials that are critical for obtaining health insurance coverage and access to health care services in non-English prevalent languages*

Information is deemed to be critical for obtaining health insurance coverage or access to health care services if the material is required by law or regulation to provide the document to an individual.

To obtain language services for an Enrollee, contact WellCare Provider Services. Face-to-face and American Sign Language services should be requested as soon as possible, or at least 5 business days before the appointment. All providers (Medical, Behavioral, Pharmacy, etc.) can request language services by calling our ***Provider Services at: 1-877-389-9457 (TDD/TTY 711).*** *You may also call the toll-free number on the back of our Enrollee's ID card.*

Restrictions Related to Interpretation or Facilitation of Communication

- *Providers may not request or require an individual with limited English proficiency to provide their own interpreter.*
- *Providers may not rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency.*
- *Providers may not use an accompanying adult or minor child to interpreter or facilitate communication*
- *Exceptions to these expectations include:*
    - *In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available;*
    - *Accompanying adults (minors are excluded) where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances for minimal needs.*

  Providers are encouraged to document in the Enrollee's medical record any Enrollee denial of professional interpreters and the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.

- *Electronic Media*
    - *Telephone system adaptations – Enrollees have access to the TTY line for hearing-impaired services. WellCare's Customer Service Department is*

responsible for any necessary follow-up calls to the Enrollee. The toll-free TTY number can be found on the enrollee identification card.

- *Linkage to Community*
  - *WellCare is dedicated to partnering with community organizations to promote cultural understanding and to meet the needs of the diverse population. Wherever possible, WellCare will pursue linkages with national, state and local organizations dedicated to advancing both the broad interests and the health interests of groups having needs for culturally based supports.*
- *Enrollee/Patient Education*
  - *The multicultural basis of WellCare's patient education program is drawn from the Healthy People 2030 initiative. Healthy People 2030 "identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being." To learn more, go to* ***health.gov/healthypeople****.*
  - *Given the nature of the population WellCare serves, from the list of conditions with disparate impacts on racial and ethnic minorities, WellCare has chosen behavioral health conditions, adult prevention services, child and adolescent wellness, diabetes, maternal health, congestive heart failure, coronary artery disease, hypertension, chronic obstructive pulmonary disease and asthma as the areas its enrollee health education will focus on.*
  - *Upon enrollment, Enrollees receive a welcome packet that includes an enrollee handbook, which outlines WellCare's Disease Management Program.*
- *Enrollee Rights*
  - *WellCare adopts and acts based on the Medicaid Enrollee rights and responsibilities as approved by each state's Medicaid agency. All associates, including Customer Service representatives, are expected to treat Enrollees in a manner that respects their rights and the expectations of their responsibilities.*
- *Provider Education*
  - *WellCare's Cultural Competency Program educates providers on the Department's Cultural Competency requirements in an effort to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity.*
  - *Providers are encouraged to self-identify race, ethnicity, and languages spoken*
  - *Providers must take WellCare's cultural competency training, located on the provider portal and website, to meet annual cultural competency training requirements. Providers are able to participate in training opportunities administered by the State, nationally recognized organizations, or training provided by other organizations. For additional information regarding resources and trainings, visit:*
    - *On the Office of Minority Health's website, you will find "A Physician's Practical Guide to Culturally Competent Care." By taking this course online, you can earn up to* ***nine CME credits****, or nine contact hours for free. The course may be found at* ***cccm.thinkculturalhealth.hhs.gov****.*
    - *Think Cultural Health's website includes classes, guides and tools to assist you in providing culturally competent care. The website thinkculturalhealth.hhs.gov.*
    - *The Agency for Healthcare Research and Quality website, which offers a toolkit as a way for primary care practices to assess their services for*

*health literacy considerations, raise awareness of their entire staff, and work on specific areas. The toolkit can be found at **ahrq.gov**.*

- *The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) website at **hrsa.gov** . Providers can find free online courses on topics such as addressing health literacy, cultural competency and limited English proficiency.*

- *Provider Performance Monitoring*
  - *If enrollees file complaints or grievances with WellCare concerning a provider that behaves in a manner inconsistent with standards for culturally and linguistically appropriate services, WellCare will investigate the matter with the same degree of concern applied to any other complaint or grievance. Offending providers will be expected to take corrective measures, and WellCare will follow up to make certain that such action indeed was taken.*
  - *If WellCare observes patterns in complaint and grievance information that suggest there are systemic deficiencies in providers' conformance to cultural competency aims, WellCare will investigate the root causes and define broad performance improvement projects to eliminate the weakness.*
- *Ongoing Self-Assessment*
  - *WellCare will continually assess the cultural competency of the company, both nationally and at the level of each health plan unit, to ensure that WellCare is meeting the diverse needs of its Enrollees, providers and staff. A component of the self-assessment will be to utilize focus groups of enrollees, providers and staff to explore the needs of all WellCare constituent groups and to listen to suggestions for improving its Cultural Competency Program.*
  - *Annually, the Cultural Competency Program will be reviewed, revised and presented to the Quality Improvement Committee to ensure compliance with the program objectives.*

Providers must adhere to the Cultural Competency Program as described above.

WellCare as part of its credentialing will evaluate the cultural competency level of its network providers and provide access to training and tool kits to assist providers in developing culturally competent and culturally proficient practices.

Network providers must ensure:

- *Enrollees understand that they have access to qualified medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them*
- *Medical care is provided with consideration of the Enrollee's race/ethnicity and language and its impact/influence on the Enrollee's health or illness*
- *Office staff that routinely interact with Enrollees have access to and participate in cultural competency training and development*
- *Office staff responsible for data collection make reasonable attempts to collect race- and language-specific Enrollee information. Staff will also explain race/ethnicity categories to an Enrollee so that the Enrollee is able to identify the race/ethnicity of themselves and their children*
- *Treatment plans are developed with consideration of the Enrollee's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, gender identity, and other characteristics that may influence the Enrollee's perspective on healthcare*

- *Office sites have posted and printed materials in English and Spanish, and other prevalent non-English languages required by the Kentucky Department of Health and Human Services (DHHS).*

The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of your patients. WellCare is committed to helping you reach this goal. Take into consideration the following as you provide care to the WellCare of Kentucky Enrollees:

- *What are your own cultural values and identity?*
- *How do or can cultural differences impact your relationship with your patients?*
- *How much do you know about your patient's culture and language?*
- *Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?*
- *Do you embrace differences as allies in your patients' healing process?*

The U.S. Department of Health and Human Services' Office of Minority Health has published a suite of online educational programs to Advance Health Equity at Every Point of Contact through development and promotion of culturally and linguistically appropriate services. Visit Think Cultural Health at ***ThinkCulturalHealth.hhs.gov*** *to access these free online resources.*
For more information on the Cultural Competency Program, registered Provider Portal users may access the Cultural Competency training at ***wellcareky.com/providers/medicaid/training****. A paper copy, at no charge, may be obtained upon request by contacting Provider Services or a Provider Relations representative.*

Enrollee Administrative Guidelines

Overview
WellCare will make information available to enrollees on the role of the PCP, how to obtain care and what Enrollees should do in an emergency or urgent medical situation as well as enrollees' rights and responsibilities. WellCare will convey this information through various methods, including an Enrollee Handbook.

Enrollee Handbook
All newly enrolled Enrollees will be sent an enrollee handbook within five business days of receiving the notice of enrollment from WellCare. The Enrollee handbook may also be sent via email (upon consent from the enrollee) and is posted at ***wellcareky.com/Enrollees****.*

Enrollment
WellCare must obey laws that protect from discrimination or unfair treatment. WellCare does not discriminate based on a person's health status, need for health services, race, color, disability, religion, sex, sexual orientation, gender identity, health, ethnicity, creed, age or national origin.

Upon enrollment in WellCare, enrollees are provided with the following:

- *Terms and conditions of enrollment;*
- *Description of Covered Services in network and out of network (if applicable);*
- *Information about PCPs, such as location, telephone number and office hours;*
- *Information regarding out-of-network emergency services;*
- *Grievance and appeal procedures; and*

- *Brochures describing certain benefits not traditionally covered by Medicaid and other value-added items or services, if applicable.*

Enrollee Identification Cards

Enrollee identification cards are intended to identify WellCare Enrollees, the type of plan they have and to facilitate their interactions with healthcare Providers. Information found on the enrollee identification card may include the enrollee's name, identification number, plan type, PCP's name and telephone number, health plan contact information and claims filing address. Possession of the enrollee identification card does not guarantee eligibility or coverage. Providers are responsible for ascertaining the current eligibility of the cardholder via the Department's eligibility portal.

Eligibility Verification

An enrollee's eligibility status can change at any time. Therefore, all providers should consider requesting and copying an enrollee's identification card, along with additional proof of identification such as a photo ID and filing them in the medical record.

Providers may do one of the following to verify eligibility:

- *Access the WellCare website at **wellcareky.com**. Providers must be registered on WellCare's site and log in;*
- *Access WellCare's Interactive Voice Response (IVR) system. Providers will need their Provider ID number to access enrollee eligibility;*
- *Access the Commonwealth of Kentucky's KY Health Net System website at **chfs.ky.gov/agencies** and/or*
- *Contact the Provider Services Department.*

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 the Provider Contract for additional details.

Eligibility Requirements

If an enrollee changes managed care organizations and the provider delivers services to an individual who is no longer an enrollee of WellCare but is an enrollee of another managed care organization, WellCare is entitled to recoup any payment made to the provider.

Hospital Admission Prior to the Enrollee's Transition

If the enrollee is an in-patient in any facility at the time of transition, the managed care organization responsible for the enrollee's care at the time of admission shall continue to provide coverage for the enrollee at that facility, including all professional services, until the recipient is discharged from the facility for the current admission. An inpatient admission within 14 calendar days of discharge for the same diagnosis shall be considered a "current admission." The "same diagnosis" is defined as the first five digits of a diagnosis code.

For an enrollee who loses eligibility during an inpatient stay, WellCare is responsible for the care through discharge if the hospital is compensated under a DRG methodology or through the day of ineligibility if the hospital is compensated under a per diem methodology.

Outpatient Facility Services and Non-Facility Services

Effective on the enrollee's transition date, the new managed care plan will be responsible for outpatient services both facility and non-facility. Outpatient reimbursement includes outpatient hospital, ambulatory surgery centers, and renal dialysis centers.

Enrollee Rights and Responsibilities

WellCare enrollees, both adults and children, have specific rights and responsibilities outlined concerning the enrollee's healthcare . WellCare Enrollees have the right to:

- *To receive information about WellCare, its services, its practitioners and providers and enrollee rights and responsibilities;*
- *To get information about their rights and responsibilities;*
- *Be treated with respect and recognition of their dignity and their right to privacy;*
- *Confidentiality, accessibility and nondiscrimination;*
- *Participate with practitioners in making decisions about their care;*
- *A candid discussion of appropriate or medically necessary treatment options for their conditions, no matter the cost or benefit coverage, and the choices and risks involved. The information must be given in a way they understand;*
- *To have a say in WellCare's Enrollee rights and responsibilities policy;*
- *A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;*
- *Consent for or refusal of treatment and active participation in decision choices;*
- *Ask questions and receive complete information relating to the enrollee's medical condition and treatment options, including specialty care;*
- *Voice grievances and receive access to the grievance process, receive assistance in filing an appeal, and request a state fair hearing from the contractor and/or the department;*
- *Timely access to care that does not have any communication or physical access barriers;*
- *Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;*
- *Assistance with medical records in accordance with applicable federal and state laws;*
- *Timely referral and access to medically indicated specialty care;*
- *Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;*
- *Receive information in accordance with 42 C.F.R. 438.10;*
- *Be furnished healthcare services in accordance with 42 C.F.R. Part 438; and*
- *Any American Indian enrolled with the contractor eligible to receive services from a participating I/T/U Provider or an I/T/U PCP shall be allowed to receive services from that provider if part of contractor's network.*

WellCare enrollees have the responsibility:

- *To become informed about enrollee rights;*
- *To supply information (to the extent possible) that WellCare, its practitioners and its providers need in order to provide care;*
- *To abide by WellCare's and the Department's Policies and Procedures;*
- *To become informed about service and treatment options;*
- *To actively participate in personal healthcare decisions and practice healthy lifestyles;*
- *To report suspected fraud and abuse;*
- *To follow plans and instructions for care that they have agreed to with their Provider;*

- *To understand their health problems;*
- *To participate in developing mutually agreed-upon treatment goals, to the degree possible, with their Provider;*
- *To read the Enrollee Handbook to understand how the plan works;*
- *To carry their Enrollee ID cards at all times;*
- *To carry their Medicaid cards at all times;*
- *To show their ID cards to each Provider;*
- *To schedule appointments for all non-emergency care through their Provider;*
- *To get a referral from their Provider for specialty care;*
- *To cooperate with the people who provide their healthcare;*
- *To be on time for appointments;*
- *To tell the doctor's office if they need to cancel or change an appointment;*
- *To respect the rights of all Providers;*
- *To respect the property of all Providers;*
- *To respect the rights of other patients;*
- *To not be disruptive in the doctor's office;*
- *To know the medicines they take, what they are for and how to take them the right way;*
- *To make sure their Providers have copies of all previous medical records; and*
- *To let WellCare know within 48 hours, or as soon as possible, if they are admitted to the hospital or get emergency room care.*

Assignment of Primary Care Providers

All Kentucky Medicaid Enrollees enrolled in a WellCare Medicaid plan, except presumptively eligible and dual eligible Enrollees must choose a PCP or they will be assigned to a PCP that is within WellCare's network within 24 hours. To ensure quality and continuity of care, the PCP is responsible for arranging all of the Enrollee's healthcare needs from providing primary care services to coordinating referrals to specialists and Providers of ancillary or non-emergency hospital services.

If a Provider's name is not identified as the Primary Care Provider on the Enrollee's card, the Enrollee may see that Provider as long as the Provider is a participating Provider within WellCare's network.

An Enrollee without SSI shall be offered an opportunity to: (1) choose a new PCP affiliated within WellCare's network or (2) stay with their current PCP as long as such PCP is affiliated with the plan's network. Each Enrollee shall be allowed to choose their PCP from among all available in-network PCPs and specialists, as is reasonable and appropriate for Enrollee.

An Enrollee who has SSI but is not a dual eligible shall be offered an opportunity to: (1) choose a new PCP who is affiliated with the plan's network or (2) stay with their current PCP as long as such PCP is affiliated with the network. Each Enrollee shall be allowed to choose their Primary Care Provider from among all available in-network Primary Care Providers and specialists as is reasonable and appropriate for Enrollee.

Changing Primary Care Providers

WellCare Enrollees have the freedom to choose a PCP from our comprehensive provider network. Within 10 calendar days of enrollment, WellCare will send new Enrollees a welcome kit with their ID card and Enrollee handbook with information on how to change their PCP. Enrollees may change their PCP selection at any time by calling Customer Service. Providers can also assist Enrollees in changing their designated PCP while the Enrollee is in the Provider's office by completing the PCP Change Request Form at ***wellcareky.com/providers/medicaid/forms****.*

If WellCare assigns the Enrollee a PCP prior to offering the Enrollee the process above for self-selection, and WellCare receives a request from the Enrollee within 30 days for a reassignment, the reassignment shall be retroactively effective to the date of the Enrollee's assignment to WellCare.

DENTAL HOME MODEL

A dental home serves as the Enrollee's primary care dentist (PCD) for all aspects of oral health care. The PCD has an ongoing relationship with the Enrollee to provide comprehensive, continually accessible, coordinated and family centered care. The PCD also makes referrals to dental specialists when appropriate. Federally Qualified Health Centers, individuals who are general dentists, and pediatric dentists can serve as main dental homes. The Dental Home is inclusive of all aspects of oral health and involves parents, the patient, dentists, dental professionals, and non-dental professionals. The Dental Home is the Primary Dental Provider who has accepted the responsibility for providing or coordinating the provision of all covered dental care services. The KY Medicaid Dental Home assignments apply to Enrollees under age 21 in an effort to improve pediatric oral health.

SPECIALIST RESPONSIBILITIES

WellCare of Kentucky encourages specialists to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the Enrollees' care and ensure the referred specialty physician is a participating provider within the WellCare of Kentucky network and that the PCP is aware of the additional service request. The specialty physician may order diagnostic tests without PCP involvement by following WellCare of Kentucky referral guidelines.

- *Emergency admissions will require notification to Nebraska Total Car WellCare of Kentucky's Medical Management department within the standards set forth in the Utilization Management section of this manual.*
- *All non-emergency inpatient admissions require prior authorization from WellCare of Kentucky.*

The specialist provider must:

- *Maintain contact with the PCP*
- *Obtain authorization from WellCare of Kentucky Medical Management department ("Medical Management") if needed before providing services*
- *Coordinate the Enrollee's care with the PCP*
- *Provide the PCP with consult reports and other appropriate records within five (5) business days*
- *Be available for or provide on-call coverage through another source 24 hours a day for management of Enrollee care*

- *Maintain the confidentiality of Enrollee information and medical information*
- *Actively participate in and cooperate with all WellCare of Kentucky quality initiatives and activities to improve quality of care and services to Enrollee experience. Cooperation includes collection and evaluation of data*
- *Allows use of practitioner performance data for WellCare of Kentucky quality improvement activities.*

Women's Health Specialists

PCPs may also provide routine and preventive healthcare services that are specific to female Enrollees. If a female Enrollee selects a PCP who does not provide these services, she has the right to direct in-network access to a women's health specialist for Covered Services related to this type of routine and preventive care.

Providers should submit a notification of pregnancy (NOP) form using the provider portal or the WellCare public site to improve Enrollee outcomes. This can be found on the provider portal and public web page: wellcareky.com/providers.

Providers can refer pregnant Enrollees to WellCare's Baby Steps Maternal Health Program at 1-844-901-3780.

Hearing-Impaired, Interpreter and Sign Language Services

Hearing-impaired, interpreter and sign language services are available to WellCare Enrollees through WellCare's Customer Service. PCPs should coordinate these services for WellCare Enrollees and contact Customer Service if assistance is needed. Please refer to the Quick Reference Guide at ***wellcareky.com*** *for the Customer Service telephone numbers. These services are available at no cost to the Enrollee per federal law.*

Section 3: Quality Improvement

Overview

WellCare's Quality Improvement Program (QI Program) is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable medical and behavioral healthcare and services. Strategies are identified and activities implemented in response to findings. The QI Program addresses the quality of clinical care and non-clinical aspects of service with a focus on key areas including:

- *Quantitative and qualitative improvement in enrollee outcomes;*
- *Confidentiality;*
- *Coordination and continuity of care with seamless transitions across healthcare settings/services;*
- *Cultural Competency;*
- *Quality of care/service;*
- *Credentialing;*
- *Preventive health;*
- *Complaints/grievances;*
- *Network adequacy;*
- *Appropriate service utilization;*
- *Disease and Care Management;*
- *Behavioral Health services;*
- *Appeals and grievances;*
- *Enrollee and Provider satisfaction;*
- *Components of operational service, and*
- *Regulatory/federal/state/accreditation requirements.*

The QI Program activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, HEDIS measures and/or medical record audits. The Quality Improvement Committee is delegated by WellCare's board of directors to monitor and evaluate the results of program initiatives and to implement corrective action when the results are less than desired or when areas needing improvement are identified.

The goals of the QI 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;*
- *Ensure availability and access to qualified and competent providers;*
- *Establish and maintain safeguards for Enrollee privacy, including confidentiality of enrollee health information;*
- *Engage Enrollees in managing, maintaining or improving their current states of health through fostering the development of a Primary Care Provider-patient relationship and participation in care programs;*

- *Provide a forum for enrollees, providers, various healthcare associations and community agencies to provide suggestions regarding the implementation of the QI Program; and*
- *Ensure compliance with standards as required by contract, regulatory statutes and accreditation agencies.*

Provider Participation in the Quality Improvement Program

Network practitioners and providers are contractually required to cooperate with all Quality Improvement (QI) activities to improve the quality of care and services and Enrollee experience. This includes the collection and evaluation of performance data and participation in WellCare of Kentucky's QI Programs. Practitioner and provider contracts, or a contract addendum, also require that practitioners and providers allow WellCare of Kentucky the use of their performance data for quality improvement activities. As part of this program, providers and practitioners are required to cooperate with Quality Improvement (QI) activities and allow WellCare of Kentucky to use their performance data. Medical records shall be made available for quality review both during and after the term of the Provider Contract. In addition, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule at 45 CFR 164.506 permits a covered entity (Provider) to use and disclose Protected Health Information (PHI) to health plans without enrollee authorization for treatment, payment and healthcare operations activities. Healthcare operations include, but are not limited to, the health plan conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing healthcare costs, care management and care coordination.

Providers are invited to volunteer for participation in the QI Program. Avenues for participation include committee representation, quality/performance improvement projects, EPSDT assessments and feedback/input via satisfaction surveys, grievances and calls to Provider Services. Provider participation in quality activities helps facilitate integration of service delivery and benefit management.

Information regarding the QI Program is available upon request and includes a description of the QI Program and a report assessing the progress in meeting goals. WellCare evaluates the effectiveness of the QI Program on an annual basis. An annual report is published which reviews completed and continuing QI activities that address the quality of clinical care and service, trends and measures to assess performance in quality of clinical care and quality of service, identifies any corrective actions implemented or corrective actions which are recommended or in progress, and identifies any modifications to the QI Program. This report is available as a written document.

Enrollee Satisfaction

On an annual basis, WellCare conducts an enrollee satisfaction survey of a representative sample of enrollees. Satisfaction with access to services, quality, provider communication and shared decision-making is evaluated. The results are compared to WellCare's performance goals, and improvement action plans are developed to address any areas not meeting the standard.

Early and Periodic Screening, Diagnosis and Treatment Periodicity Schedule

*The preventive pediatric healthcare guidelines for children are at **wellcareky.com/providers/tools/clinical-guidelines**.*

An enrollee should have an initial health check screening in the following situations:

- *Within 90 days of joining WellCare or upon change to a new PCP if prior medical records do not indicate current compliance with the periodicity schedule; and*
- *Within 24 hours of birth for newborns.*

The child may enter the periodicity schedule at any time. For example, if a child has an initial screening at age 4, then the next periodic screening should be performed at age 5.

The medical record must contain documentation of a comprehensive health history during the initial visit in addition to a complete unclothed physical examination to determine if the child's development is within the normal range for the child's age and health history.

Each provider office is required to have the following equipment to provide a complete health check:

- *Weight scale for infants;*
- *Weight scale for children and adolescents;*
- *Measuring board or device for measuring length or height in the recumbent position for infants and children up to age 2;*
- *Measuring board or device for measuring height in the vertical position for children who are 2 years or older;*
- *Blood pressure apparatus with infant, child and adult cuffs;*
- *Screening audiometer;*
- *Centrifuge or other device for measuring hematocrit or hemoglobin;*
- *Eye charts appropriate to children by age;*
- *Developmental and behavioral screening tools; and*
- *Ophthalmoscope and otoscope.*

Additional points of emphasis regarding EPSDT screens include the following:

- ***Visit Requirements** – An interval health history, age-appropriate assessment of physical and mental health development, assessment of nutrition, complete/unclothed physical exam, age-appropriate health education/anticipatory guidance and growth chart are completed at each visit.*
- ***Immunizations** are administered at required age parameters and intervals with dates documented. If the immunizations are not up to date according to age and health history, the Provider should document why immunizations were not given at the time of the EPSDT screen. For the immunization schedule, refer to the preventive pediatric healthcare guidelines for children at **wellcareky.com/providers**. Note that certain immunizations may not be covered in the context of covered benefits.*
- ***PCP Responsibilities** – A PCP must perform all required components of an EPSDT health screen, as per the AAP and ACIP periodicity schedules, and document appropriately in the enrollee's medical record. If a PCP chooses not to provide the immunization component of the screen, she or he has accountability to refer the Enrollee to another network provider (such as a health department entity) who can provide this service in a timely manner. WellCare will expect the PCP to follow up with the referred provider to obtain documentation regarding the provision of the immunization(s) to maintain an accurate and complete medical record. WellCare will monitor for compliance to these*

requirements by reviewing immunization rates by the PCP. If the immunization rate of the PCP is less than the network average, WellCare will assess for practice access and availability by:

- *Conducting an audit to verify compliance with access and availability;*
- *Requiring adoption of a corrective action plan (CAP) if access and availability standards are not met; and*
- *Performing a focused medical record review. Based on negative findings, a CAP will be requested.*
  - *If compliance to the CAP is not demonstrated, WellCare will assess for a fee reduction; and*
  - *If lack of compliance continues, WellCare will petition for removal from network participation.*

- ***Lead Exposure Assessment** is done at the 6-month through 6-year age visits. Lead blood level for children with low-risk history is done at the 12-month and 2-year age visit. Lead blood levels in children with a high-risk history are done immediately. Any risk identified through lead risk assessment should be both documented in the medical record and addressed.*
- ***Annual Tuberculosis (TB) Skin Testing** is done if the enrollee is in a high-risk category. Only those children locally identified at high-risk for TB disease should be tested. Results of TB risk assessment and testing as needed should be documented in the child's medical record.*
- ***Developmental Delay** is to be assessed by use of a formalized tool at 9 months and 18 months and at 2.5 years and 3 years.*
- ***120-Day Non-Compliant Report** is a report that WellCare will send providers. It includes a monthly membership list of EPSDT-eligible children who have not had a screen within 120 days of enrolling in WellCare or who are not in compliance with the EPSDT periodicity schedule. The PCP shall contact these enrollees' parents or guardians to schedule an appointment. WellCare will also send letters to the parents and guardians of EPSDT-eligible children to remind them of preventive services needed based on the child's age.*
- ***Establish and maintain a tracking system** to monitor acceptance and refusal of EPSDT service, whether eligible enrollees are receiving the recommended health assessments, and all necessary diagnosis and treatment, including EPSDT Special Services, when needed.*

Clinical Practice Guidelines

WellCare adopts validated evidence-based Clinical Practice Guidelines and utilizes the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other provider may supersede Clinical Practice Guidelines, the guidelines provide clinical staff and providers with information about medical standards of care to assist in applying evidence from research in the care of both individual enrollees and populations. The Clinical Practice Guidelines are based on peer-reviewed medical evidence and are relevant to the population served. Providers are also measured annually for their compliance with Clinical Practice Guidelines. Areas identified for improvement are tracked and corrective actions are taken as indicated. The effectiveness of corrective actions is monitored until the problem is resolved. Approval of Clinical Practice Guidelines occurs through the Quality Improvement Committee as well as through the Kentucky Department for Medicaid Services. Clinical Practice Guidelines, including preventive health guidelines, are at ***wellcareky.com/providers/tools/clinical-guidelines.***

The website provides access to new clinical practice guidelines as well as any updates or revisions to existing guidelines. Practitioners are provided information on how to access the guidelines through this provider manual, the WellCare website, and in the provider newsletters, provider report. The following is a sample of the clinical practice guidelines adopted by WellCare:

- *American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care*
- *American Diabetes Association: Standards of Medical Care in Diabetes*
- *Center for Disease Control and Prevention (CDC):Adult and Child Immunization Schedules*
- *National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell*
- *U.S. Preventive Services Task Force Recommendations for Adult Preventive Health*

Healthcare Effectiveness Data and Information Set (HEDIS ®)

HEDIS is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. The tool comprises 96 measures across six domains of care, including:

- *Effectiveness of care*
- *Access and availability of care*
- *Experience of care*
- *Utilization and Risk Adjusted Utilization*
- *Health Plan Descriptive Information*
- *Measures Collected Using Electronic Clinical Data Systems*

HEDIS is a mandatory process that occurs annually. It lets WellCare and providers demonstrate the quality and consistency of care available to enrollees. Medical records and claims data are reviewed for capture of required data. Compliance with HEDIS standards is reported on an annual basis with results available to Providers upon request. Through compliance with HEDIS standards, Enrollees benefit from the quality and effectiveness of care received, and providers benefit by delivering industry recognized standards of care to achieve optimal outcomes.

Medical Records

Medical records should be comprehensive and reflect all aspects of care for each enrollee. Records are to be maintained in a timely, legible, current, detailed and organized manner in order to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to:

- *Medical charts*
- *Prescription files*
- *Hospital records*
- *Provider specialist reports*
- *Consultants' and other healthcare professionals' findings*
- *Appointment records*
- *Other documentation sufficient to disclose the quantity, quality appropriateness and timeliness of service provided*

Medical records must be signed and dated by the provider of service.

The Enrollee's medical record is the property of the provider who generates the record. However, each enrollee or her or his representative is entitled to one free copy of their medical record. Additional copies shall be made available to enrollees at cost. Medical records shall generally be preserved and maintained for at least five years unless federal requirements mandate a longer retention period (for example, immunization and tuberculosis records are required to be kept for a person's lifetime).

An enrollee's medical record shall include at a minimum for hospitals and mental hospitals:

1. *Identification of the beneficiary.*
2. *Physician name.*
3. *Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission; the plan of care (as required under 42 CFR 456.172 (mental hospitals) or 42 CFR 456.70 (hospitals).*
   Initial and subsequent continued stay review dates (described under 42 CFR 456.233 and 42 CFR 465.234 (for mental hospitals) and 42 CFR 456.128 and 42 CFR 456.133 (for hospitals)
4. *Reasons and plan for continued stay if applicable.*
5. *Other supporting material the committee believes appropriate to include.*
6. *For non-mental hospitals only:*
   a. *Date of operating room reservation.*
   b. *Justification of emergency admission if applicable.*

All Behavioral Health services shall be provided in conformance with the access standards established by the Department of Medicaid Services. When assessing enrollees for Behavioral Health services, the plan and its providers shall use the most current version of DSM classification. The plan may require use of other diagnostic and assessment instrument/outcome measures in addition to the most current version of DSM. Providers shall document DSM diagnosis and assessment/outcome information in the Enrollee's medical record.

PCPs and identified high-volume specialists are measured at least once every three years for their compliance with medical record documentation standards. All providers must honor the request for medical records. Identified areas for improvement are tracked, and corrective actions up to and including network termination are taken as indicated. Effectiveness of corrective actions is monitored until problem resolution occurs.

Confidentiality of enrollee information must be maintained at all times. Records are to be stored securely with access granted to authorized personnel only. Access to records should be granted to WellCare or its representatives without a fee to the extent permitted by state and federal laws. Providers should have procedures in place to permit the timely access and submission of medical records to WellCare upon request. Information from the medical records review may be used in the re-credentialing process as well as quality activities.

For more information on the confidentiality of Enrollee information and release of records, refer to Section 8: Compliance.

Patient Safety to Include Quality of Care and Quality of Service

Programs promoting patient safety are a public expectation, a legal and professional standard and an effective risk-management tool. As an integral component of healthcare delivery by all inpatient and outpatient providers, WellCare supports identification and implementation of a complete range of patient safety activities. These activities include medical record legibility and documentation standards, communication and coordination of care across the healthcare network, medication allergy awareness/documentation, drug interactions, utilization of evidence-based clinical guidelines to reduce practice variations, tracking and trending adverse events/quality-of- care issues/quality-of-service issues, and grievances related to safety.

Patient safety is also addressed through adherence to clinical guidelines that target preventable conditions. Preventive services include:

- *Regular checkups for adults and children*
- *Prenatal care for pregnant women*
- *Well-baby care*
- *Immunizations for children, adolescents and adults; and*
- *Tests for cholesterol, blood sugar, colon and rectal cancer and bone density, tests for sexually transmitted diseases, Pap smears and mammograms.*

Preventive guidelines address prevention and/or early detection interventions and the recommended frequency and conditions under which interventions are required. Prevention activities are based on reasonable scientific evidence, best practices and the Enrollee's needs. Prevention activities are reviewed and approved by the Utilization Management Medical Advisory Committee (UMAC) with input from participating providers and the Quality Improvement Committee (QIC). Activities include distribution of information, encouragement to utilize screening tools and ongoing monitoring and measuring of outcomes. While WellCare can and does implement activities to identify interventions, the support and activities of families, friends, Providers and the community have a significant impact on prevention.

Diamond Designation™ Program

The Diamond Designation Program provides ratings on the quality and efficiency of care across 14 different specialty areas; however, specialties vary per market. The specific specialties included for Kentucky Medicaid are listed below. The Program emphasizes quality over efficiency. Provider ratings are determined and reported at a medical practice/group level based on Tax Identification Number.

We aim to update the Diamond Designation Program at least every two years with the Program Year 2025 update becoming effective in the fourth quarter of 2025.

Specialty Types Included in Program Year 2025 for Kentucky Medicaid

Specialty Types	
Cardiology	*Orthopedic Surgery*
Counselors	*Podiatry*
Gastroenterology	*Psychiatry*
General Surgery	*Psychology*
Nephrology	*Pulmonology*

Neurology	

Some primary care providers want to understand more about the quality and efficiency of specialty physicians and other clinicians. Rating results from the Program are made available to our primary care providers to potentially consider as they refer patients to specialty care. Individuals are advised to consider all relevant factors and that Program ratings should not be the sole basis of their decision-making.

The Diamond Designation Program methodology for evaluation is based on national standards and incorporates feedback from physicians and other clinicians as well as members. The health plan seeks to produce evaluation results that are as accurate as possible. Ratings from the Diamond Designation Program are only a partial evaluation of quality and efficiency and should not solely serve as the basis for specialist provider selection (as such ratings have a risk of error). Other factors may be important in the selection of a specialist. The Program and its results are not utilized to determine payment under pay-for-performance programs. Specialty Provider groups evaluated within the Program have the opportunity to request a change or correction to information used in determining their efficiency or quality scores.

For additional information regarding the Diamond Designation Program, please visit ***DiamondDesignation.com****. This site includes a description of the most current methodology used in determining Program ratings and specific instructions for Providers to submit requests for reconsideration of their results. The health plan values Provider feedback and welcomes comments and questions. Please send them by email to* ***ContactUs@DiamondDesignation.com****.*

Web Resources

WellCare periodically updates clinical, coverage and preventive guidelines as well as other resource documents posted on the WellCare website. Please check WellCare's website frequently for the latest news and updated documents at ***wellcareky.com/providers/medicaid****.*

Section 4: Utilization Management (UM), Care Management (CM) and Disease Management (DM)

Utilization Management

For purposes of this Utilization Management section, terms and definitions may be contained within this section, in Section 12: Definitions and Abbreviations, or both.

The focus of the UM Program is on:

- *Evaluating requests for services by determining the Medical Necessity, efficiency, appropriateness and consistency with the Enrollee's diagnosis and level of care required;*
- *Providing access to medically appropriate, cost-effective healthcare services in a culturally sensitive manner and facilitating timely communication of clinical information among Providers;*
- *Reducing overall expenditures by developing and implementing programs that encourage preventive healthcare behaviors and Enrollee partnership;*
- *Facilitating communication and partnerships among Enrollees, families, Providers, delegated entities and WellCare in an effort to enhance cooperation and appropriate utilization of healthcare services;*
- *Reviewing, revising and developing medical coverage policies to ensure Enrollees have appropriate access to new and emerging technology; and*
- *Enhancing coordination and minimizing barriers in the delivery of behavioral and medical healthcare services.*

WellCare's UM Program includes components of Prior Authorization and prospective, concurrent and retrospective review activities. Each component is designed to provide for the evaluation of healthcare and services based on WellCare Enrollees' coverage and the appropriateness of such care and services and to determine the extent of coverage and payment to Providers of care.

WellCare does not reward its associates or any practitioners, physicians or other individuals or entities performing UM activities for issuing denials of coverage, services or care, and financial incentives, if any, do not encourage or promote underutilization of Covered Services.

Medically Necessary Services

The determination of whether a covered benefit or service is Medically Necessary shall:

- *Be based on an individualized assessment of the recipient's medical needs; and*
- *Comply with the requirements established in this paragraph. To be Medically Necessary or a Medical Necessity, a covered benefit shall be:*
    - *Reasonable and required to identify, diagnose, treat, correct, cure, palliate or prevent a disease, illness, injury, disability or other medical condition, including pregnancy;*
    - *Appropriate in terms of the service, amount, scope and duration based on generally accepted standards of good medical practice;*
    - *Provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver or the healthcare Provider, or for cosmetic reasons;*

- *Provided in the most appropriate location, with regard to generally accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;*
- *Needed, if used in reference to an emergency medical service, to exist using the prudent layperson standard;*
- *Provided in accordance with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements for individuals under 21 years of age; and*
- *Provided in accordance with 42 C.F.R. 440.230.*

Criteria for Utilization Management Decisions

WellCare has adopted utilization review criteria developed by InterQual® products to determine medical necessity for healthcare services. InterQual® appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual® criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual® is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the Participant's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

The review criteria and guidelines are available to Providers upon request. Providers may request a copy of the criteria used for specific determination of Medical Necessity by calling the Provider Services Department listed on the Quick Reference Guide at ***https://www.wellcareky.com/providers****.*

Examples of criteria that may be utilized are Centene Clinical Policies and InterQual® criteria appropriate to clinical condition and Enrollee's unique needs (e.g. Adult, Geriatric, Child, Adolescent, and Behavioral Health/Psychiatry). Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. Providers may advise and comment on the development and adoption of clinical criteria through their Provider Relations representative who can provide contact information for the Chair of the Medical Policy Committee or another WellCare Medical Director.

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

- *Centene/ WellCare Clinical Policies and InterQual® criteria appropriate to clinical condition and Enrollee's unique needs (e.g. Adult, Geriatric, Child, Adolescent, and Behavioral Health/Psychiatry)*
- *WellCare Clinical Coverage Guidelines;*
- *Local Coverage Determinations*
- *State Medicaid Contract;*
- *State Provider Handbooks, as appropriate;*
- *Federal and state statutes and regulations;*
- *Medicaid and Medicare guidelines; and*
- *Hayes Health Technology Assessment.*
- *Level of Care Utilization System (LOCUS);*

- *Child and Adolescent Service Intensity Instrument (CASII)*
- *Child and Adolescent Needs and Strengths Scale (CANS);*
- *Early Childhood Service Intensity Instrument (ECSII); and*
- *American Society of Addiction Medicine (ASAM).*

Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted through Provider Services by calling WellCare's main toll-free phone number at ***1-877-389-9457*** *and asking for a Peer Review with the Medical Director. A care manager may also coordinate communication between the Medical Director and requesting practitioner.*

Utilization Management Process

WellCare affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. WellCare does not reward practitioners or other individuals for issuing denials of service or care. Financial incentives for UM decision makers does not encourage decisions that result in underutilization.

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

- *Notifications;*
- *Referrals;*
- *Prior Authorizations;*
- *Concurrent review; and/or*
- *Retrospective review.*

Decision and notification time frames are determined by National Committee for Quality Assurance (NCQA®) requirements, contractual requirements or a combination of both.

WellCare forms for the submission of notifications and authorization requests can be found at ***wellcareky.com/providers****.*

After-Hours Utilization Management

WellCare provides authorization of inpatient admissions 24 hours a day, seven days a week. Providers requesting after-hours authorization for inpatient admission should refer to the Quick Reference Guide at ***wellcareky.com/providers*** *to contact an after-hours clinician. Discharge planning needs that may occur after normal business hours will be handled by WellCare's after-hours clinicians.*

Notification

Notifications are communications to WellCare with information related to a service rendered to an Enrollee or an Enrollee's admission to a facility. Notification is required for:

- *Prenatal Services – Notification of prenatal services enables WellCare to identify pregnant Enrollees for inclusion into the Prenatal Program and/or WellCare's High-Risk Pregnancy Program. Obstetrical Providers are required to notify WellCare of pregnancies via fax using the Prenatal Notification Form within 30 days of the initial visit. This process will also expedite care management and claims reimbursement; and*
- *Inpatient Admission – Notification of an Enrollee's Inpatient admission to a hospital is required within one business day to allow WellCare to log the hospital admission and follow-up with the facility on the following business day to receive clinical information.*

The notification should be received by provider portal, fax, or telephone and include Enrollee demographics, facility name and admitting diagnosis. Notification is necessary for WellCare to obtain clinical information to perform case management and ensure coordination of services. Failure to notify WellCare of an Inpatient admission within one business day may result in an authorization request denial and/or claim denial.

Referrals

A referral is a request by a PCP for an Enrollee to be evaluated and/or treated by a specialty Provider. WellCare does not require authorization as a condition of payment for specialist consultations provided by WellCare-contracted Providers. WellCare does not need to be notified when Enrollees are referred to in-network Providers, including specialists. Please see the Prior Authorization section below if the Enrollee is being referred to an out-of-network provider. Certain diagnostic tests and procedures considered by WellCare to be routinely part of an office visit may be conducted as part of the initial visit without an authorization. A searchable Authorization Lookup Tool is available at wellcareky.com/providers/medicaid/authorizations.

WellCare does not require Providers to perform any treatment or procedure that is contrary to the Provider's conscience, religious beliefs or ethical principles in accordance with 42 CFR 438.102. If a Provider declines to perform a service because of ethical reasons, the Enrollee should be referred to another Provider licensed, certified or accredited to provide care for the individual service, or be assigned to another PCP licensed, certified or accredited to provide care appropriate to the Enrollee's medical condition. WellCare does not prohibit or restrict a Provider from advising an Enrollee about their health status, medical care or treatment, regardless of whether benefits for such care are Covered Services, if the Provider is acting within the lawful scope of practice.

Prior Authorization

Prior Authorization is the process of obtaining approval in advance of rendering a service. Prior Authorization may or may not require a medical record review. An authorization is granted for Covered Services and is provided only after WellCare agrees the treatment is Medically Necessary and a covered benefit. Prior Authorization allows for efficient use of covered healthcare services and ensures that Enrollees receive the most appropriate level of care at the most appropriate setting. Prior Authorization may be obtained by the Enrollee's PCP, treating specialist or facility. The attending physician or designee is responsible for obtaining the Prior Authorization of the elective or non-emergent admission. Prior Authorization is not a guarantee of payment, payment level or Enrollee eligibility.

Reasons for requiring Prior Authorization may include:

- *Review for Medical Necessity;*
- *Appropriateness of rendering Provider;*
- *Appropriateness of setting; and/or*
- *Care and disease management considerations.*

Prior Authorization is ***required*** *for elective or non-emergency services as designated by WellCare. Guidelines for Prior Authorization requirements by service type may be found on the Quick Reference Guide at* ***wellcareky.com/providers****. Providers can also use the searchable Authorization Lookup Tool within the secure provider site at* ***provider.wellcare.com/Provider.***

Some Prior Authorization guidelines to note are:

- *The Prior Authorization request should include the diagnosis to be treated and the Physician's Current Procedural Terminology, (CPT) code describing the anticipated procedure. If the procedure performed and billed is different from that on the request, but within the same family of services, a revised authorization is not required.*
- *An authorization may be given for a series of visits or services related to an episode of care. The authorization request should outline the plan of care including the frequency, total number of visits requested and the expected duration of care.*

Authorization Request Forms

WellCare requests that Providers use WellCare's standardized authorization request forms to ensure receipt of all pertinent information and enable a timely response to Provider requests, including:

- *Inpatient Authorization Request Form is used to request authorization for services such as planned elective/non-urgent inpatient, inpatient skilled nursing facility and rehabilitation admissions.*
- *Outpatient Authorization Request Form is used to request authorization for services such as select outpatient hospital procedures, out-of-network services and transition of care services.*
- *DME Services Authorization Request Form is used to request authorization for items such as motorized wheelchairs, insulin pumps and Dynasplint® Systems.*
- *Skilled Therapy Services Authorization Request Form is used to request authorization for physical therapy (PT), occupational therapy (OT) and speech therapy (ST) services.*
- *Home Health Authorization Request Form is used to request authorization for services such as skilled nursing, home health aide and skilled therapy visits that are rendered in a home setting.*

Providers may also submit authorization requests by using the Department for Medicaid Services' universal Prior Authorization form available on WellCare's website.

To ensure timely and appropriate authorization decisions, all forms must:

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

*Incomplete information will result in calls and/or faxes to the ordering Provider for the missing information and could result in a delay of receipt of services to the Enrollee. All forms are at **wellcareky.com/providers/medicaid/forms**. All forms should be submitted via fax to the number listed on the form.*

Procedures for Obtaining Prior Authorization for All Medical Services Except Dental Services and 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; for example, assistant physician and 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. Please refer to consult the authorization look-up tool within

the provider portal and obtain appropriate Prior Authorization. Failure to obtain Prior Authorization where required may result in denial of the claim.

Once a procedure is approved, the approval is valid for 60 days from the date of issuance.

For an authorization of a service, WellCare shall make a decision:
(a) As expeditiously as the Enrollee's health condition requires; and
(b) Within two business days following receipt of a request for service.

In cases when Prior Authorization has been obtained for an outpatient procedure, and during the procedure it is determined that the Enrollee requires an additional or different procedure, the 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 seven calendar days 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 Enrollee 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 a clinical update will be considered timely if received within one business day of the notice of the admission.

Hospital requests for updates of 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 an Enrollee 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
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. Failure to do so will result in denial of payment.

For Prior Authorization of dental services requiring hospitalization, contact WellCare's UM Department at the telephone number listed on the Quick Reference Guide at ***wellcareky.com/providers***.

Procedures for Obtaining Prior Authorization for Transplants
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 corneal transplants as well as Medically Necessary heart, lung and heart/lung transplants for Enrollees. These records must include current medical history, pertinent laboratory findings, X-ray and scan reports, social history and test results that include serology and other relevant information.

Transplant procedures and related services must be approved by WellCare before the transplant, regardless of the age of the Enrollee. Once a transplant procedure is approved, a Prior Authorization number will be assigned. The Enrollee 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 WellCare's UM Department at the telephone number listed on the Quick Reference Guide at ***wellcareky.com/providers****.*

Review and 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.*

Notification of an Enrollee's admission to a hospital allows WellCare the ability to log the hospital admission and follow up with the facility on the following business day to receive clinical information. The notification should be received by provider portal, fax, or telephone and include Enrollee demographics, facility name and admitting diagnosis. Notification of an acute inpatient admission is required within one business day. Submission of clinical information regarding the admission is required within one business day of admission.

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 up to 72 hours of outpatient observation services.

If the patient is not stable after 72 hours, acute care criteria will be applied.

When an Enrollee 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. Observation is a covered revenue code on an inpatient claim.

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 may 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 a covered benefit, 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 Enrollee'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.

Observation services alone do not require authorization. However, if a procedure is performed during an observation stay that requires an authorization from WellCare, the facility or Provider must seek authorization approval for that procedure.

Concurrent Review

The facility is required to notify WellCare within one business day of the Enrollee being admitted if clinical information is not accompanying the notification, the Inpatient Concurrent Review Nurse will request clinical documentation to support the admission. The determination of the inpatient request is completed within a maximum of 24 hours of obtaining all necessary information.

Concurrent review activities involve the evaluation of a continued hospital, long-term acute care (LTAC) hospital, skilled nursing facility or acute rehabilitation stay for medical appropriateness utilizing the appropriate Medical Necessity criteria.

The Inpatient Concurrent Review Nurse follows the clinical status of the Enrollee through telephonic chart review and communication with the attending physician, hospital utilization manager, care management staff or hospital clinical staff involved in the Enrollee's care.

Concurrent review is initiated as soon as WellCare is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the Enrollee, complexity, treatment plan and discharge planning activity. The continued length of stay will be reviewed to:

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

The concurrent review process incorporates the use of InterQua®criteria, ASAM criteria, or WellCare Clinical Coverage Guidelines to assess quality and appropriate level of care for continued medical treatment. Reviews are performed by licensed clinicians under the direction of the WellCare Medical Director.

To ensure the review is completed timely, Providers must submit clinical information on the next business day after the admission, as well as upon request of the WellCare review clinician. Failure to submit necessary documentation for concurrent review may result in nonpayment.

There is no limit on the number of days Medicaid allows for Medically Necessary inpatient hospital care. If an Enrollee is readmitted to the hospital for the same or related problem within 14 days of discharge for the same diagnosis, 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 prepayment or post payment review. Failure to show appropriate medical justification may be cause for denial, reduction or recoupment of reimbursement.

*If a hospital determines that an outpatient hospital setting would have met the medical needs of an Enrollee after the services were provided in an inpatient setting, the services may be billed to WellCare as outpatient if the claim is received within **365** days of the ending date of the service month. If the claim is received more than **365** days after the ending date, the services are not covered.*

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

Discharge Planning

Discharge planning begins upon admission and is designed for early identification of medical and/or psychosocial issues that will need post-hospital intervention. The Inpatient Care Manager/Concurrent Review Nurse works with the attending physician, hospital discharge planner, ancillary Providers and/or community resources to coordinate care and post-discharge services to facilitate a smooth transfer of the Enrollee to the appropriate level of care. An Inpatient Care Manager/Concurrent Review Nurse may refer an inpatient Enrollee with identified complex discharge needs to Care Management for post-discharge follow-up. It is requested as a best practice for providers to submit discharge clinical documentation within 24- 48 hours of acute hospitalization for both physical and behavioral health conditions to improve transition of care and coordination of the appropriate follow up.

Retrospective Review

A retrospective review is any review of care or services that have already been provided. There are two types of retrospective reviews that WellCare may perform:

- *Retrospective review initiated by WellCare:*
    - *WellCare requires periodic documentation including, but not limited to, the medical record, UB and/or itemized bill to complete an audit of the Provider-submitted coding, treatment, clinical outcome and diagnosis relative to a submitted claim. On request, medical records should be submitted to WellCare to support accurate coding and claims submission.*
- *Post Payment Review and Technical Denials*
    - *WellCare (or its designee) conducts post-payment reviews of Provider's records related to services rendered to WellCare Enrollees. During such reviews, the Provider should allow WellCare access to or provide the medical record and billing documents requested that support the charges billed.*
    - *For post-payment reviews, medical records and/or related documentation will be reviewed as per the specific reason the records were requested. Upon completion of the medical record review, either the payment will stand or WellCare will issue a Recovery letter. The timeline for the requests of records is as follows:*
        - *Initial request: A letter will be mailed to the Provider asking that records be provided within 30 days from the date of the letter.*
        - *Second reminder: If the requested records are not received within 30 days of the initial letter, a second letter may be mailed or outbound calls may be made to the Provider, allowing the Provider an additional 30 days to respond. If the records are not received by the 60th day after the initial request, WellCare will issue a technical denial with a request for repayment, and the recoupment process will begin directly following*

the 60-day period for the amount stated in the letter, or per state Medicaid rules as applicable.

- *If the requested documentation is received after a technical denial has been issued, but within the dispute period outlined as per applicable contractual, State or Federal guidelines, the records will be reviewed. If the records submitted support payment of the original claim, the review will be closed. If the records submitted do not justify payment, a findings letter with a request for payment, with appeal rights, if applicable, will be issued to the Provider.*

The Enrollee or Provider may request a copy of the criteria used for a specific determination of Medical Necessity by contacting the Health Services' Utilization Management Department. Refer to the Quick Reference Guide at ***wellcareky.com/providers****.*

Standard and Expedited Service Authorization Decisions

Type of Authorization	***Initial Decision Time Frame***
Standard Pre-Service	*5 business days*
Expedited Pre-Service	*24 hours*
Retrospective or Post-Service	*5 calendar days after the receipt of all necessary information*

Standard Service Authorization

WellCare is committed to processing Prior Authorization requests. WellCare will fax an authorization response to the Provider fax number(s) included on the authorization request form.

Expedited Service Authorization

In the event the Provider indicates, or WellCare determines, that following the standard time frame could seriously jeopardize the Enrollee's life or health, WellCare will make an expedited authorization determination and provide notice within 24 hours of the request.

Requests for expedited authorization decisions should be submitted by telephone, not fax, or WellCare's website. *Please refer to the Quick Reference Guide at* ***wellcareky.com/providers*** *for contact information.*

Enrollees and Providers may submit an oral request for an expedited 24-hour decision.

Please note that all requests with primary substance use diagnosis are processed as expedited.

WellCare Adverse Benefit Determinations

An Adverse Benefit Determination is a denial or limited authorization of a requested service, including a determination based on the type or level of service, requirements for Medical Necessity, appropriateness, setting or effectiveness of a covered benefit. In the event of an Adverse Benefit Determination, WellCare will notify the Enrollee in writing of the Adverse Benefit Determination. The notice will contain the following:

- *The Adverse Benefit Determination that WellCare has made or intends to take;*

- *The reasons for the Adverse Benefit Determination;*
- *The right to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Enrollee's Adverse Benefit Determination, including Medical Necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits*
- *The Enrollee's right to appeal including information on exhausting the Contractor's one level of appeal as required by 42 CFR 438.402(b);*
- *The Enrollee's right to request a State Fair Hearing after receiving notice that the Adverse Benefit Determination is upheld;*
- *Procedures for exercising Enrollee's rights to appeal or file a grievance;*
- *Circumstances under which the appeal process can be expedited and how to request it;*
- *The Enrollee's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued and the circumstances under which the Enrollee may be required to pay the costs of these services;*
- *Be available in the state-established prevalent non-English languages in its service area;*
- *Be available in alternative formats for persons with special needs; and*
- *Be easily understood in language and format.*

Peer-to-Peer Discussion

If Medical Necessity is not established for a requested service, a Peer-to-Peer discussion is offered to the treating physician and/or requesting Provider. The Peer-to-Peer review may be conducted prior to rendering a Medical Necessity decision, or if an Adverse Benefit Determination following a Medical Necessity review, Peer-to-Peer Discussion is offered to the treating physician on the Adverse Benefit Determination communication. If the Health Plan is unable to reach the provider to offer a Peer-to-Peer discussion, an adverse benefit determination is issues. Peer-to-Peer review is offered to the treating physician on record. The Adverse Benefit Determination notification contains instructions on how to use the Peer-to-Peer discussion process, including a toll-free number to the Medical Director Hotline to request a discussion with a WellCare Medical Director. Peer-to-Peer Discussion is available within seven business days following the receipt of the written Adverse Benefit Determination notification by the Provider.

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

Services Requiring No Authorization

WellCare has determined that many routine procedures and diagnostic tests are allowable without medical review to facilitate timely and effective treatment of Enrollees including:

- *Certain diagnostic tests and procedures are considered by WellCare to routinely be part of an office visit.*
- *Clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories and Provider offices under a Clinical Laboratory Improvement Amendment (CLIA) waiver do not require Prior Authorization. There are exceptions to this rule for specialty laboratory tests which require authorization regardless of place of service:*
    - *Reproductive laboratory tests;*
    - *Molecular laboratory tests; and*
    - *Cytogenetic laboratory tests.*

- *Certain tests described as CLIA-waived may be conducted in the Provider's office if the Provider is authorized through the appropriate CLIA certificate. A copy of the certificate must be submitted to WellCare.*

The CLIA regulations require a facility to be appropriately certified for each test performed. WellCare will deny reimbursement for any laboratory tests billed by a Provider or laboratory that does not have the appropriate CLIA certificate or waiver.

All services performed without Prior Authorization are subject to retrospective review by WellCare.

Second Medical Opinion

A second medical opinion may be requested in any situation where there is a question related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. A second opinion may be requested by any Enrollee of the healthcare team, including an Enrollee, parent(s) and/or guardian(s), or a social worker exercising a custodial responsibility.

The second opinion must be provided at no cost to the Enrollee by a qualified healthcare professional within network, or a non-participating provider if there is not a participating Provider with the expertise required for the condition.

Emergency/Urgent Care and Post-Stabilization Services

Emergency services are not subject to Prior Authorization requirements and are available to WellCare Enrollees 24 hours a day, seven days a week. An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms.

An Emergency Medical Condition is:

A. *A medical 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 that the absence of immediate medical attention to result in:*
   - *Placing the 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; or*
     - *Serious dysfunction of any bodily organ or part; or*

B. *With respect to a pregnant woman having contractions:*
     - *That there is insufficient time to effect a safe transfer to another hospital before delivery; or*
     - *That the 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. WellCare will pay for all emergency services that are Medically Necessary until the Enrollee is stabilized. WellCare will also pay for any medical screening examination conducted to determine whether an emergency medical condition exists. The attending emergency room Provider, or the Provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge.

WellCare will consider the following criteria when reviewing claims for emergency healthcare services:

- *The age of the patient;*
- *The time and day of the week the patient presented for services;*
- *The severity and nature of the presenting symptoms;*
- *The patient's initial and final diagnosis; and*
- *Any other criteria prescribed by the Department, including criteria specific to patients younger than 18 years of age.*

WellCare reserves the right to review medical records for claims for emergency services to validate the prudent layperson standard was met in accordance to KRS 304.17A-708. There is no single determining factor for determining the prudent layperson standard, but rather the evaluation of service shall be based on a variety of factors including, but not limited to, the list above.

Services that are determined to be non-emergent under the prudent layperson standard are not Covered Services in accordance with the Medicaid Managed Care Contract. Claims for emergency room visits that cannot be documented as true medical emergencies or potential medical emergencies may be retrospectively reviewed.

Upon request, Providers must submit medical documentation for all retrospective emergency room review requests. Each claim submitted for review should contain the complete medical record that provides full insight on the Enrollee's visit to the emergency room. All documentation will be reviewed and a letter of determination (indicating if the initial decision was upheld or overturned) will be sent for the claim.

In the event a claim payment decision is overturned based upon the review of the medical documentation, Providers are afforded the opportunity to appeal the decision through the formal appeal process. Providers may submit the claim for review under the formal appeals process. Providers have 60 days from the date of the decision to appeal.

Appeals for emergency room visits should be sent to WellCare's external reviewer as directed in Provider notification/EOP.

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's, hospitals or fiscal agent's failure to notify the Enrollee's PCP, or WellCare representative, of the Enrollee's screening and treatment within said time frames.

Once the Enrollee's condition is stabilized, unplanned urgent admissions must be followed by notification to WellCare by calling the Provider Hotline and reporting the urgent or emergent admission within 24 hours of the admission. The caller should provide the following:

- *Enrollee's name*
- *WellCare Enrollee ID number*
- *Name of admitting hospital*
- *Referring Provider*
- *Diagnosis of Enrollee*

Additional clinical information must be submitted to WellCare by the next business day for use in making a final authorization determination. If available, clinical information may be provided at the time of notification.

1. *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 Enrollee that they will not be accepted as a WellCare Enrollee, and, in the event the Enrollee elects to receive services, the Enrollee will be responsible for all charges incurred. If an Enrollee is not accepted for treatment as a WellCare Enrollee, hospitals should offer the following alternatives to the Enrollee:*
    - *Refer the Enrollee to a specific alternate healthcare setting where they can obtain care the same day or next day; and*
2. *Instruct the Enrollee 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 Enrollee in true medical emergencies. However, more than one non-emergency visit by the same Enrollee, to the same hospital, in one day is subject to review for Medical Necessity and possible denial.

Urgent care is care for a condition not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment. Urgent care services should be provided within 48 hours.

Post-stabilization services are services related to an emergency medical condition that are provided after an Enrollee is stabilized in order to maintain the stabilized condition or improve or resolve the Enrollee's condition. Post-stabilization services are covered without Prior Authorization up to the point WellCare is notified that the Enrollee's condition has stabilized.

Continuity of Care

WellCare will allow Enrollees in active treatment to continue care with a terminated treating Provider, when such care is Medically Necessary, through completion of treatment of a condition for which the Enrollee was receiving care at the time of the termination, until the Enrollee selects another treating Provider. None of the above may exceed six months after the termination of the Provider's contract.

WellCare will allow pregnant Enrollees who have initiated a course of prenatal care, if the covered person is beyond the twenty-fourth week of pregnancy, the plan's obligation to pay for services extends through the delivery of the child, immediate postpartum care, and examination within the first six weeks following delivery.

For continued care under this provision, WellCare and the terminated Provider shall continue to abide by the same terms and conditions as existed in the terminated contract.

Transition of Care

Authorization is not required for certain Enrollees with previously approved services by another managed care plan. Retroactive Medicaid coverage is defined as a period of time up to three months before the application month. WellCare shall cover all Medically Necessary services provided the Enrollee during the retroactive coverage without a Prior Authorization. WellCare shall allow a Provider to submit a claim outside of the timely filing period when the Provider is notified after the end of WellCare's timely filing period of a retroactive change in MCO by receipt

of a recoupment letter, and WellCare shall not deny the claim based on timely filing. WellCare will allow a Provider to submit a claim outside of the timely filing period when the Provider is notified after the end of the Contractor's timely filing period of a retroactive change in MCO by receipt of a recoupment letter, and the Contractor shall not deny the claim based on timely filing.

WellCare will continue to be responsible for the costs of continuation of such Medically Necessary Covered Services, without any form of prior approval and without regard to whether such services are being provided within or outside WellCare's network until such time as WellCare can reasonably transfer the Enrollee to a service and/or network Provider without impeding service delivery that might be harmful to the Enrollee's health. However, notification to WellCare is necessary to properly document these services and determine any necessary follow-up care.

When relinquishing Enrollees, WellCare will cooperate with the receiving health plan regarding the course of ongoing care with a specialist or other Provider.

When WellCare becomes aware that a covered Enrollee will be disenrolled from WellCare and will transition to a Medicaid fee-for-service program or another managed care plan, a WellCare Review Nurse/Care Manager who is familiar with that Enrollee will provide a Transition of Care report to the receiving plan or appropriate contact person for the designated fee-for-service program.

If a Provider receives an adverse claim determination which they believe was a transition of care issue, the Provider should fax the adverse claim determination to the Appeals Department with documentation of approval for reconsideration. For contact information, please refer to the Quick Reference Guide at ***wellcareky.com/providers****.*

WellCare will participate in transition planning and continued Care Coordination for Enrollees with SMI who are transitioning from licensed Personal Care Homes, psychiatric hospitals, or other institutional settings to integrated, community based housing.

WellCare will perform a comprehensive physical and behavioral health assessment designed to support the successful transition to community based housing within 14 days of transition. To perform such assessment, WellCare will review the Enrollee's Person-Centered Recovery Plan and level of care determination developed by the provider agency in tandem with WellCare's routine UM procedures and will provide services that are recommended in the Person-Centered Recovery Plan and that meet Medical Necessity criteria.

Non-Covered Services

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

- *Any laboratory service performed by a Provider without current certification in accordance with the CLIA. This requirement applies to all facilities and individual Providers of any laboratory service*
- *Cosmetic procedures or services performed solely to improve appearance*
- *Hysterectomy procedures, if performed for hygienic reasons or for sterilization only*
- *Medical or surgical treatment of infertility (for example, the reversal of sterilization, in vitro fertilization, etc.)*

- *Induced abortion and miscarriage performed out of compliance with federal and Kentucky laws and judicial opinions*
- *Paternity testing*
- *Personal service or comfort items*
- *Postmortem services*
- *Services that are investigational, mainly for research purposes, or experimental in nature. This includes, but is not limited to, drugs*
- *Gender reassignment services*
- *Sterilization of a mentally incompetent or institutionalized Enrollee*
- *Services provided in countries other than the United States, unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services*
- *Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Kentucky Medicaid Program regulations referenced herein*
- *Services for which the Enrollee has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage*

Limits to Abortion, Sterilization and Hysterectomy Coverage

For any Medicaid service provided by WellCare that requires the completion of a specific form (for example, hospice, sterilization, hysterectomy, or abortion), the form shall be completed according to the appropriate Kentucky Administrative Regulation (KAR).

Abortion

Abortions are covered for eligible WellCare Enrollees 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. Elective abortions are not covered if used for family planning purposes.

An Abortion/Miscarriage Certification Form (MAP 235) must be properly executed and submitted to WellCare with the Provider's claim. This form may be filled out and signed by the Provider and can be found at www.kymmis.com.

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 ICD-10 codes to ensure that abortions are not being billed using other procedure codes. A link to ICD-10 procedure codes can be found in the Compliance Section of this Manual.

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 she or he signs the consent;*
- *Is not mentally competent; or*
- *Is institutionalized in a correctional facility, mental hospital or other rehabilitation facility.*

A copy of the required Sterilization Consent Form can be obtained through Health and Human Services website at chfs.ky.gov/agencies/dms/MAPForms/consentforsterilization.

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 Enrollee's signature.

In the case of premature delivery or emergency abdominal surgery performed within 30 calendar days of signed consent, the Provider 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 Enrollee 30 calendar days before 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 Enrollee must sign the consent form at least 30 calendar days, but not more than 180 calendar days, prior to the sterilization. The Provider must sign the consent form after the sterilization has been performed.

A link to ICD-10-CM procedure codes associated with sterilization can be found in the Compliance Section of this Manual. 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.

Hysterectomy

Prior Authorization is required for the administration of a hysterectomy to validate Medical Necessity. WellCare reimburses Providers for hysterectomy procedures only when the following requirements are met:

- *The Provider ensured that the individual was informed, orally 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 Enrollee and the attending physician must sign and date the Hysterectomy Consent Form (MAP 251);*
- *In the case of prior sterility or emergency hysterectomy, an Enrollee is not required to sign the consent form; and*
- *The Provider submits the properly executed Hysterectomy Consent Form (MAP 251) with the claim prior to submission to WellCare.*

*Forms are at **wellcareky.com/providers/medicaid/forms**.*

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 that have 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. The consent form does not need to be submitted with the request for authorization but does need to be submitted with the claim.

A link to ICD-10-CM procedure codes associated with hysterectomies can be found in the Compliance Section of this Manual. 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.

Delegated Entities

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

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

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

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

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

Population Health Management Program

WellCare offers comprehensive integrated Population Health Management program where both Care Management and Disease Management are embedded in the program. The PHM program provides Enrollees with select health conditions and/or their caregivers, with education, guidance, support, and health coaching. Through the PHM program Enrollees are encouraged to make behavioral changes, improve health outcomes and quality of life, as well as reduce disease progression. Care Managers facilitate patient assessment, planning and advocacy in order to improve health outcomes for patients. WellCare trusts Providers will help coordinate the placement and cost-effective treatment of patients who are eligible for WellCare Population Health Programs.

The WellCare PHM program includes:

- *Health Promotion and Wellness to Enrollees*
- *Care Coordination for management of Chronic Conditions*
- *Complex Care Management*

The priority conditions include:

1. *Asthma;*
2. *Heart disease;*
3. *Diabetes;*
4. *Obesity;*
5. *Tobacco use;*
6. *Cancer;*
7. *Infant mortality;*
8. *Low birth weight*
9. *Behavioral health and substance use disorder; and*
10. *Others as determined by the Contractor and/or the Department.*

The priority populations include:

1. *Adults and Children with Special Health Care Needs*
2. *Maternal Health (pre and postpartum), including high-risk pregnant women*
3. *Other populations as determined by the Contractor and/or the Department*

Additional priorities of the PHM program include:

- *Providing assertive engagement to underserved and disenfranchised communities, including Black, Indigenous, and People of Color (BIPOC), and sexual orientation and gender identification (SOGI).*
- *Disaggregation of data in order to identify existing disparities, including any racial/ethnic/social inequities*
- *Selection and engagement in at least two (2) data-driven activities to reduce racial/ethnic/social disparities; and*
- *Monitoring of equitable access to and utilization of services within communities of color, individuals who are currently unhoused, and others who are at an increased risk due to related health disparities.*

Care Management

WellCare's multidisciplinary Care Management teams are comprised of Care Managers who are specially trained clinicians who perform a comprehensive assessment of the Enrollee's clinical status, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate outcomes for possible revisions of the care plan. The Care Managers work collaboratively with PCPs and specialists to coordinate care for the Enrollee and expedite access to care and needed services.

WellCare's Care Management teams also serve in a supportive capacity to the PCP and assist in actively linking the Enrollee to Providers, medical and behavioral services, and residential, social and other support services, as needed. A Provider may request Care Management services for any WellCare Enrollee.

The PHM process begins with Enrollee identification and follows the Enrollee until discharge from the program. Enrollees may be identified for Care Management by:

- *Referral from an Enrollee's Primary Care Provider or other specialist;*
- *Self-referral;*
- *Referral from a family Enrollee;*
- *Referral after a hospital discharge;*

- *After completing a Health Risk Assessment (HRA); and*
- *Data mining for high-risk Enrollees.*

WellCare care management is a comprehensive and Enrollee-centric program, dedicated to providing coordination and support services for acute and preventive care; it may or may not lower the cost of care. Care management is a multi-disciplinary program designed to respond to the needs of WellCare Enrollees across the continuum of care.

Program components include providing coordination through episodic care management, including management across transitions that include timely follow-up post hospitalization, emergency department (ED) visits and stays in other institutional settings, symptom and disease management, medication reconciliation and management, and support for exacerbations of chronic illness.

WellCare's philosophy is that the Care Management Program is an integral management process to provide a continuum of care for WellCare Enrollees. Key elements of the Care Management process include:

- ***Clinical Assessment and Evaluation** – A comprehensive assessment of the Enrollee is completed to determine where they are in the health continuum. This assessment gauges the Enrollee's support systems and resources and seeks to align the Enrollee with appropriate clinical needs.*
- ***Care Planning** – Collaboration with the Enrollee and/or caregiver, the PCP and other Providers involved in the Enrollee's care to identify the best way to fill any identified gaps or barriers to improve access and adherence to the Provider's plan of care.*
- ***Service Facilitation and Coordination** – Working with community resources to facilitate Enrollee adherence with the plan of care. Activities may be as simple as reviewing the plan with the Enrollee and/or caregiver or as complex as arranging services, transportation and follow-up. Behavioral Health services are coordinated with the regional Community Mental Health Center (CMHC).*
- ***Enrollee Advocacy** – advocating on behalf of the Enrollee within the complex labyrinth of the healthcare system. Care Managers assist Enrollees with seeking services to optimize their health. Care Management emphasizes continuity of care for Enrollees through the coordination of care among physicians, CMHCs and other Providers.*
- ***Education***
- ***Medication reconciliation**; and*
- ***Referrals to community-based services***

WellCare uses enrollee data to stratify and prioritize for care management outreach. Based on the stratification Enrollees are identified as having low, moderate or high risk. The automated case management assignment process takes into account the risk level and scoring model that was used to assess the Enrollees score.

Enrollees commonly identified for WellCare's Care Management Program include those with:

- ***Catastrophic Injuries** – Traumatic injuries, e.g., amputations, blunt trauma, spinal cord injuries, head injuries, burns and multiple traumas.*
- ***Multiple Chronic Conditions** – Multiple comorbidities such as diabetes, chronic obstructive pulmonary disease (COPD) and hypertension, or multiple intricate barriers to quality healthcare, for example, Acquired Immune Deficiency Syndrome (AIDS).*

- ***Complex Discharge Needs*** *– Enrollees discharged home from acute inpatient or skilled nursing facilities (SNF) with multiple service and coordination needs (i.e., DME, PT/OT, home health); complicated, non-healing wounds, advanced illness, etc.*
- ***Special Healthcare Needs*** *– Children or adults who have serious medical or chronic conditions with severe chronic illnesses, physical, mental and developmental disabilities.*

An Enrollee may be discharged from the Care Management Program if they:

- *Are meeting primary care plan goals*
- *Declined additional care management services*
- *Are disenrolled (eligibility terminates) from WellCare*
- *Are unable to be contacted by WellCare*

Individuals with Special Healthcare Needs

ISHCN are persons who have or are at high risk for a chronic physical, developmental, behavioral, neurological or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISCHN may have an increased need for healthcare or related services due to their conditions. Individuals with these conditions include:

- *Children in/or receiving foster care or adoption assistance;*
- *Blind/disabled children younger than age 19 and related populations eligible for SSI;*
- *Adults over the age of 65;*
- *Homelessness (upon identification);*
- *Individuals with chronic physical health illnesses;*
- *Individuals with chronic behavioral health illnesses; and*
- *Children receiving EPSDT Special Services.*

For more information, please refer to Section 2: Provider and Enrollee Administrative Guidelines.

Disease Management Program

Disease Management (DM) and Behavioral Healthcare Management are embedded in the Care Management Program. The DM part of the program provides Enrollees with select health conditions and/or their caregivers with education, guidance, support and health coaching. Enrollees are encouraged to make behavioral changes, to improve health outcomes, quality of life, as well as reduce disease progression. The goals and objectives of the behavioral health activities are congruent with the health model and incorporated into the overall care management model program description. Case review conferences with care managers and medical directors from both behavioral health and physical health occur on an as needed basis.

The Disease Management Program targets the following conditions:

- *Asthma – adult and pediatric*
- *Coronary artery disease (CAD)*
- *Congestive heart failure (CHF)*
- *COPD*
- *Diabetes – adult and pediatric*
- *Hypertension*
- *Depression*

- *Smoking Cessation*
- *Cancer*
- *Substance Abuse*
- *Mental Health*
- *Alzheimer and Dementia*

WellCare's Disease Management Program educates Enrollees and their caregivers regarding the standards of care for chronic conditions, triggers to avoid and appropriate medication management. The program also focuses on educating the Provider with regards to the standards of specific disease states and current treatment recommendations. Intervention and education can improve the quality of life of Enrollees, improve health outcomes and decrease medical costs. In addition, WellCare makes available to Providers and Enrollees general information regarding health conditions at ***wellcareky.com/providers****.*

Candidates for Disease Management

WellCare encourages referrals from Providers, Enrollees, hospital discharge planners and others in the healthcare community.

Interventions for Enrollees identified vary depending on their level of need and stratification level. Interventions are based on industry-recognized Clinical Practice Guidelines. Enrollees identified at the highest stratification levels receive a comprehensive assessment by a Disease Management nurse, disease-specific educational materials, identification of a care plan and goals and follow-up assessments to monitor adherence to the plan and attain goals.

Disease-specific Clinical Practice Guidelines adopted by WellCare may be found at ***wellcareky.com/providers/tools/clinical-guidelines****.*

Access to Care and Disease Management Programs

If a Provider would like to refer a WellCare Enrollee as a potential candidate to the Care Management Program or the Disease Management Program or would like more information about one of the programs, they may call the WellCare Care Management Referral Line or complete and fax the request to the number on the Quick Reference Guide. Enrollees may self-refer by calling the Care Management toll-free line or contacting the Nurse Advice Line after hours or on weekends (TTY available).

For more information on the Care Management Referral Line, refer to the Quick Reference Guide at ***wellcareky.com/providers****.*

Chronic Care Management Programs (CCMP)

As a part of WellCare's services, Chronic Care Management Programs (CCMP) are offered to participants. Chronic Care Management/Disease Management is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care.

Chronic care management supports the physician or practitioner/patient relationship and plan of care, emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

WellCare programs include but are not limited to asthma, diabetes and congestive heart failure. Our programs promote a coordinated, proactive, disease-specific approach to management that will improve participants' self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical conditions.
Not all participants having the targeted diagnoses will be enrolled in the CCMP. Participants with selected disease states will be stratified into risk groups that will determine need and level of intervention. High-risk participants with co-morbid or complex conditions will be referred for care management program evaluation.

To refer a participant for chronic care management:

- *Call KY Care Management Call Line at* ***1- 844-901-3780***

Section 5: Claims

Overview
The focus of WellCare's Claims Department is to process claims in a timely manner. WellCare has established toll-free telephone numbers for Providers to access a representative in WellCare's Provider Services Department. For more information, refer to the Quick Reference Guide at ***wellcareky.com/providers****.*

Updated Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Process

WellCare (in partnership with PaySpan) has implemented an enhanced online Provider registration process for electronic funds transfer (EFT) and electronic remittance advice (ERA) services.

Once registered, this no-cost secure service offers Providers a number of options for viewing and receiving remittance details, ERAs can be imported directly into practice management or patient accounting system, eliminating the need to rekey remittance data.

Multiple practices and accounts are supported. Providers can reuse enrollment information to connect with multiple payers. Different payers can be assigned to different bank accounts.

Providers will no longer receive paper Explanation of Payments (EOPs).
EOPs can be viewed and/or downloaded and printed from PaySpan's website, once registration is completed.

Providers can register using PaySpan's enhanced Provider registration process at ***payspanhealth.com****. How to Register with PaySpan webinars are offered. Providers can register for the date and time that works best for them by contacting PaySpan directly.*

PaySpan Health Support can be reached at ***Providersupport@payspanhealth.com****, at* ***1-877-331-7154*** *or at* ***payspanhealth.com****.*

Timely Claims Submission
Unless otherwise stated in the Provider Contract, Providers must submit claims (initialed, corrected and voided) within 12 months (or six months from the Medicaid or primary insurance payment date, whichever is later) from the date of service for outpatient services or the date of discharge for inpatient services. For more information, please refer to the Department's website at ***chfs.ky.gov/agencies/dms****. Unless prohibited by federal law or the Centers for Medicare & Medicaid Services (CMS), WellCare may deny payment for any claims that fail to meet WellCare's submission requirements for Clean Claims or that are received after the time limit in the Provider Contract for filing Clean Claims.*

The following items can be accepted as proof that a "Clean" Claim was submitted timely:

- *A clearinghouse electronic acknowledgement indicating the claim was electronically accepted by WellCare; and*
- *A Provider's electronic submission sheet with all the following identifiers: patient name, Provider name, date of service to match Explanation of Benefit (EOB)/claim(s) in question, prior submission bill dates and WellCare product name or line of business.*
- *In cases of retro-eligibility assignment, another MCO's recoupment letter.*

The following items are not acceptable as evidence of timely submission:

- *Strategic National Implementation Process (SNIP) Rejection Letter; and*
- *A copy of the Provider's billing screen.*

Tax Identification and National Provider Identifier Requirements

To avoid claim delays or rejections, Providers will need to submit claims that contain the following information in alignment with the KY State DMS Roster Registration data:

- *Billing NPI, Taxonomy, Billing Address (ZIP-5 or ZIP-9 which matches the roster)*
- *Rendering NPI, Taxonomy (if Rendering is different from Billing Provider)*
- *Atypical Providers are excluded but must be previously added on the WellCare atypical Provider list*
- *Attending, Ordering, Referring NPI*

Please compare the identification values on the claim to the information registered with KY DMS. If the State Roster is not accurate, please contact DMS to update the information before resubmission of claims. For any additional questions or concerns, please reach out to WellCare's EDI Ops team at ***EDI-Master@wellcare.com***.

You will receive a claim rejection error if:

- *A unique and effective Medicaid ID for the Billing Provider and/or Rendering Provider submitted on the claim cannot be found on the DMS State Roster*
- *An Ordering, Referring, Prescribing and Attending Provider (OPR) is not enrolled in Kentucky Medicaid*

Providers of Kentucky Medicaid patients must be registered with the state Medicaid Program using their National Provider Identifier ("NPI"), Taxonomy Code and Billing address with the Kentucky Department for Medicaid Services (KY DMS).

WellCare will reject claims without the Tax ID and NPI, with the exception of Atypical Providers, defined as Providers who do not provide medical services (ex: non-emergency transportation, case management or environmental modifications). Atypical Providers must preregister with DMS and WellCare before submitting claims to avoid NPI rejections. More information on NPI requirements, including HIPAA's NPI Final Rule Administrative Simplification, is available on the CMS website at ***www.cms.gov***.

Taxonomy

Providers are required to submit claims with the correct taxonomy code consistent with Provider specialty and services being rendered in order to appropriately adjudicate the claim. WellCare may reject the claim or pay it at the lower reimbursement rate if the taxonomy code is incorrect or omitted. For additional details on taxonomy as it relates to KY roster edits, see the above Tax Identification and National Provider Identifier Requirements section.

Preauthorization Number

If a preauthorization number was obtained, Providers must include this number in the appropriate data field on the claim.

National Drug Codes

WellCare follows CMS guidelines regarding National Drug Codes (NDC). Providers must submit NDCs as required by CMS.

Strategic National Implementation Process

All claims and encounter transactions submitted via paper, direct data entry (DDE) or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines. The SNIP validations used by WellCare to verify transaction integrity/syntax are available at ***wellcareky.com/providers****.*

If a claim is rejected for lack of compliance with WellCare's claim and encounter submission requirements, the rejected claim should be resubmitted within timely filing limits. For more information, see the Encounters Data Section below.

Claims Submission Requirements

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 ICD-10-CM or its successor mandated by CMS for all coding. In addition, the CPT-4 coding and/or Healthcare Common Procedure Coding System (HCPCS) is required for all outpatient surgical, obstetrical, injectable drugs, diagnostic laboratory and radiology procedures. When coding, the Provider 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 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.

Providers using electronic submission shall submit all claims to WellCare or its designee, as applicable, using the HIPAA-compliant 837 electronic format, or a CMS 1500 and/or UB-04, or their successors. Claims shall include the Provider's NPI, Tax ID and the valid taxonomy code that most accurately describes the services reported on the claim. The Provider acknowledges and agrees that no reimbursement is due for a Covered Service and/or no claim is complete for a Covered Service unless performance of that Covered Service is fully and accurately documented in the Enrollee's medical record prior to the initial submission of any claim. The Provider also acknowledges and agrees that at no time shall Enrollees be responsible for any payments to the Provider with the exception of Enrollee expenses and/or non-covered services. For more information on paper submission of claims, refer to the Quick Reference Guide at ***wellcareky.com/providers****.*

For more information on Covered Services under WellCare's Kentucky Medicaid plans, refer to ***wellcare.com/Kentucky****.*

Electronic Claims Submissions

WellCare accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to WellCare must be in the ANSI ASC X12N format, version 5010A, or its successor. For more information on EDI implementation with WellCare, refer to the Wellcare Companion Guides at ***wellcareky.com/providers****.*

Because most clearinghouses can exchange data with one another, Providers should work with their existing clearinghouse, or a WellCare contracted clearinghouse, to establish EDI with WellCare. For a list of WellCare contracted clearinghouses, refer to the WellCare Resource Guides, at ***wellcareky.com/providers***.

A unique WellCare Payer ID was included in the Provider welcome letter from WellCare. This WellCare Payer ID must be used to identify WellCare on electronic claims submissions. For more information on WellCare Payer IDs or to contact WellCare's EDI team, refer to the Quick Reference Guide at ***wellcareky.com/providers***.

275 Claim Attachment Transactions via EDI

Providers may submit unsolicited attachments ***(related to prejudicated claims****). In addition, the Plan may solicit claims attachments via 275 transactions through the clearinghouse to the billers that use the clearinghouse. At this time, electronic attachments (275 transactions) are not intended to be used for appeals, disputes or grievances.*

What are Acceptable Electronic Data Interchange Healthcare Claim Attachment 275 Transactions?
Electronic attachments (275 transactions) are supplemental documents providing additional patient medical information to the payer that cannot be accommodated within the ANSI ASC X12, 837 claim format. Common attachments are certificates of medical necessity (CMNs), discharge summaries, itemized bills and operative reports to support a healthcare claim adjudication. The 275 transaction is not intended to initiate Provider or Enrollee appeals, grievances or payment disputes.

For more information on EDI implementation with WellCare, refer to the WellCare Companion Guides on WellCare's website at ***wellcareky.com/providers***.

HIPAA Electronic Transactions and Code Sets
HIPAA Electronic Transactions and Code Sets is a federal mandate that requires healthcare payers such as WellCare, as well as Providers engaging in one or more of the identified transactions, to have the capability to send and receive all standard electronic transactions using the HIPAA-designated content and format.

Specific WellCare requirements for claims and encounter transactions, code sets and SNIP validation are described as follows: To promote consistency and efficiency for all claims and encounter submissions to WellCare, it is WellCare's policy that these requirements also apply to all paper and DDE transactions.

For more information regarding EDI implementation with WellCare, please refer to the WellCare Companion Guides at ***wellcareky.com/providers/medicaid/claims***.

Paper Claims Submissions
For timelier processing of claims, Providers are encouraged to submit electronically. Claims not submitted electronically may be subject to penalties if specified in the Provider Contract. For

assistance in creating an EDI process, contact WellCare's EDI team by referring to the Quick Reference Guide at ***wellcareky.com/providers/medicaid***.

If permitted under the Provider Contract and until the Provider has the ability to submit electronically, paper claims (UB-04 and CMS-1500, or their successors) must contain the required elements and formatting described below:

- *Paper claims must only be submitted on an original (red ink on white paper) claim form.*
- *Any missing, illegible, incomplete or invalid information in any field will cause the claim to be rejected or processed incorrectly.*
- *Per CMS guidelines, the following process should be used for Clean Claims submission:*
    - *The information must be aligned within the data fields and must be:*
        - *On an original red ink on white paper claim forms;*
        - *Typed. Do not print, handwrite or stamp any extraneous data on the form.*
        - *In black ink;*
        - *In a large, dark font such as PICA or ARIAL, and 11- or 12-point type; and*
        - *In capital letters.*
    - *The typed information must not have:*
        - *Broken characters;*
        - *Script, italics or stylized font;*
        - *Red ink;*
        - *Mini font; or*
        - *Dot matrix font.*

CMS Fact Sheet about UB-04
www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837I-FormCMS-1450-ICN006926.pdf

CMS Fact Sheet about CMS-1500
Error! Hyperlink reference not valid.*www.cms.gov/training-education/medicare-learning-network/compliance*

Claims Processing
Seventy-Two Hour Rule

WellCare will not reimburse outpatient services provided within the three calendar days prior to an inpatient admission (including but not limited to: outpatient services followed by admission before midnight of the following day, preadmission diagnostic services, and other preadmission services). WellCare will apply this policy regardless of the status of the outpatient Provider/facility, including (but not limited to) cases in which preadmission services were performed by outpatient Provider/facility that (i) is the same as the inpatient facility; (ii) is an affiliate of the inpatient Provider/facility; (iii) bills under the same tax identification number as the inpatient Provider/facility; (iv) is part of the same hospital system/facility as the inpatient Provider; or (v) is owned by the same corporate parent as the inpatient Provider/facility.

Disclosure of Coding Edits

WellCare utilizes clinical coding software to perform industry standard claim validity checks in accordance with all applicable rules and regulations which have been set forth by CMS (such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule Manuals),

the American Medical Association (AMA), the Kentucky Department for Medicaid Services and medical specialty societies.

WellCare uses claim editing software to assist in determining proper coding for Provider claim reimbursement. The review process may include sending batched claim files to an external vendor where the vendor compares the claim components (e.g., service codes, place of service) to the payment policies adopted by WellCare after which the vendor recommends that the incorrectly coded services receive the post payment adjustment or denial. The outbound Explanation of Payment (EOP) contains the description explaining the edit applied to the claim line. The claim editing software programs may result in either a post payment adjustment or a claim denial that states the reason for the denial or requests submission of medical records that relate to the claim for WellCare review. Providers may dispute or appeal any claim adjustment or denial by submitting a request for reconsideration as long as it follows the timely filing guidelines. Specific guidance as to where to submit claim disputes and appeals can be found in the ***Provider Quick Reference Guide****. A reduction in payment or a denial as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.*

Prompt Payment

Refer to the Provider Contract. In addition, WellCare will comply with the Prompt-Pay Statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and 99-123, as may be amended.

Coordination of Benefits (COB)

WellCare shall coordinate payment for Covered Services in accordance with the terms of an Enrollee's benefit plan, applicable state and federal laws and CMS guidance.

WellCare gathers COB information regarding our Enrollees from multiple sources. This ensures we pay claims appropriately and that Medicaid is the payor of last resort (42 C.F.R. 433.139). In accordance with our contract with the Department for Medicaid Services (Section 14.2), if WellCare is aware of other Third Party Resources, WellCare shall avoid payment by "cost avoiding" (denying) the claim and redirecting the provider to bill the other Third Party Resource as a primary payer. If WellCare does not become aware of another Third Party Resource until after the payment for service, WellCare will seek recovery from the Third Party Resource. Please note this does not occur in instances where the Enrollee has Medicare as primary.

Providers shall bill primary insurers for items and services they provide to an Enrollee before they submit claims for the same items or services to WellCare. Any balance due after receipt of payment from the primary payer should be submitted to WellCare for consideration and the claim must include information verifying the payment amount received from the primary plan. Coordination of Benefits (COB) information can be submitted to WellCare by an EDI transaction with the COB data completed in the appropriate COB elements. Only paper submitters need to send a copy of the EOB. Providers shall follow WellCare Policies and Procedures regarding subrogation activity.

If Medicaid does not have a price for codes included on a crossover claim because it is covered by Medicare but not Medicaid, the Medicare coinsurance and deductible will be paid.

Encounters Data

Overview

This section is intended to provide delegated vendors, Providers and independent physician associations (IPAs) with the necessary information to allow them to submit encounter data to WellCare. If encounter data does not meet the service level agreements for timeliness of submission, completeness or accuracy, the Department has the ability to impose significant financial sanctions on WellCare. WellCare requires all delegated vendors and delegated Providers to submit encounter data, even if they are reimbursed through a capitated arrangement.

Timely and Complete Encounters Submission

Unless otherwise stated in the Provider Contract, vendors and Providers should submit complete and accurate encounter files to WellCare as follows:

- *Encounters submission will be weekly;*
- *Capitated entities will submit within 10 calendar days of service date; and*
- *Non-capitated entities will submit within 10 calendar days of the paid date.*

The above apply to both corrected claims (error correction encounters) and cap-priced encounters.

Accurate Encounters Submission

All encounter transactions submitted via Direct Data Entry (DDE) or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines as per the state requirements. SNIP Levels 1 through 5 shall be maintained. Once WellCare receives a delegated vendor's or Provider's encounters, the encounters are loaded into WellCare's Encounters System and processed. The encounters are subjected to a series of SNIP editing to ensure that the encounter has all the required information and that the information is accurate.

For more information on Workgroup for Electronic Data Interchange (WEDI) SNIP Edits, refer to their Transaction Compliance and Certification white paper at ***www.wedi.org/knowledge-center/comment-letters-testimony/resources****.*

For more information regarding submitting encounters electronically, please refer to the WellCare Companion Guides at ***wellcareky.com/providers/medicaid/claims****.*

Vendors are required to comply with any additional encounter validations as defined by the Commonwealth and/or CMS.

Encounters Submission Methods

Delegated vendors and Providers may submit encounters electronically, through WellCare's contracted clearinghouse(s), via DDE or using WellCare's Secure File Transfer Protocol (SFTP) and process.

Submitting Encounters Using WellCare's SFTP Process (Preferred Method)

WellCare accepts electronic claims submission through EDI as its preferred method of claims submission. Encounters may be submitted using WellCare's SFTP process. Refer to WellCare's ANSI ASC X12 837I, 837P and, 837D Health Care Claim/Encounter Institutional, Professional and Dental Guides for detailed instructions on how to submit encounters electronically using SFTP.

For more information on EDI implementation with WellCare, refer to ***wellcareky.com/providers/medicaid/claims****.*

Because most clearinghouses can exchange data with one another, Providers should work with their existing clearinghouse, or a WellCare contracted clearinghouse, to establish EDI with WellCare. For a list of WellCare contracted clearinghouses, refer to the *WellCare Provider Resource Guide* *at* ***wellcareky.com/providers****.*

A unique WellCare Payer ID was included in the Provider welcome letter. This WellCare Payer ID must be used to identify WellCare on electronic claims submissions. For more information on the WellCare Payer IDs or to contact WellCare's EDI team, refer to the *Quick Reference Guide* *at* ***wellcareky.com/providers****.*

Submitting Encounters Using Direct Data Entry (DDE)

Delegated vendors and Providers may submit their encounter information directly to WellCare using WellCare's DDE portal. The DDE tool can be found on the Provider portal at ***wellcareky.com/providers****. For more information on free DDE options, refer to the* *Provider Resource Guide* *at* ***wellcareky.com/providers****.*

Encounters Data Types

There are four encounter types for which delegated vendors and Providers are required to submit encounter records to WellCare. Encounter records should be submitted using the HIPAA-standard transactions for the appropriate service type. The four encounter types are:

- *Dental – 837D format;*
- *Professional – 837P format;*
- *Institutional – 837I format; and*
- *Pharmacy – NCPDP format.*

This document is intended to be used in conjunction with WellCare's ANSI ASC X12 837I, 837P and 837D Health Care Claim/Encounter Institutional, Professional and Dental Guides.

Encounters submitted to WellCare from a delegated vendor or Provider can be a new, void or replacement encounter. The definitions of the types of encounters are as follows:

- *New Encounter – A new encounter is an encounter that has never been submitted to WellCare previously.*
- *Void Encounter – A void encounter is an encounter that directs WellCare/KY Medicaid to reverse payment of a Paid claim.*
- *Replacement Encounter – A replacement encounter is an encounter that directs WellCare/KY Medicaid to replace the previously accepted version of a claim with a new version of the claim.*

Balance Billing

Providers shall accept payment from WellCare for Covered Services provided to WellCare Enrollees in accordance with the reimbursement terms outlined in the Provider Contract. Payment made to Providers constitutes payment in full by WellCare for covered benefits, with the exception of Enrollee expenses. For Covered Services, Providers shall not balance bill Enrollees any amount in excess of the contracted amount in the Provider Contract. An

adjustment in payment as a result of WellCare's claims policies and/or procedures does not indicate that the service provided is a non-covered service, and Enrollees are to be held harmless for Covered Services.

A Provider may provide a service to a recipient on a non-Medicaid basis if the recipient agrees to receive the service on a non-Medicaid basis before the service begins and the service is not a Medicaid-covered service.

Provider-Preventable Conditions

WellCare follows CMS guidelines regarding "Hospital Acquired Conditions," "Never Events," and other "Provider-Preventable Conditions (PPCs)." Under Section 42 CFR 447.26 these PPCs are non-payable for Medicaid and Medicare. Additional PPCs may be added by individual states.

WellCare will not pay a Provider for a provider-preventable condition that meets the following criteria:

A. *Is identified in the State Medicaid plan;*
B. *Has been found by the Kentucky Department for Medicaid Services, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;*
C. *Has a negative consequence for the Enrollee;*
D. *Is auditable; and*
E. *Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.*

All Providers are to report provider-preventable conditions associated with claims for payment or Enrollee treatments for which payment would otherwise be made.

Never Events are defined as a surgical or other invasive procedure to treat a medical condition when the practitioner erroneously performs:

- *A different procedure altogether;*
- *The correct procedure but on the wrong body part; or*
- *The correct procedure on the wrong patient.*

*Hospital Acquired Conditions are additional non-payable conditions listed on the CMS website at **cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond** and include such events as an air embolism, falls and catheter-associated urinary tract infections.*

Healthcare Providers may not bill, attempt to collect from, or accept any payment from WellCare or the Enrollee for PPCs or hospitalizations and other services related to these non-covered procedures.

Hold Harmless Dual-Eligible Enrollees

Those dual-eligible Enrollees whose Medicare Part A and B Enrollee expenses are identified and paid for at the amounts provided for by Kentucky Medicaid shall not be billed for such Medicare Part A and B Enrollee expenses, regardless of whether the amount a Provider receives is less than the allowed Medicare amount or Provider charges are reduced due to limitations on additional reimbursement provided by Kentucky Medicaid. Providers shall accept WellCare's payment as payment in full or will bill Kentucky Medicaid if WellCare has not assumed the

Department's financial responsibility under an agreement between WellCare and the Department.

Claim Payment Appeals

The claims appeal process is designed to address claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes and non-covered codes, etc. Claim payment appeals must be submitted to WellCare in writing within 24 months of the date of denial of the EOP.

Documentation consists of:

- *Date(s) of service;*
- *Enrollee name;*
- *Enrollee WellCare ID number and/or date of birth;*
- *Provider name;*
- *Provider Tax ID;*
- *Total billed charges;*
- *The Provider's statement explaining the reason for the appeal; and*
- *Supporting documentation when necessary (for example, proof of timely filing, medical records).*

To initiate the process, please mail documentation to the address or fax it to the fax number listed in the Quick Reference Guide at ***wellcareky.com/providers****.*

In accordance with 907 KAR 17:035, if you receive an adverse final decision of a denial, in whole or in part, of a health service or claim for reimbursement related to this service, you may request an external independent third-party review. You may only do so after first completing an internal appeal process with WellCare of Kentucky.

You must submit your request for external independent third-party review within 60 days from the date of receipt of the final adverse decision notice. Please note that all Providers ***must*** *exhaust all internal WellCare appeal rights prior to requesting an external independent review.*

You may submit your request to WellCare of Kentucky via one of the following methods:
Email: ***kyexternalreview@wellcare.com***
Fax: ***1-800-509-8203***
Mail: ***WellCare Health Plans***
Attention: External Independent Third-Party Review
13551 Triton Park Blvd. Suite 1200
Louisville, KY 40223

WellCare will confirm receipt of your request for external third-party review within five business days of receiving your request.

As required by 907 KAR 17:035, if you request an external third-party review, WellCare will forward to the Department for Medicaid Services all documentation submitted by you during the appeal or dispute process within 15 business days of receiving your request. No additional documentation will be allowed for consideration by the external independent third-party review.

Additionally, if WellCare's decision is upheld by the external independent third-party review, you have the right to request an administrative hearing in accordance with 907 KAR 17:040 within 30 calendar days of the Department's written notice. You must submit your request for administrative hearing to:

Department for Medicaid Services
Appeals and Complaints Branch
Attention: Administrative Hearings
275 E. Main St., Mail Stop 6E-D
Frankfort, KY 40621
Email: DMS.hearings@ky.gov
Fax: (502) 564-0223
Phone: (502) 564-9394

Corrected or Voided Claims

Corrected and/or voided claims are subject to timely claims submission (i.e., timely filing) guidelines.

How to submit a corrected or voided claim electronically:

- *Loop 2300 Segment CLM composite element CLM05-3 should be '7' or '8'– indicating to replace '7' or void '8'*
- *Loop 2300 Segment REF element REF01 should be 'F8' indicating the following number is the control number assigned to the original bill (original claim reference number)*
- *Loop 2300 Segment REF element REF02 should be 'the original claim number' – the control number assigned to the original bill (original claim reference number for the claim you are intended to replace.)*
- *Example: REF✻F8✻WellCare Claim number here~*

These codes are not intended for use for original claim submission or rejected claims.

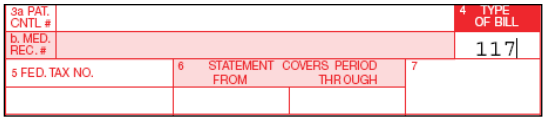
PLEASE NOTE: *A corrected claim submission will void and replace the previously processed claim. A new claim number will be issued. Please be sure to bill all claim lines within the corrected claim that were billed in the original claim.*

To submit a corrected or voided claim via paper:

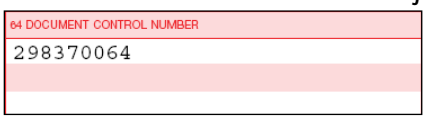
- *For Institutional claims, Provider must include the original WellCare claim number and bill frequency code per industry standards.*

Example:

Box 4 – Type of Bill: the third character represents the "Frequency Code"



Box 64 – Place the Claim number of the Prior Claim in Box 64



- *For Professional claims, the Provider must include the original WellCare claim number and bill frequency code per industry standards. When submitting a Corrected or Voided claim, enter the appropriate bill frequency code left justified in the left-hand side of Box 22.*

  Example:

Any missing, incomplete or invalid information in any field may cause the claim to be rejected.

***Please Note:** If the Provider handwrites, stamps or types "Corrected Claim" on the claim form without entering the appropriate Frequency Code "7" or "8" along with the Original Reference Number as indicated above, the claim will be considered a first-time claim submission.*

The Correction or Void Process involves two transactions:

1. *The original claim will be negated – paid or zero payment (zero net amount due to a co-pay, coinsurance or deductible) – and noted "Payment lost/voided/missed." This process will deduct the payment for this claim, or zero net amount if applicable.*
2. *The corrected or voided claim will be processed with the newly submitted information and noted "Adjusted per corrected bill." This process will pay out the newly calculated amount on this corrected or voided claim with a new claim number.*

The Payment Reversal for this process may generate a negative amount, which will be seen on a later EOP than the EOP that is sent out for the newly submitted corrected claim.

Reimbursement

If there are no site-of-service payment differentials specified on the Kentucky Medicaid website, WellCare follows the CMS Site of Service logic with the exception of POS: 02 and 55. Services performed at POS: 02 will be paid per the applicable Non-Facility fee schedule rates. Residential services performed at POS: 55 will be paid per the applicable Facility fee schedule rates.

Surgical Payments

Reimbursement to the surgeon for surgical services includes charges for preoperative evaluation and care, surgical procedures and postoperative care. The following claims payment policies apply to surgical services:

- ***Incidental Surgeries/Complications**: A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for extra payment. Any complicated procedure that warrants consideration for extra payment should be identified with an operative report and the appropriate modifier. A determination will be made by a WellCare Medical Director on whether the proposed complication merits additional compensation above the usual allowable amount.*
- ***Admission Examination**: One charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.*
- ***Follow-up Surgery Charges**: Charges for follow-up surgery visits are considered to be included in the surgical service charge and are not reimbursed separately.*

Follow-up days included in the global surgical period vary by procedure and are based on CMS policy.

- ***Multiple Procedures**: Payment for multiple procedures is based on current CMS methodologies. When multiple surgeries are performed in a single session, reimbursement for facility services will be 100% of the surgical group rate for the primary procedure and 50% of the surgical group rate for the secondary and/or tertiary procedures. The percentages apply when eligible multiple surgical procedures are performed under one continuous medical service, or when multiple surgical procedures are performed on the same day and by the same surgeon.*
    - *According to the Ambulatory Surgical Centers Manual, Transmittal #6, Page 5.2, when multiple surgeries are performed in a single session, reimbursement for facility services will be 100% of the surgical group rate for the primary procedure and 50% of the surgical group rate for the secondary procedure.*
- ***Assistant Surgeon**: If there are no reimbursement guidelines on the Kentucky Medicaid website for payment of assistant-at-surgery services, payment for an assistant surgeon and/or a non-physician practitioner for assistant surgery is based on current CMS percentages and methodologies.*
- ***Co-Surgeon**: Payment for a co-surgeon is based on guidance provided by the Department. In these cases, each surgeon should report their distinct operative work by adding the appropriate modifier to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier '62' added.*
- ***Medical Direction**: If there are no reimbursement guidelines on the Kentucky Medicaid website for payment of medical direction of anesthesia, payment will be based on current CMS methodologies. Providers must report the applicable modifier on medical direction claims.*
- ***Anesthesia under Medical Direction**: If there are no reimbursement guidelines on the Kentucky Medicaid website for payment of anesthesia under medical direction, payment will be based on current CMS methodologies. Providers must report the applicable modifier on claims for anesthesia under medical direction.*

Modifier

If there are no reimbursement guidelines specific to a modifier(s) on the Kentucky Medicaid website, WellCare follows CMS guidelines regarding modifiers and only reimburses modifiers reimbursed by CMS. Pricing modifier(s) should be placed in the first position(s) of the claim form.

Allied Providers

If there are no reimbursement guidelines on the Kentucky Medicaid website specific to payment for non-physician practitioners or Allied Health Professionals, WellCare follows CMS reimbursement guidelines regarding Allied Health Professionals.

Overpayment Recovery

WellCare strives for 100% payment accuracy but recognizes that a small percentage of financial overpayments will occur while processing claims. An overpayment can occur due to reasons

such as inappropriate coding, duplication of payments, non-authorized services, erroneous contract or fee schedule reimbursement, non-covered benefit(s) and other reasons.

WellCare will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, WellCare will adhere to Kentucky Regulatory Statute KRS 304.17A-708 and limit its notice of retroactive denial to 24 months from the claim payment date. However, no such time limit shall apply to overpayment recovery efforts which are based on a reasonable belief of fraud or other intentional misconduct, or abusive billing, required by, or initiated at the request of, a self-insured plan, or required by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or Enrollees.

In all cases, WellCare or its designee will provide a written notice to the Provider identifying the specific claims, overpayment reason and amount, contact information and instructions on how to send the refund. If the retroactive denial of reimbursement results from coordination of benefits, the written notice will specify the name of the carrier and coverage period for the Enrollee. The notice will also provide the carrier address WellCare has on file but recognizes that the Provider may use the carrier address it has on file. The standard request notification provides 60 days for the Provider to send in the refund, request further information or dispute the retroactive denial.

Failure of the Provider to respond within the above time frame will constitute acceptance of the terms in the letter and will result in offsets to future payments. The Provider will receive an EOP indicating if the balance has been satisfied. In situations where the overpaid balance has aged more than three months and no refund has been received, the Provider may be contacted by WellCare, or its designee, to arrange payment.

If a Provider independently identifies an overpayment, WellCare requires the Provider to: 1) report that an overpayment has been received; 2) return the overpayment within 60 calendar days of the date the overpayment was identified; and 3) notify WellCare in writing as to the reason for the overpayment to:

WellCare – Comprehensive Health Management
Attn: Recovery/Cost Containment Unit (CCU)
P.O. Box 947945
Atlanta, GA 30394-7945
For more information on contacting WellCare Customer Service, refer to the Quick Reference Guide at ***wellcareky.com/providers****.*

Benefits During Disaster and Catastrophic Events
Refer to the Provider Contract.

Section 6: Credentialing

Overview

Credentialing is the process by which the appropriate peer review bodies of WellCare evaluate the credentials and qualifications of practitioners including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/healthcare delivery organizations. For purposes of this Credentialing section, all references to "practitioners" shall include Providers delivering health or health-related services including the following: physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/healthcare delivery organizations.

This evaluation includes (as applicable to practitioner type):

- *Background*
- *Education*
- *Postgraduate training*
- *Certification(s)*
- *Experience*
- *Work history and demonstrated ability*
- *Patient admitting capabilities*
- *Licensure, regulatory compliance and health status which may affect a practitioner's ability to provide healthcare*
- *Accreditation status, as applicable to non-individuals*

Practitioners are required to be credentialed prior to being listed as participating network Providers of care or services to WellCare Enrollees.

The Credentialing Department, or its designee, is responsible for gathering all relevant information and documentation through a formal application process. The practitioner credentialing application must be attested to by the applicant as being correct and complete. The application captures professional credentials and contains a questionnaire section that asks for information regarding professional liability claims history and suspension or restriction of hospital privileges, criminal history, licensure, Drug Enforcement Administration (DEA) certification or Medicare/Medicaid sanctions.

Please take note of the following credentialing process highlights:

- *Primary source verifications are obtained in accordance with state and federal regulatory agencies, accreditation and WellCare policy and procedure requirements, and include a query to the National Practitioner Data Bank.*
- *Physicians, allied health professionals and ancillary facilities/healthcare delivery organizations are required to be credentialed in order to be network Providers of services to WellCare Enrollees.*
- *Satisfactory site inspection evaluations are required to be performed in accordance with state, federal and accreditation requirements.*
- *After the credentialing process has been completed, a timely notification of the credentialing decision is forwarded to the Provider.*

Credentialing may be done directly by WellCare or by an entity approved by WellCare for delegated credentialing. If that credentialing is delegated to an outside agency, the agency shall be required to meet WellCare's criteria to ensure that the credentialing capabilities of the delegated entity clearly meet federal and state accreditation (as applicable) and WellCare requirements.

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, credentialing forms and files.

Practitioner Rights

Practitioner Rights are listed below and included in the application/re-application cover letter.

Practitioner's Right to be Informed of Credentialing/Re-Credentialing Application Status

*Written requests for information may be emailed to the Provider Data Management team (PDM) to **KY_ProviderCorrection@wellcare.com**. Upon receipt of a written request, WellCare will provide written information to the practitioner regarding the status of the credentialing/re-credentialing application, generally within 15 business days. The information provided will advise of any items pending verification, needing to be verified, any non-response in obtaining verifications and any discrepancies in verification information received compared with the information provided by the practitioner.*

Practitioner's Right to Review Information Submitted in Support of Credentialing/ Re-Credentialing Application

All practitioners participating within the WellCare network have the right to review information obtained by WellCare that is used to evaluate their credentialing and/or re-credentialing applications. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing agencies, subject to any WellCare restrictions. WellCare, or its designee, will review the corrected information and explanation at the time of considering the practitioner's credentials for Provider network participation or re-credentialing. This does not allow a practitioner to review peer review-protected information such as references, personal recommendations, or other information.

The Credentialing Verification Organization (CVO) that KY utilizes is Verisys. Once the credentialing process is initiated for practitioners and facilities, a letter is sent communicating the review process has begun. If there are missing or expired Documents, the CVO will make up to three attempts to obtain the missing information. Practitioners are directed to the application portal for Council for Affordable Quality Healthcare (CAHQ) regarding application status updates. Facilities are communicated status updated via email, fax, or mail due to the lack of an application portal for facilities to access.

Right to Correct Erroneous Information and Receive Notification of the Process and Time Frame

Should a practitioner identify any erroneous information used in the credentialing/re-credentialing process, or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner, the practitioner has the right to correct any erroneous information submitted by another party. To request release of such information, a practitioner must submit a written request to WellCare Credentialing

Department. Upon receipt of this information, the practitioner has 14 days to provide a written explanation detailing the error or the difference in information to WellCare The WellCare Credentialing Committee will then include the information as part of the credentialing/re-credentialing process.

WellCare will provide written notification to the practitioner of the discrepant information.

WellCare's written notification to the practitioner includes:

- *The nature of the discrepant information;*
- *The process for correcting the erroneous information submitted by another source;*
- *The format for submitting corrections;*
- *The time frame for submitting the corrections;*
- *The addressee in Credentialing to whom corrections must be sent;*
- *WellCare's documentation process for receiving the correction information from the Provider; and*
- *WellCare's review process.*

Baseline Criteria

Baseline criteria for practitioners to qualify for Provider network participation are:

***License to Practice** – Providers must have a current, valid, unrestricted license to practice.*

***Kentucky Medicaid Eligibility** – All affiliated Providers delivering Covered Services for WellCare must currently be enrolled and active as providers in the Kentucky Medicaid Program.*

***Drug Enforcement Administration Certificate** – Providers must have a current, valid DEA certificate (as applicable to practitioner specialty), and if applicable to the state where services are performed, hold a current CDS or CSR certificate (applicable for M.D., D.O., D.P.M., D.D.S., D.M.D.).*

***Work History** – Providers must provide a minimum of five years of relevant work history as a health professional.*

***Board Certification** – Physicians (M.D., D.O., D.P.M.) must maintain Board Certification in the specialty being practiced as a Provider for WellCare or must have verifiable education/training from an accredited training program in the specialty requested.*

***Hospital-Admitting Privileges** – Specialist Providers shall have hospital-admitting privileges at a WellCare-participating hospital (as applicable to specialty). PCPs may have hospital-admitting privileges or may enter into a formal agreement with another WellCare-participating Provider who has admitting privileges at a WellCare-participating hospital for the admission of Enrollees.*

***Ability to Participate in Medicaid and Medicare** – Providers must have the ability to participate in Medicaid and Medicare. Any individual or entity excluded from participation in any government program is not eligible for participation in any WellCare company plan. In order to participate with WellCare of Kentucky, a Provider must complete a Provider Contract and submit all necessary credentialing information and their Kentucky Medicaid Provider Number. Providers are not eligible for participation if the Provider owes money to the Medicaid Program*

or if the Office of the Attorney General has an active fraud investigation involving the Provider. Existing Providers who are sanctioned and thereby restricted from participation in any government program are subject to immediate termination in accordance with WellCare Policies and Procedures.

***New Providers and Providers Not Participating in Medicaid** – If a potential provider has not obtained a Kentucky Medicaid Provider Number, the provider must enroll via the States' provider portal at **medicaidsystems.ky.gov/Partnerportal**. WellCare of Kentucky Provider Relations shall provide reasonable assistance, upon request, to the provider in submission of required materials to the Department of Medicaid for processing of the enrollment. When WellCare of Kentucky staff has submitted the required data in the transmission of the provider file that indicates inclusion in the Plan's Network:*

- *The Department will enter the provider number on the master provider file; and*
- *The transmitted data will be loaded to the provider file.*

The Department will supply WellCare of Kentucky with a report within two (2) weeks of transactions being accepted, suspended or denied.

***Providers Who Opt Out of Medicare** – A Provider who opts out of Medicare is not eligible to become a participating Provider. An existing Provider who opts out of Medicare is not eligible to remain as a participating Provider for WellCare.*

At the time of initial credentialing, WellCare reviews the state-specific opt-out listing maintained on the designated State Carrier's website to determine whether a Provider has opted out of Medicare. WellCare monitors the opt-out website on an ongoing/ quarterly basis.

Liability Insurance

WellCare Providers (all disciplines) are required to carry and continue to maintain professional liability insurance in the minimum limits of $1,000,000/$3,000,000 per Provider, unless otherwise agreed by WellCare in writing.

Providers must furnish copies of current professional liability insurance certificate to WellCare, concurrent with expiration.

Site Inspection Evaluation

Site Inspection Evaluations (SIEs) are conducted in accordance with federal, state and accreditation requirements. Focusing on quality, safety and accessibility, performance standards and thresholds were established for:
Office-site criteria:

- *Physical accessibility;*
- *Physical appearance; and*
- *Adequacy of waiting room and examination room space.*
- *Medical/treatment record-keeping criteria.*

SIEs are conducted for:

- *Unaccredited Facilities;*
- *State-specific initial credentialing requirements;*
- *State-specific re-credentialing requirements; and*
- *When a complaint is received relative to office site criteria.*

In those states where initial SIEs are not a requirement for credentialing, there is ongoing monitoring of Enrollee complaints. SIEs are conducted for those sites where a complaint is received relative to office site criteria listed above. SIEs may be performed for an individual complaint or quality-of-care concern if the severity of the issue is determined to warrant an on-site review.

Covering Providers

Primary care physicians in solo practice must have a covering physician who also participates with or is credentialed with WellCare.

Allied Health Professionals

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

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

- *APRN;*
- *Certified Nurse Midwife (CNM);*
- *PA; and*
- *Osteopathic Assistant (OA).*

Independent AHPs include, but are not limited to, the following:

- *Licensed clinical social worker;*
- *Licensed mental health counselor;*
- *Licensed marriage and family therapist;*
- *Physical therapist;*
- *Occupational therapist;*
- *Audiologist; and*
- *Speech/language therapist/pathologist.*

Ancillary Healthcare Delivery Organizations

Ancillary and organizational applicants must complete an application and, as applicable, undergo a SIE if unaccredited. WellCare is required to verify accreditation, licensure, Medicare certification (as applicable), regulatory status and liability insurance coverage prior to accepting the applicant as a WellCare Provider.

Re-Credentialing

In accordance with regulatory and accreditation requirements and WellCare Policies and Procedures, re-credentialing is required every three years. A notice will be sent by mail that contains a preprinted re-credentialing application and instructions 180 days before a Provider's three-year re-credentialing due date. Notwithstanding KRS 304.17A-576(3), WellCare will not make any Provider Contract effective before the date of the completion of credentialing.

Updated Documentation

In accordance with contractual requirements, Providers should furnish copies of current professional or general liability insurance, license, DEA certificate and accreditation information (as applicable to Provider type) to WellCare prior to or concurrent with expiration.

Office of Inspector General Medicare/Medicaid Sanctions Report

On a monthly basis, WellCare or its designee accesses the listings from the Office of Inspector General (OIG) Medicare/Medicaid Sanctions (exclusions and reinstatements) Report, for the most current available information. This information is cross-checked against the network of Providers. If Providers are identified as being currently sanctioned, such Providers are subject to immediate termination and notification of termination of contract, in accordance with WellCare Policies and Procedures.

Termination of Providers

WellCare must terminate any Provider who:

- *Engages in an activity that violates any law or regulation and results in suspension, termination or exclusion from the Medicare or Medicaid program;*
- *Has a license, certification or accreditation terminated, revoked or suspended;*
- *Has medical staff privileges at any hospital terminated, revoked or suspended; or*
- *Engages in behavior that is a danger to the health, safety or welfare of Enrollees.*

In such instances, WellCare is required to notify the Department of the reason(s) for the termination.

WellCare will notify any Enrollee of a Provider's involuntary termination provided such Enrollee has received a service from the terminated Provider within the previous six months. Such notice shall be mailed within 15 days of the action taken if it is a PCP and within 30 days for any other Provider.

If a Provider terminates participation with WellCare, WellCare will notify any Enrollee of the Provider's termination provided such Enrollee has received a service from the terminating Provider within the previous six months. Such notice shall be mailed the later of the following: (i) 30 days prior to the effective date of the termination or (ii) within 15 days of receiving notice.

WellCare may terminate from participation any Provider who materially breaches the Provider Contract and fails to timely and adequately cure such breach in accordance with the terms of the Provider Contract.

WellCare will notify any Enrollee of the Provider's termination provided such Enrollee has received a service from the terminating Provider within the previous six months. Such notice shall be mailed the later of the following: (i) within 15 days of providing notice or (ii) 30 days prior to the effective date of the termination.

Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials

On a monthly basis, WellCare or its designee contacts state licensure agencies to obtain the most current available information on sanctioned Providers. This information is cross-checked against the network of WellCare Providers. If a network Provider is identified as being currently under sanction, appropriate action is taken in accordance with WellCare Policies and Procedures. If the sanction imposed is revocation of license, the Provider is subject to immediate termination. Notifications of termination are given in accordance with contract and WellCare Policies and Procedures.

If a sanction imposes a reprimand or probation, written communication is made to the Provider requesting a full explanation, which is then reviewed by the Credentialing/Peer Review Committee. The committee makes a determination as to whether the Provider should continue participation or whether termination should be initiated.

Participating Provider Appeal Through the Dispute Resolution Peer Review Process

WellCare may immediately suspend, pending investigation, the participation status of a participating Provider who, in the opinion of the Medical Director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare or safety of Enrollees. In such instances, the Medical Director investigates on an expedited basis.

WellCare has a Participating Provider Dispute Resolution Peer Review Panel Process in the event WellCare chooses to alter the conditions of participation of a Provider based on issues of quality of care, conduct or service, and if such process is implemented, may result in reporting to regulatory agencies.

The Provider Dispute Resolution Peer Review Process has two levels. All disputes in connection with the actions listed below are referred to as a first-level Peer Review Panel consisting of at least three qualified individuals of whom at least one is a participating Provider and a clinical peer of the practitioner that filed the dispute.

The practitioner also has the right to consideration by a second level Peer Review Panel consisting of at least three qualified individuals. At least one individual on the Panel will be a participating Provider and a clinical peer of the practitioner who filed the dispute. The second level panel is comprised of individuals who were not involved in earlier decisions.

The following actions by WellCare entitle the practitioner affected to the Provider Dispute Resolution Peer Review Panel Process:

- *Suspension of participating practitioner status for reasons associated with clinical care, conduct or service;*
- *Revocation of participating practitioner status for reasons associated with clinical care, conduct or service; or*
- *Non-renewal of participating practitioner status at time of re-credentialing for reasons associated with clinical care, conduct, service or excessive claims and/ or sanction history.*

Notification of the adverse recommendation, together with reasons for the action, and the practitioner's rights and process for obtaining the first and/or second level Dispute Resolution Peer Review Panel processes, are provided to the practitioner. Notification to the practitioner will be mailed by overnight recorded or certified return-receipt mail.

The practitioner has a period of up to 30 days from the date WellCare receives the notification return receipt back in the mail to file a written request via recorded or certified return-receipt mail to access the Dispute Resolution Peer Review Panel Process.

Upon timely receipt of the request, the Medical Director or her or his designee shall notify the practitioner of the date, time and telephone access number for the Panel hearing. WellCare then notifies the practitioner of the schedule for the Review Panel hearing.

The practitioner and WellCare are 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 therefrom, are arbitrary, unreasonable or capricious.

The Dispute Resolution Peer Review Panel shall consider and decide the case objectively and in good faith. The Medical Director, within five business days after final adjournment of the Dispute Resolution Peer Review Panel hearing, shall notify the practitioner of the results of the first level Panel hearing. If the findings are positive for the practitioner, the second level review shall be waived.

If the findings of the first-level Panel hearing are adverse to the practitioner, the practitioner may access the second-level Peer Review Panel by following the notice information contained in the letter notifying the practitioner of the adverse determination of the first level Peer Review Panel.

Within 10 calendar days of the request for a second level Peer Review Panel hearing, the Medical Director or their designee shall notify the practitioner of the date, time and access number for the second level Peer Review Panel hearing.

The second level Dispute Resolution Peer Review Panel shall consider and decide the case objectively and in good faith. The Medical Director, within five business days after final adjournment of the second-level Dispute Resolution Peer Review Panel hearing, shall notify the practitioner of the results of the second level Panel hearing via certified or overnight recorded delivery mail. If the findings of the second-level Peer Review Panel result in an adverse determination for the practitioner, the findings of the second level Peer Review Panel shall be final.

A practitioner who fails to request the Provider Dispute Resolution Peer Review Process within the time and in the manner specified waives any right to such review to which she or he might otherwise have been entitled. WellCare may proceed to implement the termination and make the appropriate report to the National Practitioner Data Bank and State Licensing Agency as appropriate and if applicable.

Delegated Entities

All participating Providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a monthly/quarterly basis and formal audits are conducted annually. Please refer to the Section 9: Delegated Entities section in this Provider Manual for further details.

Section 7: Appeals and Grievances

Provider Appeals Process

A Provider may request an appeal regarding payment or contractual issues on their own behalf by mailing, by the secure provider portal online, or faxing a letter of appeal and/or an appeal form with supporting documentation such as medical records.

Providers have 60 calendar days from the original utilization management or claim denial to file an appeal. Appeals submitted after that time will be denied for untimely filing. If the Provider feels she or he filed the appeal within the appropriate time frame, the Provider may submit documentation showing proof of timely filing. The only acceptable proof of timely filing is fax confirmation, a registered postal receipt signed by a representative of WellCare or similar receipt from other commercial delivery services.

Upon receipt of all required documentation, WellCare has 30 calendar days to review the appeal for Medical Necessity and conformity to WellCare guidelines and to render a decision to reverse or affirm its original decision. WellCare will appoint a person not involved in the prior decision to review the appeal. Appeals will be reviewed by a Committee which will consist of at least three (3) qualified individuals. If the appeal is not resolved within 30 days, WellCare may request a 14-day extension from the Provider. If the Provider requests the extension, the extension shall be approved by WellCare.

Appeals received without the necessary documentation may be denied for lack of information. It is the responsibility of the Provider to submit the requested documentation within the allotted time frame to have the case reviewed. Records and documents received after that time frame will not be reviewed and the appeal will remain closed.

Medical records and patient information shall be supplied at the request of WellCare or appropriate regulatory agencies when required for appeals. The Provider is not allowed to charge WellCare or the Enrollee for copies of medical records provided for this purpose.

Please refer to the WellCare of Kentucky Quick Reference Guide for detailed instructions on submitting various types of appeals: wellcareky.com/providers.

Reversal of Denial

If it is determined during the review that the Provider has complied with WellCare protocols and that the appealed services were Medically Necessary, the denial will be reversed. The Provider will be notified of this decision in writing.

The Provider may file a claim for payment related to the appeal, if one has not already been submitted. If a claim has been previously submitted and denied, it will be adjusted for payment after the decision to reverse the denial has been made. WellCare will ensure that claims are processed and comply with federal and state requirements.

Affirmation of Denial

If it is determined during the review that the Provider did not comply with WellCare protocols and/or Medical Necessity was not established, the denial will be upheld. The Provider will be notified of this decision in writing.

For denials based on Medical Necessity, the criteria used to make the decision will be provided in the letter. The Provider may also request a copy of the benefit provision, guideline, protocol and other similar criteria used in making the appeal decision by sending a written request to the appeals addresses listed in the decision letter.

Independent External Third Party Review

In accordance with 907 KAR 17:035, if a Provider receives an adverse final decision of a denial, in whole or in part, of a health service [including a denial, in whole or in part, involving emergency services] or claim for reimbursement related to this service, the Provider may request an external independent third-party review. A Provider may only do so after first completing an internal appeal process with WellCare. A request for independent external third party review must be submitted to WellCare within 60 days of receiving the final decision letter from WellCare.

Requests for independent external third party reviews may be submitted to WellCare via one of the following methods:

1) *Email:* ***kyexternalreview@wellcare.com***
2) *Fax:* ***1-800-509-8203***
3) *Mail:* ***WellCare Health Plans***
   Attention: External Independent Third-Party Review
   13551 Triton Park Blvd., Suite 1200
   Louisville, KY 40223

WellCare will confirm receipt of your request for external third-party review within five business days of receiving your request.

As required by 907 KAR 17:035, if you request an external third-party review, WellCare will forward to the Department for Medicaid Services all documentation submitted by you during the appeal process within 15 business days of receiving your request. No additional documentation will be allowed for consideration by the external independent third-party review.

Additionally, if WellCare's decision is upheld by the external independent third-party review, Providers have the right to request an administrative hearing in accordance with 907 KAR 17:040 within 30 calendar days of the Department's written notice. You must submit your request for administrative hearing to:

Department for Medicaid Services
Appeals and Complaints Branch
Attention: Administrative Hearings
275 E. Main St., Mail Stop 6E-D
Frankfort, KY 40621
Email: DMS.hearings@ky.gov
Fax: (502) 564-0223
Phone: (502) 564-9394

If the administrative hearing officer upholds WellCare's decision, the Provider must reimburse the Department for Medicaid Services in the amount of $600 (per hearing) within 30 days of the issuance of the final order.

Enrollee Appeals Process

Overview

An Enrollee appeal is a formal request from an Enrollee for a review of an Adverse Benefit Determination taken by WellCare. An appeal may also be filed on the Enrollee's behalf by an authorized representative or a Provider with the Enrollee's written consent. All appeal rights described in Section 7: Appeals and Grievances of this Provider Manual that apply to Enrollees will also apply to the Enrollee's authorized representative or a Provider acting on behalf of the Enrollee with the Enrollee's written consent. Appeals received from Providers that are on the Enrollee's behalf for denied services with requisite consent of the Enrollee are deemed Enrollee appeals. To appeal, the Enrollee, or their representative, may file an appeal request either orally via WellCare's Customer Service or in writing within 60 calendar days of the date of the Adverse Benefit Determination.

If an appeal is filed orally via WellCare's Customer Service, the request must be followed up with a written, signed appeal to WellCare within 10 calendar days of the oral filing. For oral filings, the time frames for resolution begin on the date the oral filing was received by WellCare. Unless written confirmation of a standard oral appeal request is received, the case is closed as an invalid appeal and a decision is not made on the appeal. This requirement does not apply to requests for expedited appeal requests.

Examples of actions that can be appealed include, but are not limited to, the following:

- *Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting or effectiveness of a covered benefit;*
- *The reduction, suspension or termination of a previously authorized service;*
- *The denial, in whole or in part, of a payment for service;*
- *The failure to provide services in a timely manner, as defined by the Kentucky Department for Medicaid Services;*
- *The failure of WellCare to complete the authorization request in a timely manner as defined in 42 CFR 438.408;*
- *For a resident of a rural area with only one plan, the denial of an Enrollee's request to exercise their right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the network; and*
- *The denial of an Enrollee's request to dispute a financial liability, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.*

If the Enrollee's request for appeal is submitted after 60 calendar days, then good cause must be shown in order for WellCare to accept the late request. Examples of good cause include, but are not limited to, the following:

- *The Enrollee did not personally receive the notice of Adverse Benefit Determination or received the notice late;*
- *The Enrollee was seriously ill, which prevented a timely appeal;*
- *There was a death or serious illness in the Enrollee's immediate family;*
- *An accident caused important records to be destroyed;*

- *Documentation was difficult to locate within the time limits; and/or*
- *The Enrollee had incorrect or incomplete information concerning the appeal process.*

WellCare will not take or threaten to take any punitive action against any Provider acting on behalf of or in support of an Enrollee in requesting an appeal or an expedited appeal.

WellCare ensures that the decision makers assigned to appeals were not involved in previous levels of review or decision making. When deciding an appeal of a denial based on lack of Medical Necessity, a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeal involving clinical issues, the appeal reviewers will be healthcare professionals with clinical expertise in treating the Enrollee's condition/disease or will have sought advice from Providers with expertise in the field of medicine related to the request.

Enrollees are provided reasonable assistance in completing forms and other procedural steps for an appeal including, but not limited to, providing interpreter services and toll-free telephone numbers with TTY capability.

Enrollees and their authorized representative can give additional information if they think it will help their appeal. Enrollee's may submit additional information for both standard and expedited appeals in writing or in person. This can be done at any time during the appeals process; however, there will be limited time to submit additional information for an expedited appeal due to the fast resolution time frame.

Enrollees may also ask for a copy of the appeal file any time during or after the completion of the appeal. Upon request, a copy of the appeal file will be provided free of charge.

Types of Appeals

An Enrollee may file for a standard pre-service (utilization management denial), retrospective or an expedited appeal determination.

Standard pre-service appeals are requests for services that the Enrollee has not received and WellCare has determined are not Covered Services, are not Medically Necessary, or are otherwise outside of the Enrollee's benefit plan. Pre-service appeals are utilization management denial types and Providers must have the Enrollee's written consent to assist the Enrollee through this process.

Retrospective, or post-service, appeals are typically requests for payment for care or services that the Enrollee has already received. Accordingly, a retrospective appeal would never result in the need for an expedited review. These are the only appeals that may be made by the Provider on their own behalf.

Only pre-service appeals may be expedited. Expedited pre-service appeals are considered Enrollee appeals and Providers must have the Enrollee's written consent to assist the Enrollee through this process.

Appointment of Representative

If the Enrollee wishes to use a representative, then she or he must complete an Appointment of Representative (AOR) statement. The Enrollee and the person who will be representing the Enrollee must sign the AOR statement. The form is at ***wellcareky.com/providers****.*

In accordance with 907 KAR 17:010 Section 4; A Provider shall not be an authorized representative of an Enrollee without the Enrollee's written consent for the specific action that is being appealed or that is the subject of a state fair hearing.

For authorized representative purposes, written consent unique to an appeal or state fair hearing shall be required for the appeal or state fair hearing.

A single written consent shall not qualify as written consent for more than one:

a. *Hospital admission;*
b. *Physician or other Provider visit; or*
c. *Treatment plan.*

Appeal Decision Time Frames

WellCare must make a determination from the receipt of the request on an Enrollee appeal and notify the appropriate party within the following time frames:

- *Acknowledgment of Appeal:* ***5 Business Days***
- *Standard Pre-Service Request:* ***30 calendar days***
- *Retrospective Request:* ***30 calendar days***
- *Expedited Request:* ***3 calendar Days***

If WellCare fails to resolve an appeal within 30 calendar days, the Enrollee is deemed to have exhausted WellCare's internal appeal process and may initiate a State Fair Hearing.

The standard pre-service, expedited and retrospective determination periods noted above may be extended by up to 14 calendar days if the Enrollee requests an extension or if WellCare justifies a need for additional information and documents how the extension is in the interest of the Enrollee. If an extension is not requested by the Enrollee, WellCare will provide the Enrollee with written notice of the reason for the delay within two business days of the decision to extend the time frame. The Enrollee will also be informed of the right to request a grievance if they disagree with the plans request to extend the appeal file.

Standard Pre-Service and Retrospective Appeals Process

An Enrollee may file a standard pre-service or retrospective appeal determination. An Enrollee may also present their appeal in person.

Standard Pre-Service or Retrospective Appeal Decisions

If WellCare reverses its original decision denying an Enrollee's request for a service (pre-service request), then WellCare will issue an authorization for the pre-service request or send payment if the service has already been provided.

If WellCare affirms its initial Adverse Benefit Determination and/or denial (in whole or in part), it will:

- *Issue a Notice of Adverse Benefit Determination to the Enrollee and/or appellant;*

- *Include in the Notice the specific reason for the appeal decision in easily understandable language with reference to the benefit provision, guidelines, protocol or other similar criteria on which the appeal decision was based;*
- *Inform the Enrollee:*
    - *Of the right to request a State Fair Hearing and how to do so;*
    - *Of the right to representation;*
    - *Of the right to continue to receive benefits pending a State Fair Hearing; and*
    - *That they may be liable for the cost of any continued benefits if WellCare's action is upheld.*

Expedited Appeals Process

To request an expedited appeal, an Enrollee or a Provider (regardless of whether the provider is affiliated with WellCare) must submit an oral or written request directly to WellCare. A request to expedite an appeal determination will be considered in situations where applying the standard procedure could seriously jeopardize the Enrollee's life, health or ability to regain maximum function, including cases in which WellCare makes a less than fully favorable decision.

Expedited appeals must be submitted via our customer service department or via fax. Call us at ***1-877-389-9457*** *(TTY 711 or* ***1-877-247-6272****) or fax it to* ***1-866-201-0657****.*

Enrollees, or their authorized representatives, who orally request an expedited appeal are not required to submit a written appeal request.

A request for payment of a service already provided to an Enrollee is not eligible to be reviewed as an expedited appeal.

WellCare will provide the Enrollee with prompt oral notification within 24 hours regarding the denial of an expedited request and will follow up with written notification to the Enrollee within two calendar days which:

- *Explains that WellCare will automatically transfer and process the request using the 30 calendar daytime frame for standard appeals beginning on the date WellCare received the original request.*

Upon acceptance of an expedited appeal, WellCare will complete the expedited appeal and give the Enrollee (and the Provider involved, as appropriate) notice of its decision as expeditiously as the Enrollee's health condition requires, but no later than 72 hours after receiving a valid, complete request for appeal.

If WellCare overturns its initial action and/or the denial, it will issue an authorization to cover the requested service and notify the Enrollee orally within 72 hours of receipt of the expedited appeal request followed with written notification of the appeal decision.

Denial of an Expedited Appeal Request

If WellCare affirms its initial Adverse Benefit Determination and/or denial (in whole or in part), it will:

- *Issue a Notice of Adverse Benefit Determination to the Enrollee and/or appellant;*

- *Include in the Notice the specific reason for the appeal decision in easily understandable language with reference to the benefit provision, guidelines, protocol or other similar criteria on which the appeal decision was based;*
- *Inform the Enrollee:*
    - *Of the right to request a State Fair Hearing and how to do so;*
    - *Of the right to representation;*
    - *Of the right to continue to receive benefits pending a State Fair Hearing; and*
    - *That she or he may be liable for the cost of any continued benefits if WellCare's action is upheld.*

State Fair Hearing for Enrollees

An Enrollee or their authorized representative may request a State Fair Hearing if they are dissatisfied with an action that has been taken by WellCare. The hearing request must be post marked within 120 calendar days from the date of the plan's final decision letter.

If the Enrollee wishes to use a representative, she or he must complete an Appointment of Representative (AOR) statement. The Enrollee and the person who will be representing the Enrollee must sign the AOR statement. The form is at ***wellcareky.com/providers****.*

A request for a State Fair Hearing should be sent to:

Agency: ***Office of the Ombudsman***
Address: ***Department for Medicaid Services, Appeals and Complaints Branch***
Attn: Administrative Hearings
275 E. Main Street, Mail Stop 6E-D
Frankfort, KY 40621

Phone: ***1-502-564-5497***
Fax: ***1-502-564-9523***

Please note that Enrollees ***must*** *exhaust all internal WellCare appeal rights prior to requesting a State Fair Hearing.*

State Fair Hearings are not the appropriate forum for billing or payment disputes. For process of appeal of a claim's payment or grievance, please see Section 5: Claims.

All documents supporting WellCare's action must be received by the Department no later than five days from the date WellCare receives notice from the Department that a State Fair Hearing request has been filed. These records shall be made available to the Enrollee upon request by either the Enrollee or the Enrollee's authorized representative. The Department will provide the Enrollee with a hearing process that shall adhere to 907 KAR 1:563, 42 CFR 438 Subpart F and 42 CFR 431 Subpart E.

Failure of WellCare to comply with the State Fair Hearing requirements of the state and federal Medicaid law in regard to an action taken by WellCare or to appear and present evidence will result in an automatic ruling in favor of the Enrollee.

Continuation of Benefits while the Appeal and Medicaid Fair Hearing Are Pending

WellCare shall continue the Enrollee's benefits if all of the following are met:

- *The Enrollee or the service Provider files a timely appeal of the WellCare Adverse Benefit Determination or the Enrollee requests a State Fair Hearing within 120 days from the date on WellCare's Notice of Adverse Benefit Determination*
- *The appeal involves the termination, suspension or reduction of a previously authorized course of treatment*
- *The services were ordered by an authorized service Provider*
- *The time period covered by the original authorization has not expired*
- *The Enrollee requests extension of the benefits*

WellCare shall provide benefits until one of the following occurs:

- *The Enrollee withdraws the appeal*
- *The Enrollee fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after the notice of an adverse resolution to the Enrollee's appeal*
- *The Department issues a State Fair Hearing decision adverse to the Enrollee*
- *The time period or service limits of a previously authorized service has been met*

If the final resolution of the appeal is adverse to the Enrollee and WellCare's Adverse Benefit Determination is upheld, WellCare may recover the cost of the services furnished to the Enrollee while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(d).

If WellCare or the Department reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, WellCare will authorize or provide the appealed services promptly, as expeditiously as the Enrollee's health condition requires, but not later than 72 hours from the date that WellCare receives notice reversing the determination, if the services were not furnished while the appeal was pending and the State Fair Hearing results in a decision to reverse WellCare's decision to deny, limit, or delay services.

If WellCare or the Department reverses a decision to deny, limit or delay services and the Enrollee receives the appealed services while the appeal is pending, WellCare will pay for those services.

Grievance Process

Provider

Providers have the right to file a grievance no later than 30 calendar days from the date the Provider becomes aware of the issue generating the grievance. Written resolution will be provided to the Provider within 30 calendar days from the date the grievance is received by WellCare. If additional time is needed, WellCare shall orally request a 14- day extension from the Provider. If the Provider requests the extension, the extension shall be approved by WellCare.

Provider grievances may involve, but not be limited to, the following:

- *Process/policies*
- *Claims Processing (not an appeal)*
- *Communications*
- *Fraud/Waste/Abuse*
- *Contracting/Credentialing*

A Provider may not file a grievance on behalf of the Enrollee without written consent from the Enrollee.

WellCare will provide all Providers written notice of the Provider grievance procedures at the time they enter into contract. A Provider grievance is considered to be any Provider who is dissatisfied with WellCare's policies, procedures, administrative functions or any aspect of the plan.

For more information, see the ***Grievance Submission*** *section below.*

Enrollee

An Enrollee or an Enrollee's representative, including the legal guardian of a minor Enrollee or incapacitated adult or a Provider acting on behalf of the Enrollee with written consent, has the right to file a grievance request either orally or in writing at any time.

WellCare will acknowledge the Enrollee or Enrollee's representative grievance in writing within five business days from the date the grievance is received by WellCare. The acknowledgement letter will include:

- *Name and telephone number of the Grievance Coordinator;*
- *The expected date of the grievance resolution; and*
- *A request for any additional information needed to investigate the issue.*

Examples of grievances that can be submitted include, but are not limited to:

- *Provider service including, but not limited to:*
  - *Rudeness by Provider or office staff*
  - *Failure to respect the Enrollee's rights*
  - *Quality of care/services provided*
  - *Refusal to see Enrollee (other than in the case of patient discharge from office); and/or*
  - *Office conditions*
- *Services provided by WellCare including, but not limited to:*
  - *Hold time on telephone*
  - *Rudeness of staff*
  - *Involuntary disenrollment from WellCare; and/or*
  - *Unfulfilled requests*
- *Access availability including, but not limited to:*
  - *Difficulty getting an appointment*
  - *Wait time in excess of one hour*
  - *Handicap accessibility*

Upon receipt of the grievance, a written resolution will be mailed to the Enrollee within 30 calendar days from the date the grievance is received by WellCare. This resolution letter may not take the place of the acknowledgment letter, unless a decision is reached before the written acknowledgement is sent, then one letter shall be sent which includes the acknowledgement and the decision letter. The resolution letter will include:

- *The results/findings of the resolution*
- *All information considered in the investigation of the grievance*
- *The date of the grievance resolution*

WellCare will ensure that no punitive action is taken against a Provider who, as an authorized representative, files a grievance on behalf of an Enrollee, or supports a grievance filed by an Enrollee. Documentation regarding the grievance will be made available to the Enrollee, if requested.

If the Enrollee wishes to use a representative, she or he must complete an Appointment of Representative (AOR) statement. The Enrollee and the person who will be representing the Enrollee must sign the AOR statement. The form is at ***https://www.wellcareky.com/providers/medicaid/forms.html****.*

If an Enrollee wishes to disenroll from WellCare, the Enrollee, or the Enrollee's authorized representative, must first file a formal grievance with WellCare, either orally or in writing. The Enrollee must include in their request for disenrollment:

- *Enrollee's First and Last Name*
- *Social Security Number*
- *The KY Medicaid ID number for the Enrollee and all the household Enrollees requesting disenrollment*
- *The Enrollee's current address and phone number*
- *The reason for the disenrollment request*

If the Enrollee's disenrollment request is not approved, a letter will be sent to the Enrollee explaining the reason for the denial decision and notifying the Enrollee of their right to appeal the decision to the Department for Medicaid Services (DMS) Enrollment Processing Branch (EPB). The DMS EPB will review the Disenrollment for Cause appeal request and render a final determination, which will then be communicated to WellCare and the Enrollee.

If the Enrollee is not satisfied with the DMS EPB's decision, the Enrollee, or Enrollee's authorized representative, may request a State Fair Hearing. WellCare has 30 days to address the grievance and communicate with the Enrollee regarding the resolution.

Grievance Submission

An oral grievance request shall be filed through the established toll-free number to the WellCare Customer Service Department. An oral request may be followed up with a written request by the Enrollee, but the time frame for resolution begins the date the oral filing is received by WellCare. A written Provider grievance shall be mailed directly to WellCare's Grievance Department at:

WellCare of Kentucky
Attention: Grievance Department
13551 Triton Park Blvd., Suite 1200
Louisville, KY 40253

For the submission address, telephone and fax number, please refer to the Quick Reference Guide at ***wellcareky.com/providers****.*

Within five working days of receipt of a grievance, WellCare will provide the Enrollee with written notice that the grievance has been received and the expected date of its resolution.

Grievance Resolution

An Enrollee or Enrollee's representative shall be notified of the decision as expeditiously as the case requires, based on the Enrollee's health status, but no later than 30 calendar days after the date WellCare receives the oral or written grievance, consistent with applicable federal law. Unless an extension is elected, WellCare will send a closure letter upon resolution of the Enrollee's grievance.

An extension may be requested up to 14 calendar days by the Enrollee's or the Enrollee's representative. WellCare may also initiate an extension if it can justify the need for additional information and it is in the Enrollee's best interest. In all cases, extensions must be well-documented. WellCare will provide the Enrollee or the Enrollee's representative written notification regarding WellCare's decision to extend the time frame within two working days with the decision to extend the time frame of the grievance resolution.

Grievance and Appeal Files

All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the Department or its designee, upon request, for review. Grievance or appeal files shall be retained for 10 years following the final decision by WellCare, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

Files will contain sufficient information to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the Enrollee of receipt of the grievance or appeal, all correspondence between WellCare and the Enrollee, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the Enrollee and all other pertinent information. Documentation regarding the grievance shall be made available to the Enrollee, if requested.

Section 8: Compliance

WellCare's Compliance Program

Overview

WellCare maintains a Corporate Compliance Program (Compliance Program) that promotes ethical conduct in all aspects of the company's operations, and ensures compliance with WellCare policies, and applicable federal and state regulations. The Compliance Program includes information regarding WellCare's Policies and Procedures related to fraud, waste and abuse, and provides guidance and oversight as to the performance of work by WellCare, WellCare employees, contractors (including delegated entities) and business partners in an ethical and legal manner. All Providers, including Provider employees and Provider subcontractors and their employees, are required to comply with WellCare Compliance Program requirements.

International Classification of Diseases (ICD)

ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). WellCare utilizes ICD for diagnosis code validation and follows all CMS mandates for any future ICD changes, which includes ICD-10 or its successor.

*All Providers must submit HIPAA compliant diagnoses codes ICD-10-CM. Please refer to the CMS website for more information about ICD-10 codes at **www.cms.gov**, and the ICD-10 Lookup Tool at **cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup** for specific codes.*

*Information on ICD-10 transition and codes can also be found at **www.wellcare.com/kentucky/Providers/ICD10-Compliance**.*

WellCare's compliance training requirements include, but are not limited to:

- *Compliance Program Training*
  - *To ensure policies, procedures and related compliance concerns are clearly understood and followed.*
  - *To provide a mechanism to report suspected violations and disciplinary actions to address violations.*
- *HIPAA Privacy and Security Training*
  - *To encompass privacy and security requirements in accordance with the federal standards established pursuant to HIPAA.*
  - *Must include, but is not limited to:*
    - *Uses and disclosures of PHI;*
    - *Enrollee rights; and*
    - *Administrative, physical and technical safeguards.*
- *Fraud, Waste and Abuse (FWA) Training*
  - *Must include, but is not limited to:*
    - *Laws and regulations related to fraud, waste and abuse (for example, False Claims Act, Anti-Kickback Statute, HIPAA, etc.);*
    - *Obligations of the Provider, including Provider employees and Provider subcontractors and their employees, to have appropriate policies and procedures to address fraud, waste and abuse;*

        - *Process for reporting suspected fraud, waste and abuse;*
        - *Protections from retaliation for employees and subcontractors who report suspected fraud, waste and abuse; and*
        - *Types of fraud, waste and abuse that can occur.*
- *Cultural Competency Training*
    - *Programs to educate and identify the diverse cultural and linguistic needs of the Enrollees that Providers serve.*
- *Disaster Recovery and Business Continuity*
    - *Development of a Business Continuity Plan that includes the documented process of continued operations of the delegated functions in the event of a short-term or long-term interruption of services.*

Providers, including Provider employees and/or Provider subcontractors, must report to WellCare any suspected fraud, waste or abuse, misconduct or criminal acts by WellCare, or any Provider, including Provider employees and/or Provider subcontractors, or by WellCare Enrollees. Reports may be made anonymously through the Fraud, Waste and Abuse Hotline at ***1-866-685-8664****.*

Details of the Corporate Ethics and Compliance Program may be found at centene.com/who-we-are/ethics-and-integrity.

Code of Conduct and Business Ethics

Overview

WellCare has established a Code of Conduct and Business Ethics that outlines ethical principles to ensure that all business is conducted in a manner that reflects an unwavering allegiance to ethics and compliance. Details of the Corporate Ethics and Compliance Program may be found at centene.com/who-we-are/ethics-and-integrity.

The Code of Conduct and Business Ethics (the Code) is the foundation of iCare, WellCare's Corporate Ethics and Compliance Program. It describes WellCare's firm commitment to operating in accordance with the laws and regulations governing WellCare's business and accepted standards of business integrity. All Providers should familiarize themselves with WellCare's
Code of Conduct and Business Ethics. Participating Providers and other contractors of WellCare are encouraged to report compliance concerns and any suspected or actual misconduct. Report suspicions of Fraud Waste and Abuse by calling the Fraud, Waste and Abuse Hotline at ***1-866-685-8664****.*

Fraud, Waste and Abuse

WellCare is committed to the prevention, detection and reporting of healthcare fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements. WellCare has developed an aggressive, proactive fraud and abuse program designed to collect, analyze and evaluate data in order to identify suspected fraud and abuse. Detection tools have been developed to identify patterns of healthcare service use, including overutilization, unbundling, upcoding, misuse of modifiers and other common schemes.

Federal and state regulatory agencies, law enforcement and WellCare vigorously investigate incidents of suspected FWA. Providers are cautioned that unbundling, fragmenting, upcoding and other activities designed to manipulate codes contained in the International Classification

of Diseases (ICD), Physicians' Current Procedural Terminology (CPT) 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.

Participating Providers must be in compliance with all CMS rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicaid managed care organization meet annual compliance and education training requirements with respect to FWA. To meet federal regulation standards specific to Fraud, Waste and Abuse (§ 423.504), Providers and their employees must complete an annual FWA training program.

To report suspected fraud and abuse, please refer to the Quick Reference Guide at ***wellcareky.com/providers*** *or call WellCare's confidential and toll-free compliance hotline. Details of the Corporate Ethics and Compliance Program, and how to contact the Fraud, Waste and Abuse Hotline, may be found at centene.com/who-we-are/ethics-and-integrity.*

Confidentiality of Enrollee Information and Release of Records

Medical records should be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules and regulations and shall not be released without the written authorization of the Enrollee or an Enrollee's legal guardian or authorized representative . All consultations or discussions involving the Enrollee or her or his case should be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the HIPAA privacy and security rules and regulations, as may be amended. All Provider practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure there is a procedure or process in place for maintaining the confidentiality of Enrollees' medical records and other PHI and that the practice is following those procedures and/or obtaining appropriate authorization from Enrollees to release information or records where required by applicable state and federal law. Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI. Employees who have access to Enrollee records and other confidential information are required to sign a Confidentiality Statement.

When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis. Providers and community mental health programs must obtain written consent from the Enrollee to release information to coordinate care regarding primary care and mental health services or substance abuse services or both.

Providers shall provide documentation of all instances in which consent was not given, and if possible, the reason why, and submit this information to WellCare on each occurrence but no later than thirty (30) calendar days following the end of the fiscal year.

WellCare will share medical record information, as appropriate, with network providers and care coordinators.

Every Provider practice is required to provide Enrollees with a Notice of Privacy Practices (NPP). The NPP advises Enrollees how the Provider practice may use and share an Enrollee's PHI and how an Enrollee can exercise their health privacy rights. HIPAA provides for the release of Enrollee medical records to WellCare for payment and quality purposes, and/or health plan operations. HIPAA regulations require each covered entity, such as healthcare Providers, to provide a NPP to each new patient or Enrollee.

Some examples of confidential information include:

- *Medical records;*
- *Communication between an Enrollee and a Provider regarding the Enrollee's medical care and treatment;*
- *All personal and/or Protected Health Information as defined under the federal HIPAA privacy regulations, and/or other state or federal laws;*
- *Any communication with other clinical persons involved in the Enrollee's health, medical and mental care (for example, diagnosis, treatment and any identifying information such as name, address, Social Security Number (SSN), etc.);*
- *Enrollee transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem; and*
- *Any communicable disease, such as AIDS or HIV testing that is protected under federal or state law.*

Refer to Section 3: Quality Improvement for guidance in responding to WellCare's requests for Enrollee health records for the purposes of treatment, payment and healthcare activities.

Medical Records Transfer for New Enrollees

When an Enrollee changes primary care providers, upon request, his or her medical records or copies of medical records must be forwarded to the new primary care provider within ten (10) business days from receipt of request or prior to the next scheduled appointment to the new primary care provider whichever is earlier.

All PCPs are required to document in the Enrollee's medical record attempts to obtain historical medical records for all newly assigned WellCare Enrollees. If the Enrollee or Enrollee's guardian is unable to enroll where they obtained medical care, or they are unable to provide addresses of the previous providers, then this should also be noted in the medical record.

Medical Records Audits

WellCare may conduct random medical record audits as part of its Quality Improvement Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to Enrollees, including over/under utilization of specialists, as well as the outcome of such services also may be assessed during a medical record audit. WellCare will provide written notice prior to conducting a medical record review.

Access to Records and Audits by WellCare

Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit WellCare or its designated representative access to Provider's Records, at Provider's place of business in this State during normal business hours, or remote access of such Records, in order to audit, inspect, review, perform chart reviews, and duplicate such Records. If performed on site, access to Records for the purpose of an audit shall be scheduled at mutually agreed upon times, upon at least thirty (30) business days prior written notice by WellCare or its designated representative, but not more than sixty (60) days following such written notice.

EMR Access

Provider will grant WellCare access to Provider's Electronic Medical Record (EMR) system in order to effectively case manage Enrollees and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to WellCare for this access.

Disclosure of WellCare Information to WellCare Enrollees

Periodically, Enrollees may inquire as to the operational and financial nature of their health plan. WellCare will provide that information to the Enrollee upon request. Enrollees can request the above information orally or in writing.

For more information on how to request this information, Enrollees may contact WellCare's Customer Service Department using the toll-free telephone number found on the Enrollee's ID card. Providers may contact WellCare's Customer Service Department by referring to the Quick Reference Guide at ***wellcareky.com/providers****.*

Provider Education and Outreach

Providers may:

- *Display state-approved, WellCare-specific materials in-office;*
- *Announce a new affiliation with a health plan; and*
- *Co-sponsor events such as health fairs and advertise indirectly with a health plan via television, radio, posters, flyers and print advertisement.*

Providers are prohibited from:

- *Orally, or in writing, comparing benefits or Provider networks among health plans, other than to confirm their participation in a health plan's network;*
- *Furnishing lists of their Medicaid patients to any health plan with which they contract, or any other entity;*
- *Furnishing health plans' membership lists to the health plan, including WellCare, or any other entity; and*
- *Assisting with health plan enrollment.*

All subcontractors and Providers must submit any marketing or information materials that refer to WellCare by name to WellCare for approval prior to disseminating the materials.

Section 9: Delegated Entities

Overview

WellCare may, by written contract, delegate certain functions under WellCare's contracts with CMS and/or applicable State governmental agencies. These functions include, but are not limited to, contracts for administration and management services, sales and marketing, utilization management, quality management, case management, disease management, claims processing, credentialing, network management, Provider appeals, and customer service. WellCare may delegate all or a portion of these activities to another entity (a Delegated Entity). WellCare oversees the provision of services provided by the Delegated Entity and/or sub-delegate and is accountable to federal and state agencies for the performance of all delegated functions. It is the sole responsibility of WellCare to monitor and evaluate the performance of the delegated functions to ensure compliance with regulatory requirements, contractual obligations, accreditation standards and WellCare policies and procedures.

Delegation Oversight Process

WellCare's Delegation Oversight Committee (DOC) was formed to be the governing body for the delegation oversight process, which provides oversight of subcontracted vendors where specific services are delegated. WellCare defines a "delegated entity" as a subcontractor which performs a core function under one of WellCare's government contracts. The Delegation Oversight Committee is chaired by the Director, Corporate Compliance Oversight. The committee Enrollees include appointed representatives from the following areas: Corporate Compliance, Legal, Shared Services Operations, Clinical Services Organization, and market representatives from each Regional Area. The Chief Compliance Officer has ultimate authority as to the composition of the Delegation Oversight Committee membership. The Delegation Oversight Committee will hold monthly meetings or more frequently as circumstances dictate.

Refer to Section 8: Compliance for additional information on compliance requirements.

WellCare monitors compliance through the delegation oversight process and the Delegation Oversight Committee by:

- *Validating the eligibility of proposed and existing Delegated Entities for participation in the Medicaid and Medicare programs*
- *Conducting pre-delegation audits and reviewing the results to evaluate the prospective entity's ability to perform the delegated function*
- *Providing guidance on written agreement standards with Delegated Entities to clearly define and describe the delegated activities, responsibilities, and required regulatory reports to be provided by the entity*
- *Conducting ongoing monitoring activities to evaluate an entity's performance and compliance with regulatory requirements and accreditation standards*
- *Conducting annual audits to verify the entity's performance and processes support sustained compliance with regulatory requirements and accreditation standards.*
- *The development and implementation of Corrective Action Plans (CAPs) if the Delegated Entity's performance is substandard or terms of the agreement are violated*
- *Review and initiate recommendations to Senior Management and the Chief Compliance Officer for the revocation and/or termination of those entities not performing to the expectations of the current contractual agreement and regulatory requirements*

- *Track and trend compliance with oversight standards, entity performance, and outcomes*

Section 10: Behavioral Health

Overview
WellCare provides Behavioral Health benefits for Medicaid plans. All provisions contained within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Authorization Requests
Behavioral Health inpatient and residential services can be requested by calling our Pre-Certification Team. Providers requesting after-hours authorization for these admissions should refer to the Quick Reference Guide at ***wellcareky.com/providers*** *or call* ***1-855-620-1861*** *to contact an after-hours Care Manager.*

Requests for other services can be requested using WellCare's standardized authorization request forms to ensure receipt of all pertinent information and enable a timely response to Provider requests. Behavioral Health Request Forms can be found on WellCare's Provider website.

Providers may also submit authorization requests using the universal Prior Authorization form available on the WellCare website.

Prior Authorization
Services requiring Prior Authorization must be authorized prior to the service being rendered. Please Enrollee to consult the authorization look-up tool on the provider portal and obtain appropriate Prior Authorization. Failure to obtain Prior Authorization where required may result in denial of the claim.

Requests for Prior Authorization may be submitted up to 14 business days prior to the planned admission or procedure. Once a procedure is approved, the approval is valid for up to 90 days from the date of issuance.

After-Hours Utilization Management
WellCare Behavioral Health provides authorization of inpatient admissions 24 hours a day, seven days a week. Providers requesting after-hours authorization for inpatient admission should refer to the Quick Reference Guide at ***wellcareky.com/providers*** *or call* ***1-855-620-1861*** *to contact an after-hours Care Manager.*

Behavioral Health Program
WellCare's Behavioral Health Program incorporates the following core values for Medicaid Enrollees:

- *Enrollees have the right to retain the fullest control possible over their behavior health treatment. Behavioral Health Services shall be responsive, coherently organized, and accessible to those who require behavioral healthcare.*
- *WellCare shall provide the most normative care in the least restrictive setting and serve Enrollees in the community to the greatest extent possible.*
- *WellCare shall measure Enrollees' satisfaction with the services they receive.*

- *WellCare's Behavioral Health Services shall be trauma-informed, recovery and resiliency focused.*

WellCare's Behavioral Health Program ensures compliance with the Mental Health Parity and Addiction Equity Act of 2008 and 42 C.F.R. 438 Subpart K, including the requirements that treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by WellCare and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

Some Behavioral Health services may require Prior Authorization including those services provided by non-participating providers. WellCare uses InterQual® criteria, a well-known and nationally accepted guidelines for assessing level of care criteria. In addition, WellCare utilizes Level of Care Utilization System (LOCUS); for children: Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children: Early Childhood Service Intensity Instrument (ECSII); and for substance use: American Society of Addiction Medicine (ASAM).

For complete information regarding benefits, exclusions and authorization requirements, or if a Provider needs to contact WellCare's Provider Services for a referral to a behavioral health Provider, please refer to the Quick Reference Guide at ***wellcareky.com/providers****.*

Responsibilities of Behavioral Health Providers

WellCare monitors Providers against the standards below to ensure Enrollees can obtain needed health services within the acceptable appointments waiting times. The provisions below are applicable only to behavioral health Providers and do not replace the provisions set forth in Section 2: Provider and Enrollee Administrative Guidelines for medical Providers. Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare.

Type of Appointment	*AccessStandard*
Behavioral Health Provider – Non-Life-Threatening Emergency	*< 6 hours*
Behavioral Health Provider – Crisis Stabilization	*< 24 hours*
Behavioral Health Provider – Urgent	*< 48 hours*
Behavioral Health Provider – Post Inpatient Psychiatric Discharge	*< 7 days*
Behavioral Health Provider – Regular Appointments	*< 30 days*
Behavioral Health Provider – Other Referrals	*< 30 days*

All Enrollees receiving inpatient psychiatric services must be scheduled for psychiatric outpatient follow-up and/or continuing treatment, prior to discharge, which includes the specific time, date, place and name of the Provider to be seen. The outpatient treatment must occur within seven days from the date of discharge.

In the event that an Enrollee misses an appointment, the behavioral health Provider must contact the Enrollee within 24 hours to reschedule.

Behavioral health Providers are expected to assist Enrollees in accessing emergent, urgent and routine behavioral services as expeditiously as the Enrollee's condition requires. Appointment and waiting times shall not exceed 30 days for regular appointments and 48 hours for urgent care. Enrollees also have access to a toll-free behavioral crisis hotline that is staffed 24 hours a day. The behavioral crisis phone number is ***1-855-661-6973*** *and printed on the Enrollee's ID card and is available on WellCare's website.*

Discharge Planning

Discharge planning begins upon admission and is designed for early identification of psychiatric, psychosocial and/or medical issues that will need post-hospital intervention. The Behavioral Healthcare Manager works with the Provider's utilization reviewer to identify the Enrollee's issues and needs, and makes appropriate referrals to Field Case Management, or Discharge Coordinators, as appropriate to coordinate care and post-discharge services and to facilitate a smooth transfer of the Enrollee to the appropriate level of care.

Readmission

If an Enrollee is readmitted to the hospital after being discharged from a psychiatric stay for the same or related problem within 24 hours of discharge for the same diagnosis, it is considered the same admission.

Medication

Behavioral Health service Providers must assist Enrollees in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.

For information about WellCare's Care Management and Disease Management Programs, including how to refer an Enrollee to these services, please see Section 4: Utilization Management (UM), Care Management (CM) and Disease Management (DM).

All Behavioral Health services shall be provided in conformance with the access standards established by the Department of Medicaid Services. When assessing Enrollees for Behavioral Health services, the plan and its Providers shall use the most current version of DSM classification. The plan may require use of other diagnostic and assessment instrument/outcome measures in addition to the most current version of DMS. Providers shall document DSM diagnosis and assessment/outcome information in the Enrollee's medical record.

Provider Education

WellCare of Kentucky works with Community Mental Health Program partners to expand suicide prevention efforts and increase awareness through the use of nationally recognized programs including Mental Health First Aid (MHFA) and ZeroSuicide. To learn more about WellCare's Mental Health First Aid Training Program and leadership seminars in ZeroSuicide practices, contact your Provider representative.

Continuity and Coordination of Care Between Medical and Behavioral Healthcare

WellCare will work with PCPs to ensure appropriate screening and evaluation procedures for the detection and treatment of or referral for any known or suspected behavioral health problems. PCPs may provide any clinically appropriate Behavioral Health services within the scope of their

practice. Conversely, behavioral health Providers may provide physical healthcare services if and when they are licensed to do so within the scope of their practice. However, if they are unable to treat the Enrollee's physical health, behavioral health Providers should refer Enrollees with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Enrollee's or the Enrollee's legal guardian's consent.

Behavioral health Providers are required to submit, with the Enrollee's or Enrollee's legal guardian's consent, an initial and quarterly summary report of the Enrollee's behavioral health status to the PCP. This requirement shall be specified in all SBIRTs. Communication with the PCP should occur more frequently if clinically indicated. WellCare encourages behavioral health Providers to pay particular attention to communicating with PCPs at the time of discharge from an inpatient hospitalization (WellCare recommends faxing the discharge instruction sheet, or a letter summarizing the hospital stay, to the PCP). Please send this communication, with the properly signed consent, to the Enrollee's identified PCP noting any changes in the treatment plan on the day of discharge.

WellCare strongly encourages open and timely communication between PCPs and behavioral health Providers. If an Enrollee's medical or behavioral condition changes, WellCare expects that both PCPs and behavioral health Providers will communicate those changes to each other, especially if there are any changes in medications that need to be discussed and coordinated between Providers.

Section 11: Pharmacy

Overview

WellCare's pharmaceutical management procedures are an integral part of the Pharmacy Program that ensure and promote the utilization of the most clinically appropriate agent(s) to improve the health and well-being of its Enrollees. The utilization management tools that are used to optimize the pharmacy program include:

- *Preferred Drug List (PDL)*
- *Step Therapy*
- *Quantity Limit*
- *Age Limit*
- *Pharmacy Lock-In Program*
- *Coverage Determination Review Process*
- *Network Improvement Program (NIP)*

These processes are described in detail below. In addition, prescriber and enrollee involvement is critical to the success of the Pharmacy Program. To help patients get the most out of their pharmacy benefit, providers are encouraged to consider the following guidelines when prescribing:

- *Follow national standards of care guidelines for treating conditions i.e., National Institutes of Health (NIH) Asthma Guideline, Joint National Committee (JNC) VIII Hypertension Guidelines*
- *Prescribe drugs listed on the PDL*
- *Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class*
- *Evaluate medication profiles for appropriateness and duplication of therapy*

WellCare uses the statewide Pharmacy Benefit Manager, MedImpact, to administer the pharmacy benefits. MedImpact will process pharmacy claims and prior authorizations for all Kentucky Medicaid Managed Care Organizations.

Pursuant to Section 1903(i) of the Social Security Act, all handwritten or computer generated/printed Medicaid prescriptions shall require one or more approved industry-recognized tamper-resistant features to prevent all three of the following:

1. *Copying of a completed or blank prescription form;*
2. *Erasure or modification of information written on the prescription pad by the prescriber; AND*
3. *Use of counterfeit prescription forms.*

This requirement does not pertain to prescriptions received by fax, telephone, or electronically.

*To contact WellCare's Pharmacy Department, please refer to the Quick Reference Guide at **wellcareky.com/providers**.*

*To contact MedImpact, the Pharmacy Benefit Manager (PBM) for WellCare and all managed care organizations, please refer to the MedImpact website at **kyportal.medimpact.com**.*

Preferred Drug List

For WellCare Medicaid, WellCare will adopt the Agency's Medicaid Preferred Drug List (PDL) and provide all prescription drugs and dosage forms listed therein.

The PDL is a published prescribing reference and clinical guide of prescription drug products selected by the Department for Medicaid Services Pharmaceutical and Therapeutics Committee (P&T Committee). WellCare shall participate in the Agency's Pharmaceutical and Therapeutics Committee, as requested by the Agency. The PDL denotes any of the pharmacy utilization management tools that apply to a particular pharmaceutical.

Drugs are selected based on the drug's efficacy, safety, side effects, pharmacokinetics, clinical literature and cost-effectiveness profile. The medications on the PDL are organized by therapeutic class, product name, strength, form and coverage details (quantity limit, age limitation, Prior Authorization and step therapy).

WellCare's Preferred Drug List (PDL) contains information for pharmaceutical management procedures including:

- *A list of covered pharmaceuticals, including restrictions and preferences, copayment information, if applicable.*
- *How to use the pharmaceutical management procedures including the prior authorization process and an explanation of limits or quotas on refills, doses & prescriptions.*
- *How to submit an exception request.*
- *The process for generic substitution, therapeutic interchange and step-therapy protocols.*

The Preferred Drug List (PDL) and pharmaceutical management edits are posted on WellCare's website. The availability of the current PDL is communicated to Enrollees and providers through the Enrollee and provider newsletter or other materials such as a postcard. Major changes in drug coverage and pharmaceutical management edits are communicated to providers and Enrollees by direct mail (e.g. fax, email, mail) as needed. All pharmaceutical management edits and coverage limitations meet State specific requirements, and any variances are preapproved by the individual State Medicaid Programs, where required.

The PDL is available on MedImpact's website at ***kyportal.medimpact.com.*** *Practitioners may call 1-800-210-7628 to receive a copy of the pharmaceutical management procedures and updates by mail, fax or email.*

To request consideration for the inclusion of a drug to WellCare's PDL, providers may contact MedImpact at ***1-800-210-7628****.*

For more information on requesting exceptions, refer to the Coverage Determination Review Process below.

Generic Medications

The use of generic medications is a key pharmaceutical management tool. Generic drugs are equally effective and generally less costly than their brand-name counterparts. Their use can contribute to cost-effective therapy.

Generic medications must be dispensed by the pharmacist when available as the therapeutic equivalent to a brand-name drug, unless the brand-name drug is preferred on the PDL.

Step Therapy

Step therapy programs are developed by the P&T Committee. These programs are designed to encourage the use of therapeutically equivalent, lower-cost medication alternatives (first-line therapy) before stepping up to less cost-effective alternatives.

Step therapy programs are a safe and effective method of reducing the cost of treatment by ensuring that an adequate trial of a proven, safe and cost-effective therapy is attempted before progressing to a more costly option. First-line medications are recognized as safe, effective and economically sound treatments. The first-line medications on the Kentucky Medicaid Pharmacy Program Single PDL have been evaluated through the use of clinical literature and are approved by the Department for Medicaid Services P&T Committee.

Medications requiring step therapy are identified on the PDL.

Quantity Limits

Quantity limits are used to ensure that pharmaceuticals are supplied in a quantity consistent with the Food and Drug Administration (FDA)-approved dosing guidelines. Quantity limits are also used to help prevent billing errors.

The PDL identifies medications with quantity limits.

Age Limits

Some drugs have an age limit associated with them. Age limits help ensure proper medication utilization and dosage, when necessary.

The PDL identifies medications with age limits.

Pharmacy Lock-In Program

Enrollees identified as overutilizing drugs in certain therapeutic classes, receiving duplicative therapy from multiple physicians or frequently visiting the Emergency Room seeking pain medication will be placed in Pharmacy Lock-in (Lock-in) status for a minimum of one year. While in Lock-in, the enrollee will be restricted to one prescriber and one pharmacy to obtain their controlled substance medications. Claims submitted by other prescribers or other pharmacies will not be paid for the enrollee. Enrollees identified will also be referred for Care Management. The Care Management team will work with the enrollee to create an individualized Care Plan. Care managers provide monitoring, education, communication and collaboration, and can assist with access to alternative treatments to improve an enrollee's health. For questions or concerns regarding the Lock-in program, Enrollees or Providers may call ***1-877-389-9457*** *(TTY* ***711****), Monday–Friday, 7 a.m. to 7 p.m. Eastern Time.*

Coverage Determination Review Process

The goal of the Coverage Determination Review Program (also known as Prior Authorization) is to ensure that medication regimens that are high-risk, have high potential for misuse or have narrow therapeutic indices are used appropriately and according to FDA-approved indications. The program also ensures there is no undue disruption of an Enrollee's access to care and prevents the penalization of the provider or the enrollee, financially or otherwise, for prior authorization requests or approvals. The Coverage Determination Review Process is required for:

- *Duplication of therapy*
- *Prescriptions that exceed the FDA daily or monthly quantity limit*
- *Most self-injectable and infusion medications (including chemotherapy)*
- *Drugs not listed on the PDL*
- *Drugs that have an age edit*
- *Drugs listed on the PDL but still requiring Prior Authorization*
- *Brand-name drugs when a generic exists, unless the brand is preferred*
- *Drugs that have a step therapy edit and the first-line therapy is inappropriate*

The Coverage Determination Review Program also ensures that:

- *Clinical review criteria is aligned with FDA approved indications, best clinical practice standards, and/or other national standards*
- *A physician peer review shall be available upon a provider's request for any denial*
- *Determinations including those from escalated reviews shall be made and communicated to the requesting provider within 24 hours from the initial request including weekends in compliance with the provisions of OBRA 1990 mandate, Section 1927 of the Social Security Act, and other federal regulations*
- *In the event a prescription is for a drug awaiting authorization and the pharmacy cannot reach the prescribing physician, and when the dispensing pharmacist using reasonable clinical judgment deems it necessary to avoid imminent harm or injury to the enrollee, a 72-hour emergency supply shall be provided. If the physician prescribed an amount of drug that is less than a 72-hour supply but is packaged so that it must be dispensed intact, the pharmacist may dispense the packaged drug and contractor shall pay for this quantity even if it exceeds a calculated 72-hour supply.*

Providers may request an exception to the Kentucky Medicaid Pharmacy Program Single PDL orally or in writing. For written requests, Providers should complete the Universal Prior Authorization Form, supplying pertinent enrollee medical history and information. The Universal Prior Authorization Form may be accessed at ***wellcareky.com/providers/medicaid/forms*****.**

To submit a request, orally or in writing, refer to the contact information listed on the Provider Quick Reference Guide at ***wellcareky.com/providers****. Upon receipt of the Coverage Determination Request Form, a decision is completed within 24 hours. If authorization cannot be approved or denied, and the drug is Medically Necessary, a three day emergency supply of the non-preferred drug can be supplied to the Enrollee.*

Prior Authorization protocols are developed and reviewed at least annually by the P&T Committee. These protocols indicate the criteria that must be met in order for the drug to be authorized (for example, specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.). The criteria are available upon request when submitted to the Pharmacy Department by the enrollee or provider.

Injectable and Infusion Services

Select self-injectable and infusion drugs may be covered under the outpatient pharmacy benefit. A list of covered drugs can be found on the PDL. Other infusion drugs may be covered by the medical benefit. Most self-injectable products and all infusion drug requests covered by the medical benefit require a Coverage Determination Request Review using the Injectable Infusion Form.

Approved self-injectable and infusion drugs are covered when supplied by retail pharmacies and infusion vendors contracted with WellCare. Please contact the Pharmacy Department regarding criteria related to specific drugs. The Injectable Infusion Form is at ***wellcareky.com/providers****.*

Medication Appeals

To request an appeal of a Coverage Determination Review decision, contact the Pharmacy Appeals Department via fax, mail, or by phone. Refer to the Quick Reference Guide at ***wellcareky.com/providers****.*

Once the appeal of the Coverage Determination Review decision has been properly submitted and obtained by MedImpact, the request will follow the appeals process described in Section 7: Appeals and Grievances.

Coverage Limitations

The following is a list of non-covered (excluded from the Medicaid benefit) drugs and/or categories:

- *Agents used for anorexia, weight gain or weight loss*
- *Agents used to promote fertility*
- *Agents used for cosmetic purposes or hair growth*
- *Drugs for the treatment of erectile dysfunction*
- *DESI drugs or drugs that may have been determined to be identical, similar or related*
- *Investigational or experimental drugs*
- *Agents prescribed for any indication that is not medically accepted*

WellCare will not reimburse for prescriptions for refills too soon, duplicate therapy or excessively high dosages for the Enrollee.

Over-the-Counter Medications

Over the counter (OTC) items listed on the PDL or OTC list require a prescription. For a complete listing, please refer to the PDL at ***kyportal.medimpact.com****.*

In addition to OTC products listed on the PDL, each household is able to order up to $25 worth of Health and Wellness items in WellCare's catalog on a monthly basis free of charge. The catalog and directions for ordering are available at ***wellcareky.com/Enrollees/medicaid/benefits****.*

Pharmacy Management – Provider Education Program

The Pharmacy Provider Education Program (PEP) is designed to provide physicians with quarterly utilization reports to identify overutilization and underutilization of pharmaceutical products. The reports will also identify opportunities for optimizing best practices guidelines

and cost-effective therapeutic options. These reports are delivered by the State Pharmacy Director and/or Clinical Pharmacy Manager to physicians identified for the program.

Enrollee Pharmacy Access

The PBM maintains a comprehensive network of pharmacies to ensure that pharmacy services are available and accessible to all Enrollees 24 hours a day.

For areas where there are no pharmacies open 24 hours a day, Enrollees may call the PBM (Pharmacy Benefit Manager) for information on how to access pharmacy services. Contact information is on the Quick Reference Guide at ***wellcareky.com/providers****.*

Section 12: Definitions and Abbreviations

Definitions

The following terms as used in this provider manual shall be construed and/or interpreted as follows, unless otherwise defined in the provider contract.

***Abuse** means Provider Abuse and Enrollee Abuse, as defined in KRS 205.8451.*

***Adverse Benefit Determination** means, as defined in 42 CFR 438.400(b), the*

- *Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting or effectiveness of a covered benefit;*
- *Reduction, suspension, or termination of a service previously authorized by the Department, its agent or WellCare;*
- *Denial, in whole or in part, of payment for a service;*
- *Failure to provide services in a timely manner, as defined by Department;*
- *Failure of WellCare or a Prepaid Health Insurance Plan (PHIP) to act within the time frames required by 42 CFR 438.408(b);*
- *For a resident of a rural area with only one MCO, the denial of a Medicaid Enrollee's request to exercise their right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside WellCare's network; or*
- *Denial of an Enrollee's request to dispute a financial liability, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.*

***Appeal** means a request for review of an Adverse Benefit Determination or a decision by or on behalf of WellCare related to the Covered Services provided, or the payment for the service.*

***Authorization** means an approval of a Prior Authorization request for payment of services and is provided only after WellCare agrees the treatment is necessary.*

***Benefit Plan** means a health benefit policy or other health benefit contract or coverage document (a) issued by WellCare, or (b) administered by WellCare pursuant to a Government Contract. Benefit Plans and their designs are subject to change periodically.*

***Carve-Out Agreement** means an agreement between WellCare and a third-party Participating Provider whereby the third party assumes financial responsibility for or may provide certain management services related to particular Covered Services. Examples of possible Carve-Out Agreements include agreements for radiology, laboratory, dental, vision or hearing services.*

***Centers for Medicare & Medicaid Services (CMS)** means the federal agency that administers Medicare, Medicaid and the Children's Health Insurance Program.*

***Clean Claim** means a claim for Covered Services provided to an enrollee that (a) is received timely by WellCare, (b) has no defect, impropriety, or lack of substantiating documentation from the Enrollee's medical record regarding the Covered Services, (c) is not subject to coordination of benefits or subrogation issues, (d) is on a completed, legible CMS 1500 form or UB-04 form or electronic equivalent that follows then current HIPAA Administrative Simplification ASC X12 837 standards and additional WellCare- specific requirements in the*

WellCare Companion Guide, including all then current guidelines regarding coding and inclusive code sets, and (e) includes all relevant information necessary for WellCare to (1) meet requirements of Laws and Program Requirements for reporting of Covered Services provided to Enrollees, and (2) determine payer liability, and ensure timely processing and payment by WellCare. A Clean Claim does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

CLIA *means the federal legislation commonly known as the Clinical Laboratories Improvement Amendments of 1988 as found at Section 353 of the federal Public Health Services Act (42 U.S.C. §§ 201, 263a) and regulations promulgated hereunder.*

Co-Surgeon *means one of multiple surgeons who work together as primary surgeons performing distinct part(s) of a surgical procedure.*

Covered Services *means items and services covered under a Benefit Plan.*

Department *means the Department for Medicaid Services.*

EPSDT *means Early and Periodic Screening, Diagnosis and Treatment Program that provides Medically Necessary healthcare, diagnostic services, preventive services, rehabilitative services, treatment and other measures described in 42 USC Section 1396d(a) to all Enrollees under the age of 21.*

EPSDT Special Services *means Medically Necessary healthcare, diagnostic services, treatment, and other measure described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses, and conditions identified by EPSDT screening services, whether or not such services are covered under the State Medicaid Plan.*

Emergency Medical Condition *means*

- *A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a person with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:*
    - *Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;*
    - *Serious impairment to bodily functions; or*
    - *Serious dysfunction of any bodily organ or part.*
- *With respect to a pregnant woman having contractions:*
    - *That there is an inadequate time to effect a safe transfer to another hospital before delivery; or*
    - *That transfer may pose a threat to the health or safety of the woman or the unborn child.*

Emergency Services *or* ***Emergency Care*** *means covered inpatient and outpatient services that are : (1) furnished by a provider who is qualified to furnish these services; and (2) needed to evaluate or stabilize an emergency medical condition.*

Encounter Data *means encounter information, data and reports for Covered Services provided to an Enrollee that meets the requirements for Clean Claims.*

Enrollee *means an individual who is properly enrolled in a benefit plan and eligible to receive Covered Services when such services are rendered.*

Enrollee Expenses *means co-payments, coinsurance, deductibles or other cost-share amounts, if any, that an Enrollee is required to pay for Covered Services under a benefit plan.*

Enrollees with Special Healthcare Needs *means Enrollees with special needs, defined as adults and children who face daily physical, mental or environmental challenges that place their health at risk and whose ability to fully function in society is limited.*

Grievance *means the definition established in 42 C.F.R. 438.400.*

Ineligible Person *means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) Federal procurement or non-procurement programs, as may be identified in the Excluded Parties List System maintained by the General Services Administration, (b) has been convicted of a criminal offense subject to OIG's mandatory exclusion authority for Federal Health Care Programs described in Section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in state medical assistance programs, including Medicaid or CHIP, or state procurement or non-procurement programs as determined by a State Governmental Authority.*

Kentucky Contract *means the Medicaid Managed Care Contract between the Commonwealth of Kentucky, Finance and Administration Cabinet and WellCare of Kentucky, Inc., and any amendments, including corrections or modifications thereto.*

LTAC *means a Long-Term Acute Care hospital.*

Medically Necessary *or* ***Medical Necessity*** *is as described in Section 4 under Medically Necessary Services.*

Periodicity *means the frequency in which an individual may be screened or re-screened.*

Periodicity Schedule *means the schedule which defines age-appropriate services and time frames for screenings within the Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) Program.*

PCP *or* ***Primary Care Provider*** *means a licensed or certified healthcare practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse, physician assistant, or health clinic, including an FQHC, primary care center, or RHC that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a Provider possessing admitting privileges, and agrees to provide 24 hours a day, seven days a week primary healthcare services to individuals, and for an Enrollee who has a gynecological or obstetrical healthcare needs, disability or chronic illness, is a specialist who agrees to provide and arrange for all appropriate primary and preventive care.*

Prior Authorization *means the process of obtaining authorization in advance of a planned inpatient admission or an outpatient procedure or service. An authorization decision is based on*

clinical information provided with the request. WellCare may request additional information, including a medical record review.

***Provider** means any person (including physicians or other healthcare professionals), partnership, professional association, corporation, facility, hospital, or institution certified, licensed, or registered by the State of Kentucky to provide healthcare services that has contracted with WellCare to provide healthcare services to Enrollees.*

***Screening** means the review of the health and health-related conditions of a recipient by a healthcare professional to determine if further diagnosis or treatment is needed.*

***Service** means healthcare, treatment, a procedure, supply, item or equipment.*

***Service Location** means any location at which an Enrollee may obtain any Covered Services from a Network Provider.*

***WellCare Companion Guide** means the transaction guide that sets forth data requirements and electronic transaction requirements for Clean Claims and encounter data submitted to WellCare or its affiliates, as amended from time to time. The WellCare Claims/Encounter Companion Guides are part of the Provider Manual.*

Abbreviations

AAP – American Academy of Pediatrics

ABD – Aged, Blind or Disabled

ACIP – Advisory Committee on Immunization Practices

ACS – American College of Surgeons

Agreement – Provider Contract

AHP – Allied Health Professionals

AIDS – Acquired Immune Deficiency Syndrome

AMA – American Medical Association

AOR – Appointment of Representative

APRN – Advanced Practice Registered Nurse

ASC – Ambulatory Surgical Centers

CAD – Coronary Artery Disease

CAP – Corrective Action Plan

CHF – Congestive Heart Failure

CHIP – Children's Health Insurance Plan

CLAS – Culturally and Linguistically Appropriate Services

CLIA – Clinical Laboratory Improvement Amendment

CM – Case Management

CMHC – Community Mental Health Center

CMS – Centers for Medicare & Medicaid Services

CNM – Certified Nurse Midwife

COPD – Chronic Obstructive Pulmonary Disease

CPT-4 – Physician's Current Procedural Terminology, 4th Edition

DDE – Direct Data Entry

DEA – Drug Enforcement Administration

Department – Kentucky Cabinet for Health and Family Services, Department for Medicaid Services

DHHS – United States Department of Health and Human Services

DM – Disease Management

DME – Durable Medical Equipment

DOC – Delegation Oversight Committee

DOH – Drivers of Health

DSM– Diagnostic and Statistical Manual of Mental Disorders

EDI – Electronic Data Interchange

EOB – Explanation of Benefits

EOP – Explanation of Payment

EPSDT – Early and Periodic Screening, Diagnosis, and Treatment

ER – Emergency Room

ESRD – End Stage Renal Disease

FDA – Food and Drug Administration

FQHC– Federally Qualified Health Center

FWA – Fraud, Waste and Abuse

HCPCS – Healthcare Common Procedure Coding System

HEDIS – Healthcare Effectiveness Data and Information Set

HIPAA – Health Insurance Portability and Accountability Act of 1996

HIV – Human Immunodeficiency Virus

HMO – Health Maintenance Organization

HRA – Health Risk Assessment

ICD-10-CM – International Classification of Diseases, 10th Revision, Clinical Modification

ICD-10-PCS – International Classification of Diseases, 10th Revision, Procedure Coding System

IEP – Individualized Education Plan

IPAs – Independent Physician Associations

ISHCN – Individuals with Special Health Care Needs

IVR – Interactive Voice Response system

JNC – Joint National Committee

KCHIP – Kentucky Children's Health Insurance Program

LTAC – Long-Term Acute Care

MCO – Managed Care Organization

NCCI – National Correct Coding Initiative

NCQA® – National Committee for Quality Assurance

NDC – National Drug Codes

NIH – National Institutes of Health

NIP – Network Improvement Program

NPI – National Provider Identifier

NPP – Notice of Privacy Practices

OA – Osteopathic Assistant

OB – Obstetrical/Obstetrician

OB-GYN – Obstetrician/Gynecologist

OIG – Office of Inspector General

OT – Occupational Therapy

OTC – Over the Counter

P&T Committee – Pharmaceutical and Therapeutics Committee

PA – Physician Assistant

PCC – Primary Care Clinic

PCP – Primary Care Provider

PDL – Preferred Drug List

PHI – Protected Health Information

PPC – Provider Preventable Condition

Provider ID – Provider Identification

PRTF – Psychiatric Residential Treatment Facility

PT – Physical Therapy

QI Program – Quality Improvement Program

RHC – Rural Health Clinic

SCM – Short-Term Case Management

SFTP – Secure File Transfer Protocol

SIE – Site Inspection Evaluations

SNF – Skilled Nursing Facility

SNIP – Strategic National Implementation Process

SSI – Supplemental Security Income

SSN – Social Security Number

ST – Speech Therapy

TB – Tuberculosis

TIN/Tax ID – Tax Identification Number

TTY – Telephone Typewriter

UM – Utilization Management

VFC – Vaccines for Children

WEDI – Workgroup for Electronic Data Interchange

WIC – Women, Infants and Children Program

Section 13: WellCare Resources

WellCare of Kentucky Homepage
https://www.wellcareky.com/

Provider Manual and Other Provider Resources
https://www.wellcareky.com/providers/medicaid.html

EPSDT Provider Manual
https://www.wellcareky.com/providers/medicaid.html

Forms and Documents https://www.wellcareky.com/providers/medicaid/forms.html

Quick Reference Guide
https://www.wellcareky.com/providers/medicaid.html

Clinical Practice Guidelines
https://www.wellcareky.com/providers/tools/clinical-guidelines.html

Clinical Coverage Guidelines
https://www.wellcareky.com/providers/tools/clinical-guidelines.html

Job Aids and Resource Guides
https://www.wellcareky.com/providers/medicaid.html

Claims Updates
https://www.wellcareky.com/providers/medicaid/claims.html

Pharmacy
https://www.wellcareky.com/providers/medicaid/pharmacy.html
https://kyportal.medimpact.com/

Quality
https://www.wellcareky.com/providers/medicaid/quality.html

Behavioral Health
https://www.wellcareky.com/providers/medicaid/behavioral-health.html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