Provider Orientation

WellCare of Kentucky

WellCare®

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About WellCare

- WellCare Health Plans, Inc. is a family of health plans that works with physicians and other healthcare professionals to provide our members with quality care

- WellCare has over 20 years experience, and is the leading provider of government sponsored health plans such as Medicare, Medicaid, State Children's Health Insurance Program and others

- WellCare is among the largest Medicaid and Medicare only contractor in the nation with approximately 2.2 million members as of December 31, 2010.

- Effective July 7, 2011, WellCare has contracted with the Kentucky Cabinet for Health and Family Services, Department for Medicaid Services (the “Department”) to provide Medicaid and Children’s Health Insurance Plan (CHIP) managed care services in seven (7) of eight (8) of the state’s regions beginning November 1, 2011.

Benefits of Partnership

When you join WellCare, you gain…

- Local market focus – dedicated staff to serve providers in your communities
- Prompt provider payment – receiving claims electronically, processing claims rapidly
- Quality improvement program – patient-focused with an emphasis on preventive care
- Diverse network – selection of experienced and qualified providers who offer multilingual capabilities and cultural competency

Program Overview

- Eligibility for Kentucky's Medicaid program is solely determined by the Kentucky Department for Medicaid Services. 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
  - The individual must qualify to receive Medicaid assistance under one of the aid categories defined by the Department including, but not limited to:
    - Temporary Assistance to Needy Families (TANF)
    - Aged, blind and disabled (ABD)
      - Medicaid only; or
      - Receiving State Supplementation or Supplemental Security Income (SSI)
    - Poverty level pregnant women and children including presumptive eligibility

- For more information on Medicaid assistance, refer to the Kentucky Department for Medicaid Services at http://chfs.ky.gov/dms/.

WellCare Resources

- Providers have access to a variety of easy-to-use reference materials at **www.kentucky.wellcare.com**, including:
  - Resource Guides related to claims, authorizations, EFT and how to contact us
  - Provider Manuals
  - Clinical Practice and Clinical Coverage Guidelines
  - Provider & Pharmacy lookup
  - Quick Reference Guides provide contact information for specific departments and authorization information
  - Provider Training
- By registering for WellCare's Provider Portal, providers have access to member eligibility and co-pay information, authorization requests, claims status and inquiry, a provider inbox to receive specific messages from WellCare and provider training.
- Provider Relations representatives are available to assist in many requests for participating WellCare providers. Contact your local market office for assistance.

Provider Responsibilities

- All participating providers are responsible for adhering to the Participation Agreement and the Provider Manual.
- The Provider Manual supplements the Agreement and provides information such as:
  - Credentialing and Re-Credentialing requirements
  - Access and availability, including after-hours coverage
  - Safeguarding member confidentiality in compliance with HIPAA
  - Medical records requirements such as record retention timeframes and Advance Directive & Living Wills documentation
  - Mandatory participation in Quality Improvement projects and medical record review activities such as HEDIS® and the Department's External Quality Review Organizations (EQRO)
  - Assisting members with special health care needs, including mental, developmental and physical disabilities and/or environmental risk factors
  - Adhering to WellCare's compliance requirements
- For more information on Provider rights and responsibilities, refer to the Provider Manual.

Member Rights

- Member rights are outlined in the Member Handbooks, which are mailed to all newly enrolled members.

- Member rights include, but are not limited to, the right to:
  - Be treated with fairness, respect and dignity
  - Have the availability of language designated materials, hearing-impaired interpreter and sign language services
  - To make complaints about WellCare or the care provided
  - To appeal medical or administrative decisions WellCare has made by using the grievance process
  - A Women's Health Specialist for female members

- For more information on Member Rights, refer to the Provider Manual.

Member Responsibilities

Members are responsible for:

- Telling their PCP and other health care providers that they are enrolled in WellCare.
- Providing their PCP and other providers the information they need to care for them, and to follow the treatment plans and instructions that they and their providers agree upon.
- Becoming familiar with their benefit coverage and the rules they must follow to get care as a member.
- Informing WellCare if they have any other health insurance coverage.
- Paying their plan premiums and any co-payments or coinsurance.
- Informing WellCare about their concerns, problems or suggestions by calling Customer Service.

❑ For more information on Member Rights, refer to the Provider Manual.

WellCare's Compliance Program

- All providers, including provider employees and sub-contractors, their employees, and delegated entities are required to comply with WellCare compliance program requirements.

- WellCare's compliance requirements include, but are not limited to, the following:
  - Provider Training Requirements
  - Limitations on Provider Marketing
  - Code of Conduct and Business Ethics
  - Cultural Competency and sensitivity
  - Fraud, Waste and Abuse
  - Americans with Disabilities Act (ADA)

- For more information on WellCare's Compliance program, refer to the Provider Manual.

Covered Services

- Covered Services currently provided to WellCare's Kentucky Medicaid members include, but are not limited to:
  - Behavioral Health Services
  - Dental Services
  - Early and Periodic Screening, Diagnosis & Treatment (EPSDT)
  - Family Planning
  - Inpatient Services
  - Outpatient Services
  - Pharmacy 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.
- For more information on Covered Services, refer to the WellCare Provider Manual. Or you may access the Department's administrative regulations, 907 KAR, online at http://www.lrc.ky.gov/kar/TITLE907.HTM.

Covered Services - EPSDT

- Providers will be sent a monthly membership list which specifies the health assessment for eligible children who have not had an encounter within 120 days of joining the plan or are not in compliance with the EPSDT Program.
- Any provider who provides Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening service are responsible for:
  - Monitoring, tracking and following up with members:
    - Who have not had a health assessment screening
    - Who miss appointments to assist them in obtaining an appointment
    - To ensure they receive the necessary medical services
  - Ensuring members receive the proper referrals to treat any conditions or problems identified during the health assessment.
  - Assisting members with transition to other appropriate care for children who age-out of EPSDT services.
- The Provider's compliance with member monitoring, tracking and follow-up, will be assessed through random Medical Record Review audits conducted by the WellCare Quality Improvement Department and corrective action plans will be required for providers who are below 80 percent compliance with all elements of the review.
- For more information on EPSDT Covered Services or the periodicity schedule, refer to the Provider Manual and the Pediatric Preventive Health Care Guidelines at www.kentucky.wellcare.com. Or for more information on the Department's administrative regulations, visit the Department's website at http://chfs.ky.gov/dms/.

Behavioral Health

- All provisions contained within the manual are applicable to medical and behavioral health providers unless otherwise noted in the *Behavioral Health* section of the Provider Manual.
- Coordination and continuity of care between behavioral health care providers and medical care providers is critical to positively influencing member outcomes.
- PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Conversely, behavioral health providers may only provide physical health care services if they are licensed to do so.
- Behavioral health providers are required to:
  - Use the DSM-IV multi-axial classification when assessing member for behavioral health services and document the DSM-IV diagnosis and assessment/outcome information in the member's medical record;
  - Contact the member within twenty-four (24) hours of a missed appointment to reschedule the missed appointment; and
  - Submit, with the member's or member's legal guardian's consent, a summary report of the member's behavioral health status quarterly, at a minimum, to the PCP.
- All members receiving inpatient psychiatric services must be scheduled for outpatient follow-up and/or continuing treatment prior to discharge, and the outpatient treatment must occur within seven (7) days from the date of discharge.
- For more information on behavioral health, refer to the Provider Manual and the Quick Reference Guide.

Pharmacy

- To ensure members receive the most out of their pharmacy benefit, please consider the following guidelines when prescribing:
  - Follow national standards of care guidelines for treating conditions;
  - Prescribe drugs on WellCare's Preferred Drug List (PDL);
  - Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class; and
  - Evaluate medication profiles for appropriateness and duplication of therapy.

- WellCare has pharmaceutical utilization management (UM) tools that are used to optimize the pharmacy program. These UM tools are described in detail in the Provider Manual including:
  - Preferred Drug List (PDL)
  - Drug Evaluation Review (DER) process
  - Mandatory Generic Policy
  - Step Therapy (ST)
  - Quantity Level Limit (QL)
  - Pharmacy Lock-In Program
  - Network Improvement Program (NIP)

Pharmacy (cont.)

Additional important information covered in the Provider Manual includes:

- Non-covered drugs and/or drug categories that are excluded from the Medicaid benefit;
- Over-the-Counter (OTC) items listed on the PDL require a prescription. All other OTC items offered as an expanded benefit by WellCare do not.
- Requesting additions and exceptions to the PDL through the Drug Evaluation Review (DER) process, including information on:
  - How to submit a DER
  - When a DER is required, including, but not limited to:
    - Most self-injectable and infusion medications
    - Drugs not listed on the PDL
    - Drugs listed on the PDL but still require a Prior Authorization
    - Brand name drugs when a generic exists
- Requesting an appeal of a DER request decision.

- For more information on WellCare's Pharmacy program, refer to the Provider Manual, the Quick Reference Guide, and the web for appropriate Forms, Documents and contact information.

Utilization Management (UM)

- WellCare's Utilization Management (UM) program includes review processes such as notifications, referrals, prior authorization, concurrent review and/or retrospective review.
- **Prior Authorization**

  - WellCare requires prior authorization for elective or non-emergency services as designated by WellCare.

  - Reasons for requiring authorization may include:

    - Review for medical necessity
    - Appropriateness of rendering provider
    - Appropriateness of setting
    - Case and Disease Management considerations

  - Decision timeframes are determined by either NCQA requirements, contractual requirements or a combination of both. See the Provider Manual for decision timeframes.

  - Prior authorizations may be requested via fax, phone or online at www.kentucky.wellcare.com. For more information on prior authorizations, and the information necessary to include in your request, refer to the Provider Manual and Quick Reference Guide.

Utilization Management (UM) (cont.)

- **Concurrent Review**
  - Is initiated as soon as WellCare is notified of a member's admission to a hospital, LTAC, skilled nursing facility or acute rehabilitation facility.
  - Subsequent reviews are based on the severity of the individual case.
  - Providers are required to submit notification and clinical information on the next business day after the admission, as well as upon request from the WellCare Concurrent Review team.
    - Failure to submit necessary documentation may result in non-payment.
  - Discharge Planning begins upon admission and is designed to identify the member's post-hospital needs
    - The attending physician, hospital discharge planner, PCP, ancillary providers and/or community resources are required to coordinate care and post-discharge services to ensure the member receives the appropriate level of care.
  - Transitional Care Management identifies members in the hospital and/or recently discharged who are at risk for hospital readmission.
    - The member is contacted by a WellCare Care Manager to assist the member in reducing avoidable readmissions and/or offer Case/Disease Management.

Utilization Review (UM) (cont.)

Retrospective Review

- WellCare will review post-service requests for authorization of inpatient admissions or outpatient services.

- This review includes making coverage determinations for the appropriate level of services, quality issues, utilization issues and the rationale behind failure to follow WellCare's prior authorization guidelines.

- A retrospective review can be initiated by WellCare or the provider.

Transition of Care

- Members identified by the treating provider as having "special circumstances" such as a disability, a congenital condition, a life-threatening illness or is past the 24th week of pregnancy, are eligible for transition of care.

- During the first 90 days of enrollment, authorization is not required for those members with previously approved services by the state or another Managed Care plan.

- The member may continue to receive ongoing out-of-network treatment until the member is transitioned to an in-network provider.

- WellCare's obligation to pay expires:
  - Beyond the 90th day after the effective date of the termination from the previous plan
  - Beyond 9 months in the case of a covered person who at the time of the termination had been diagnosed with a terminal illness
  - Beyond the first 6 weeks following delivery of a newborn.

- In the event you are providing treatment to a member identified as having "special circumstances", please notify the UM department.

Utilization Management (UM) (cont.)

- Refer to the Provider Manual for additional information including, but not limited to:
  - Criteria for UM decisions
  - Decision timeframes for service authorizations
  - Non-covered services and procedures
  - Limits to abortion, sterilization and hysterectomy coverage
  - Reconsideration for adverse determination (i.e., appeal)
  - WellCare Proposed Actions
  - Individuals with Special Health Care Needs (ISHCN)
  - Second Medical Opinion
  - Authorization request forms and Prenatal Notification Form.

- Forms are made available to assist you in gathering all pertinent information to enable WellCare to provide a timely response to your request.
- For more information on Utilization Management, Case Management and Disease Management, refer to the Provider Manual. For more information on authorizations and/or how to contact UM, CM and/or DM, refer to your Quick Reference Guide.

PCP Notification of Admissions

- Wellcare recognizes the importance of timely physician follow-up for members who are discharged from an acute care hospital to home. Timely and effective physician follow-up care enhances the quality of the member's health.

- Contracted PCPs will receive a "real-time" fax notification alerting them when an assigned member is hospitalized. The notification will contain sufficient information for the PCP to schedule timely and appropriate post-hospital follow up.

- Monthly summary reports by PCP can be generated upon request or at the discretion of Provider Relations to trend admission events by hospital and PCP.

- It is imperative providers frequently update contact information such as fax and phone numbers by contacting Customer Service or your Provider Relations representative.

Quality Improvement Program

- WellCare's Quality Improvement Program activities include, but are not limited to:
  - Monitoring clinical indicators or outcomes
  - Monitoring appropriateness of care
  - Quality studies
  - Healthcare Effectiveness Data and Information Set (HEDIS®) measures
  - Medical record audits
- Providers are contractually responsible for participating in quality improvement projects and medical record review activities.
- HEDIS® is a mandatory process that occurs annually. It is an opportunity for WellCare and providers to demonstrate the quality and consistency of care that is available to members
- WellCare is pleased to offer our Pay for Quality (P4Q) incentives for providers who meet certain quality indicators and outcomes. Additional information about this program is forthcoming.
- For more information on WellCare's Quality Improvement Program, refer to the Provider Manual.

Claim Submission Requirements

- Claims, paper and electronic, should include all necessary, completed, correct and compliant data including:
  - Current CPT and ICD-9 (or its successor) codes
  - Tax ID
  - NPI numbers
  - Provider and/or practice name(s) that match those on the W-9 initially submitted to WellCare
  - Correct taxonomy code consistent with Provider Demographic Information for the covered services being rendered
  - A preauthorization number, if applicable
- WellCare encourages providers to submit electronically via Electronic Data Interchange (EDI) or Direct Data Entry (DDE). Both are less costly than paper and, in most instances, allows for quicker claims processing.
- All claims and encounter transactions are validated for transaction integrity/syntax based on the Strategic National Implementation Process (SNIP) guidelines.
- For more information on Claims submission requirements and timeframes, refer to the Provider Manual, *Provider Resource Guide* and *Provider How-To Guide*.

Encounter Data Submission

- WellCare is required to provide encounter data to the Department for Medicaid Services that substantiates every service provided to every WellCare member.
- Financial sanctions can be imposed on WellCare by the Department for Medicaid Services if encounter data does not meet the Service Level Agreements for timeliness of submission, completeness or accuracy.
- Unless otherwise stated in the Agreement, vendors and providers should submit complete and accurate encounter files to WellCare as follows:
  - Encounters submission will be weekly
  - Capitated entities will submit within ten (10) calendar days of service date
  - Non-capitated entities will submit within ten (10) calendar days of the paid date
    - *The above apply to both corrected claims (error correction encounters) and cap-priced encounters.*
- Encounters may be submitted electronically via:
  - WellCare's preferred clearinghouse, RelayHealth
  - WellCare's Secure FTP (SFTP) process
  - WellCare's Direct Data Entry (DDE)
- For more information on Encounter Data Submission requirements and submission methods, refer to the Provider Manual.

Appeals

- Providers have the right to file an appeal regarding provider payment or contractual issues.
- If the case is not appealed within the applicable timeframe, it will be denied for untimely filing.
- WellCare will review the case for medical necessity and conformity to WellCare guidelines. Cases lacking necessary documentation will be denied.
- When submitting an appeal:
  - Supply specific, pertinent documentation that supports the appeal
  - Include all medical records that apply to the service
  - Submit the appeal & accompanying documentation to the address on the Quick Reference Guide (QRG)
- Upon review of the appeal, WellCare will either reverse or affirm the original decision and notify the provider.

- For more information on provider appeals, including submission timeframes, how to submit and determination timeframes, refer to the Provider Manual and the Quick Reference Guide.

Grievances

- A provider may not file a grievance on behalf of the member without written consent from the member as the member's representative.
- Providers have the right to file a grievance no later than thirty (30) calendar days from the date the provider becomes aware of the issue generating the grievance.
- WellCare will provide written resolution to the provider within timeframes established. Extensions may be requested by WellCare and/or the provider.
- Providers may submit a grievance in writing
- For more information on member and provider grievances, refer to the Provider Manual and Quick Reference Guide.

For More Information…

- Review the ***Provider Manual*** for more detailed information about provider requirements and how-to's including:

Provider and Member Administrative Guidelines	Claims	Credentialing
Utilization Management and Case & Disease Management	Quality Improvement	Appeals and Grievances
Delegated Entities	Compliance	Pharmacy Services

- Refer to the ***Provider Resource Guide*** and ***Provider How-To Guide*** as your one-stop-shop guides to the most common transactions with WellCare, including:
  - Registering for, and how to use, WellCare's provider portal such as member eligibility and co-pay information, authorization requests, claims status and inquiry, provider news and more;
  - How to file a claim via paper, electronically or via WellCare's Direct Data Entry (DDE);
  - How to file a grievance; and
  - How to file an appeal.
- Refer to the ***Quick Reference Guide*** for authorization requirements, addresses and phone numbers for key departments.
- Refer to the corporate ***Clinical Practice Guidelines*** and ***Clinical Coverage Guidelines*** to determine medical necessity, criteria for coverage of a procedure or technology, and best practice recommendations based on available clinical outcomes and scientific evidence.
- Contact your Provider Relations representative to schedule an in-service meeting.