# PROVIDER MANUAL

**Publication: October 29, 2015**
**Version State DRAFT 4**

WC_IA-PrvdMan_v4_20151029

# Table of Contents

**Table of Contents** ..... **1**
**Section 1: Welcome to WellCare** ..... **4**
Purpose of this Provider Manual ..... 4
WellCare's Managed Care Plans ..... 5
Covered Services and Benefits ..... 6
Non-Covered Services ..... 20
LTSS Eligibility ..... 22
Early Periodic Screening, Diagnostic and Treatment (EPSDT) Covered Services ..... 23
Cost Sharing ..... 23
Provider Services ..... 23
**Section 2: Provider and Member Administrative Guidelines** ..... **26**
Provider Administrative Overview ..... 26
Identification and Reporting of Abuse, Neglect and Exploitation of Children and Vulnerable Adults ..... 28
Access Standards ..... 28
Responsibilities of All Providers ..... 29
Responsibilities of Primary Care Physicians (PCPs) ..... 32
Vaccines for Children Program ..... 32
Domestic Violence and Substance Abuse Screening ..... 35
Smoking Cessation ..... 35
Adult Health Screening ..... 35
Cultural Competency Program and Plan ..... 35
Overview ..... 35
Cultural Competency Survey ..... 38
Member Administrative Guidelines ..... 38
Overview ..... 38
Member Handbook ..... 38
Enrollment ..... 38
Member Identification Cards ..... 38
Eligibility Verification ..... 39
Member Engagement ..... 39
Assessments for Members ..... 39
Member Rights and Responsibilities ..... 40
Assignment of Primary Care Provider ..... 41
Changing Primary Care Providers ..... 41
Women's Health Specialists ..... 41
Hearing-Impaired, Interpreter and Sign Language Services ..... 42
**Section 3: Quality Improvement** ..... **43**
Overview ..... 43
Medical Records ..... 43
Provider Participation in the Quality Improvement Program ..... 45
Member Satisfaction ..... 45
Patient Safety to Include Quality of Care (QOC) and Quality of Service (QOS) ..... 45
Web Resources ..... 49
**Section 4: Utilization Management (UM), Case Management (CM) and Disease Management (DM)** ..... **50**
Utilization Management ..... 50

Overview ..... 50
Medically Necessary Services ..... 50
Criteria for UM Decisions ..... 51
Utilization Management Process ..... 52
Peer-to-Peer Reconsideration of Adverse Determination ..... 54
Services Requiring No Authorization ..... 54
WellCare Proposed Actions ..... 55
Second Medical Opinion ..... 55
Individuals with Special Health Care Needs ..... 55
Service Authorization Decisions ..... 56
Emergency/Urgent Care and Post-Stabilization Services ..... 57
Continuity of Care ..... 57
Transition of Care ..... 57
Authorization Request Forms ..... 59
Special Requirements for Payment of Services ..... 60
Eligibility ..... 62
Case Management Program ..... 63
Delegated Entities ..... 65
**Section 5: Claims ..... 67**
Overview ..... 67
Updated Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Process ..... 67
Timely Claims Submission ..... 67
Claims Submission Requirements ..... 68
Claims Processing ..... 71
Patient Liability/Cost-Sharing ..... 71
Encounters Data ..... 72
Balance Billing ..... 74
Hold Harmless Dual-Eligible Members ..... 74
Claims Appeals ..... 74
Corrected or Voided Claims ..... 74
Reimbursement ..... 76
Overpayment Recovery ..... 77
Benefits During Disaster and Catastrophic Events ..... 78
**Section 6: Credentialing ..... 79**
Overview ..... 79
Practitioner Rights ..... 80
Baseline Criteria ..... 81
Liability Insurance ..... 81
Site Inspection Evaluation (SIE) ..... 82
Covering Physicians ..... 82
Allied Health Professionals ..... 82
Ancillary Health Care Delivery Organizations ..... 83
Re-Credentialing ..... 83
Updated Documentation ..... 83
Office of Inspector General Medicare/Medicaid Sanctions Report ..... 83
Eligibility in the Medicaid Program ..... 83
Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials ..... 83

Participating Provider Appeal through the Dispute Resolution Peer Review Process ....83
Delegated Entities ....85
**Section 7: Appeals and Grievances ....86**
Appeals Process ....86
Provider ....86
Member ....87
Expedited Appeals Process ....89
Standard Pre-Service Appeals Process ....90
Standard Retrospective Appeals Process ....90
Grievance Process ....92
Provider Complaints ....92
Member ....92
**Section 8: Compliance ....95**
WellCare's Compliance Program ....95
Overview ....95
Provider Education and Outreach ....96
Code of Conduct and Business Ethics ....98
Overview ....98
Fraud, Waste and Abuse ....98
Confidentiality of Member Information and Release of Records ....99
Disclosure of WellCare Information to WellCare Members ....100
**Section 9: Delegated Entities ....101**
Overview ....101
Compliance ....101
**Section 10: Behavioral Health ....103**
Overview ....103
Behavioral Health Program ....103
Continuity and Coordination of Care between Medical Care and Behavioral Health Care ....103
Responsibilities of Behavioral Health Providers ....104
**Section 11: Pharmacy ....106**
Overview ....106
Preferred Drug List ....106
Generic Medications ....107
Step Therapy ....107
Age Limits ....107
Injectable and Infusion Services ....107
Coverage Limitations ....108
Smoking Cessation therapy - Oral ....108
Over-the-Counter (OTC) Medications ....109
Member Co-Payments ....109
Coverage Determination Review Process (Requesting Prior Authorization) ....109
Medication Appeals ....110
Pharmacy Management – Network Improvement Program (NIP) ....110
Member Pharmacy Access ....110
Exactus Pharmacy Solutions ....110
**Section 12: Definitions ....112**
**Section 13: WellCare Resources ....117**

# Section 1: Welcome to WellCare

## Overview

WellCare of Iowa, Inc. provides managed care services targeted exclusively to government-sponsored Medicaid and Medicare health care programs, including prescription drug plans and health plans for families and children. WellCare's corporate office is located in Tampa, Florida. WellCare serves approximately 3.8 million Members. WellCare's experience and commitment to government-sponsored health care programs enables WellCare to serve its Members and Providers as well as manage its operations effectively and efficiently.

**WellCare of Iowa Contact Information:**
**7147 Vista Dr. West**
**Des Moines, IA 50266**
**1-855-599-3811 (Toll Free)**

For specific contact information, refer to the *Quick Reference Guide* on WellCare's website at **www.wellcare.com/Iowa/Providers/Medicaid**

## Mission and Vision

WellCare's vision is to be a leader in government-sponsored health care programs in partnership with the Members, Providers, governments and communities WellCare serves. WellCare will:

- Enhance Members' health and quality of life
- Partner with Providers and governments to provide quality, cost-effective health care solutions
- Create a rewarding and enriching environment for WellCare associates

WellCare values are:

- *Partnership* – Members are the reason WellCare is in business; Providers are WellCare's partners in serving its Members; and regulators are the stewards of the public's resources and trust. WellCare will deliver excellent Service to its partners.
- *Integrity* – WellCare's actions must consistently demonstrate a high level of integrity that earns the trust of those it serves.
- *Accountability* – All associates must be responsible for the commitments WellCare makes and the results it delivers.
- *Teamwork* – WellCare and its associates can expect – and are expected – to demonstrate a collaborative approach in the way they work.

## Purpose of this Provider Manual

This Provider Manual is intended for WellCare-contracted (participating) Medicaid Providers providing health care service(s) to WellCare Members enrolled in a WellCare Managed Care Plan. This manual serves as a guide to the policies and procedures governing the administration of WellCare's Medicaid plan and is an extension of and supplements the Provider Participation Agreement (the Agreement) between WellCare and health care Providers, who include, without limitation: Primary Care Providers, Hospitals and Ancillary Providers (collectively, Providers).

**This manual is available on WellCare's website at**

**https://www.wellcare.com/Iowa/Providers/Medicaid**

A paper copy may be obtained, at no charge, upon request by contacting Provider Services or a Provider Relations representative Monday – Friday, 7:30 a.m. – 6:00 p.m. CST.

In accordance with the policies and procedures clause of the Agreement, participating WellCare 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 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. Provider Bulletins that are state-specific may override the policies and procedures in this manual.

## WellCare's Managed Care Plans

**Medicaid** is as a government health insurance program for persons of all ages whose income and resources are insufficient to pay for health care. WellCare is contracted with the Iowa Department of Human Services (DHS) (Agency) to provide Medicaid managed care services.

**Iowa Department of Humans Survives (DHS) Contact Information:**
**P.O. Box 36450**
**Des Moines, IA 50315**
**1-800-338-7909 (Toll Free)**
**1-515-256-4609 (Des Moines area)**
**IMEProviderServices@dhs.state.ia.us**

### Eligibility

Membership enrollment in WellCare's Medicaid managed care plan is solely determined by DHS. For eligibility criteria, please refer to the Iowa DHS website at **http://dhs.iowa.gov/ime/members/who-receives-medicaid**

An individual must meet specific eligibility requirements in order to be eligible for Medicaid. Each program has specific income and asset limits that must be met.

The Agency requires that designated Medicaid recipients must enroll with a managed care plan. Eligible recipients will be sent an enrollment letter that indicates the MCO choice deadline. If recipients do not select an option before the deadline, they are automatically assigned to a managed care plan.

Co-payment Exceptions: WellCare ensures, in accordance with 42 CFR 447.56, that copayments are not imposed on any of the following populations:

- Individuals between ages one  and 18, eligible under 42 CFR 435.118
- Individuals under age one , eligible under 42 CFR 435.118
- Disabled or blind individuals under age 18 eligible under 42 CFR 435.120 or 42 CFR 435.130

- Children for whom child welfare services are made available under Part B of title IV of the Social Security Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age
- Disabled children eligible for Medicaid under the Family Opportunity Act
- Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60 day period following termination of pregnancy ends
- Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs
- An individual receiving hospice care, as defined in section 1905(o) of the Social Security Ac
- An American Indian/Alaska Native (as defined at 42 CFR 447.51) who is currently receiving or has ever received an item or service furnished by an American Indian/Alaska Native health care Provider or through referral under contract health services
- Individuals who are receiving Medicaid by virtue of their breast or cervical cancer diagnosis under 42 CFR 435.213

## Covered Services and Benefits

| Standard Benefits | hawk-i | Medicaid | Family Planning Program | Iowa Health and Wellness |
|---|---|---|---|---|
| **Physician Services** (Surgical Medical, Office visits, Newborn care, Well-baby, Well-child, Immunizations, Urgent care, Specialist care, Allergy testing and treatment, Mental health visits, Substance use disorder visits) | $0 co-pay | $3 co-pay | Not covered | $0 co-pay |
| **Specialty Physician Visits** | $0 co-pay | $2 co-pay | Not covered | $0 co-pay |
| **Home Health Aide (**Home health aide is limited to visits that do not exceed 28 hours per week) | $0 co-pay | $0 co-pay | Not covered | $0 co-pay; **Not Covered:** Private Duty Nursing/Personal Care |
| **Chiropractic Care (**X-ray- payment for documenting x-rays is limited to one per condition. No payment shall be made for subsequent | Not covered | $1 co-pay | Not covered | $0 co-pay |

| | | | | |
|---|---|---|---|---|
| x-rays.<br>• Chiropractic manipulative therapy eligible for reimbursement is specifically limited to the manual manipulation of the spine for the purpose of correcting a subluxation demonstrated by x-ray. There are three categories based off the patient's condition / diagnosis. A diagnosis or combination of diagnoses within category i generally required short-term treatment of 12 per 12-month period. A diagnosis or combination of diagnoses with category ii generally required moderate-term treatment of 18 per 12-month period. A diagnosis or combination of diagnoses within category iii generally required long-term treatment of 24 per 12-month period. For diagnostic combinations between categories, 28 treatments are generally required per 12-month period.) | | | | |
| **Outpatient surgery** | $0 co-pay | $0 co-pay | Not covered | $0 co-pay |
| **Allergy Testing & Injections** | $0 co-pay | $0 co-pay | Not covered | $0 co-pay |

| | | | | |
|---|---|---|---|---|
| **Dialysis** | Not covered | $0 co-pay | Not covered | $0 co-pay |
| **Anesthesia** | Not covered | $0 co-pay | $0 co-pay | $0 co-pay |
| **Walk-in Centers** | Not covered | $0 co-pay | Not covered | $0 co-pay |
| **Access to Clinical Trials** | Not covered | $0 co-pay | Not covered | $0 co-pay; Medical necessity will be determined on a case-by-case basis through the Prior Authorization process. |
| **Genetic Counseling** | Not covered | $0 co-pay | Not covered | $0 co-pay; Prior authorization required. |
| **Emergency Room Services** | $0 co-pay ($25 dollar copay if visit is not deemed an emergency) | $3 co-pay | Not covered | $0 co-pay; ($8 copay if visit is not deemed an emergency) |
| **Emergency Transportation-Ambulance and Air Ambulance** | $0 co-pay | $2 co-pay | $0 co-pay | Not covered |
| **Urgent Care Centers/Facilities Emergency Clinics (non-hospital)** | $0 co-pay | $0 co-pay | Not covered | $0 co-pay |
| **Non-Emergency Medical Transportation (NEMT)** | Not covered | $0 co-pay | Not covered | $0 co-pay |
| **General Inpatient Hospital Care** | $0 co-pay | $0 co-pay | Not covered | $0 co-pay |
| **Inpatient Physician Services** | $0 co-pay | $0 co-pay | Not covered | $0 co-pay |
| **Inpatient Surgical Services** | Not covered | $0 co-pay | Not covered | Not covered |
| **Congenital Abnormalities Correction** | Not covered | $0 co-pay | Not covered | $0 co-pay |
| **Breast Reduction** | $0 co-pay | $0 co-pay | Not | Not covered |

| | | | | |
|---|---|---|---|---|
| | | | covered | |
| **Non-Cosmetic Reconstructive Surgery** | $0 co-pay | $0 co-pay | Not covered | $0 co-pay |
| **Transplant Organ and Tissue** | Not covered | $0 co-pay | Not covered | $0 co-pay; **Covered:** Certain bone marrow/stem cell transfers from a living donor, heart, heart/lung, kidney, liver, lung, pancreas, pancreas/kidney, small bowel **Not covered:** transport of living donor, services/supplies related to mechanical or non-human organs, transplant services and supplies not listed in this section including complications |
| **Hospice Care** | $0 co-pay | $0 co-pay | Not covered | $0 co-pay |
| **Hospice Respite – Inpatient** (Paid at the inpatient rate for maximum of five days at a time when the Member is in an approved inpatient facility) | $0 co-pay | $0 co-pay | Not covered | $0 co-pay; Limited to 15 days per lifetime for inpatient respite care. 15 days per lifetime for outpatient hospice respite care. Hospice respite care must be used in increments of not more than 5 days at a time. |
| **Chemotherapy** | $0 co-pay | $0 co-pay | Not covered | $0 co-pay |
| **Radiation Therapy** | Not covered | $0 co-pay | Not covered | $0 co-pay |
| **Bariatric Surgery** | Not covered | $0 co-pay | Not covered | Not covered |
| **Breast Reconstruction** | Not covered | $0 co-pay | Not covered | $0 co-pay |
| **TMJ Treatment** | Not covered | $0 co-pay | Not | Not covered |

| | | | | |
|---|---|---|---|---|
| | | | covered | |
| **Intermediate Care Facilities for Individuals** | Not covered | $0 co-pay; Must meet level of care | Not covered | Not covered |
| **Tobacco Cessation for Pregnant Women** | Not covered | $0 co-pay | Not covered | $0 co-pay |
| **Maternity Services** | Not covered | $0 co-pay | Not covered | $0 co-pay |
| **Newborn child coverage** | Not covered | $0 co-pay | Not covered | $0 co-pay |
| **Infertility Diagnosis and Treatment** | Not covered | $0 co-pay | Not covered | $0 co-pay; Infertility treatment resulting from voluntary sterilization, relating to collection/purchase of donor semen or eggs, freezing of the same, surrogate services, infertility diagnosis and treatment, and tubal/vasectomy reversals, fertility drugs. |
| **Mental Health/Behavioral Health Inpatient Treatment** | $0 co-pay | $0 co-pay | Not covered | $0 co-pay; Those with disabling mental disorders will be considered medically exempt and enrolled in the Medicaid State Plan. Residential treatment is not covered. |
| **Mental Health/Behavioral Health Outpatient Treatment** | $0 co-pay | $0 co-pay | Not covered | $0 co-pay; Those with disabling mental disorders will be considered medically exempt and enrolled in the Medicaid State Plan. |

| | | | | |
|---|---|---|---|---|
| **Substance Use Disorder Inpatient Treatment** | $0 co-pay | $0 co-pay | Not covered | $0 co-pay; Members with disabling substance use disorder will be considered medically exempt and enrolled in the Medicaid State Plan. Residential treatment is not covered. |
| **Substance Use Disorder Outpatient Treatment** | $0 co-pay | $0 co-pay | Not covered | $0 co-pay; Members with disabling substance use disorder will be considered medically exempt and enrolled in the Medicaid State Plan. |
| **Psychiatric Medical Institutions for Children (PMIC)** | Not covered | $0 co-pay | Not covered | Not covered |
| **B3 Services** (Intensive psychiatric rehab, Community Support Services, Peer Support, Residential Substance Abuse Treatment) | Not covered | $0 co-pay | Not covered | Not covered |
| **Prescription Drugs** | $0 co-pay | **Generic** - $1<br>**Preferred** - $1<br>**Non-Preferred -** Co-pays are based on the cost of the drug as follows:<br>**Cost of Drug Co-Pay:**<br>$0 - $25: $1<br>$25.01–$50: $2<br>More than $50.01: $3 | Not covered | $0 co-pay |
| **Physical Therapy** | $0 co-pay | $1 co-pay | Not | $0 co-pay; |

| | | | | |
|---|---|---|---|---|
| (Physical therapy is limited to physician-authorized visits within guidelines defined for restorative, maintenance or trial therapy) | | | covered | Limited to 60 visits per year. Occupational only for upper extremities. **Not covered:** OT supplies, IP OT/PT in the absence of separate medical condition requiring hospitalization |
| **Occupational Therapy** (Occupational therapy is limited to physician-authorized visits within guidelines for restorative, maintenance or trial therapy) | Not covered | $2 co-pay | Not covered | $0 co-pay; Limited to 60 visits per year. Occupational only for upper extremities. **Not covered**: OT supplies, IP OT/PT in the absence of separate medical condition requiring hospitalization |
| **Speech Therapy** (Speech pathology is limited to physician-authorized visits within guidelines defined for restorative, maintenance or trial therapy) | $0 co-pay | $2 co-pay | Not covered | $0 co-pay; Limited to 60 visits per year |
| **Inhalation therapy** (Inhalation therapy is limited to physician-authorized visits within guidelines defined for restorative, maintenance or trial therapy) | Not covered | $0 co-pay | Not covered | $0 co-pay; Limit of 60 visits in a 12-month period. |
| **Medical and** | $0 co-pay | $0 co-pay | Not | $0 co-pay; |

| | | | | |
|---|---|---|---|---|
| **Surgical supplies** | | | covered | **Non-covered:** elastic stockings or bandages including trusses, lumbar braces, garter belts and similar items that can be purchased without a prescription |
| **Durable Medical Equipment (DME)** **(**Medical supplies are not to exceed a three-month supply. Diabetic supplies are covered as follows: blood glucose test or reagent strips 6 units per month (1 unit equals 50 strips); urine glucose test strips 3 units per month (1 unit equals 100 strips), lancets 4 units per month (1 unit equals 100 lancets), and needles 500 units per month (1 unit equals 1 needle). Reusable insulin pens are allowed once every six months. Diapers and disposable under pads are covered and can be provided in a 90-day period. Diaper/brief 1,080 per 90-day supply, liner/shield/guard/pad 450 per 90-day supply, pull-on 450 per 90-day supply, disposable under pads 600 per 90-day supply, reusable under pads 48- per 12 months. Maximum units can very when combinations of incontinence products are used. Hearing aid batteries are covered up to 30 batteries per | $0 co-pay | $2 co-pay | Not covered | $0 co-pay; Non-covered items include elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that are available for purchase without a prescription |

| | | | | |
|---|---|---|---|---|
| aid in a 90-day period. Ostomy supplies and accessories are covered one unit per day of regular wear or three units per month of extended wear are allowed. Services are limited to Members in a medical facility. No payment is made to medical suppliers for medical supplies or durable medical equipment for Members receiving inpatient or outpatient care in a hospital.<br>• No payment is made for medical supplies or durable medical equipment for Members for whom the facility is receiving skilled nursing care payment, except for orthotic and prosthetic services, orthopedic shoes, and therapeutic shoes for diabetics.<br>• No payment is made for durable medical equipment or supplies for Members<br>• In an intermediate care facility for intellectual disability or a facility receiving) | | | | |
| **Orthotics** | $0 co-pay | $2 co-pay | Not covered | $0 co-pay |
| **Prosthetics** | $0 co-pay | $2 co-pay | Not covered | $0 co-pay |
| **Cardiac Rehabilitation** | Not covered | $0 co-pay | Not covered | $0 co-pay |
| **Pulmonary Rehabilitation** | Not covered | $0 co-pay | Not covered | $0 co-pay |
| **Habilitation Services** | Not covered | $0 co-pay | Not covered | Not covered |
| **Acupuncture** | Not covered | $0 co-pay | Not | Not covered |

| | | | | |
|---|---|---|---|---|
| | | | covered | |
| **Skilled Nursing Services (**Skilled nursing is limited to five visits per week) | $0 co-pay | $0 co-pay | Not covered | $0 co-pay; Covered in nursing facilities, skilled nursing facilities and hospital swing beds. |
| **Nursing Facility** | Not covered | $0 co-pay; Must meet level of care | Not covered | Not covered |
| **Nursing Services** (Private duty nursing and personal care services are covered as a benefit under EPSDT as provided through a home health agency for up to 16 hours per day) | Not covered | $0 co-pay | Not covered | Not covered |
| **Lab Tests** | $0 co-pay | $3 co-pay | $0 co-pay | $0 co-pay |
| **X-Rays** | $0 co-pay | $3 co-pay | Not covered | $0 co-pay |
| **Imaging/Diagnostics (MRI CT PET)** | $0 co-pay | $3 co-pay | Not covered | $0 co-pay |
| **Sleep Studies** | Not covered | $0 co-pay | Not covered | $0 co-pay; Treatment for snoring not covered |
| **Diagnostic Genetic Tests** | Not covered | $0 co-pay | Not covered | $0; Requires prior authorization |
| **Pathology** | Not covered | $0 co-pay | Not covered | $0 co-pay |
| **Preventive Care** | $0 co-pay | $0 co-pay | Not covered | $0 co-pay; Limited to ACA required preventive services |
| **Nutritional Counseling** | $0 co-pay | $0 co-pay | Not covered | $0 co-pay; Max 40 units allowed for 12 month period |
| **Nutritional Counseling** | Not covered | $0 co-pay | Not covered | $0 co-pay; Max 20 units allowed for 12 month period |
| **Counseling and Education Services** | Not covered | $0 co-pay | Not covered | $0 co-pay; **Not covered:** |

| | | | | |
|---|---|---|---|---|
| | | | | Bereavement, family, or marriage counseling, education other than diabetes |
| **Family Planning** | $0 co-pay | $0 co-pay | $0 co-pay | $0 co-pay |
| **Vision Care Exams (Adult)** | $0 co-pay | $2 co-pay | Not covered | $0 co-pay |
| **Vision Care Exams (Child)** (Codes only allowed once per year: 92002, 92004, 92012, 92014. This does not limit the medical exams for Members. Medical exams should be coded properly for accurate claim adjudication) | $0 co-pay | $0 co-pay | Not covered | Not covered |
| **Vision Lenses and Frames (Adult)** | $0 co-pay (including corrective lenses) | $2 co-pay; Routine eye examinations are covered once in a 12-month period; Frame services are limited up to 3 times for children up to 1 year of age, up to 4 times per year for children 1 through 3 years of age, one frame every 12 months for children 4-7 years of age and once every 24 months after 8 years of age. Safety frames are allowed for children through 7 years of age.<br>• Single vision and multifocal lens services are limited up to 3 times for children up to 1 year of age, up to 4 times per year for children 1-3 years of age, once every 12 months for children 4-7 years of age, once every 24 months after 8 years | Not covered | Not covered |

| | | | | |
|---|---|---|---|---|
| | | of age.<br>• Gas permeable contact lenses are limited as follow: up to 16 lenses for children up to 1 year of age, up to 8 lenses every 12 months for children 1-3 years of age, up to 6 lenses every 12 months for children 4-7 years of age, two lenses every 24 months for Members 8 years of age and over.<br>• Replacement of glasses that have been lost or damaged beyond repair are covered for adults age 21 and over is limited to once every 12 months.<br>• Replacement for lost or damaged glasses for children less than 21 years of age is not limited. | | |
| **Vision Lenses and Frames (Child)** | $0 co-pay (including corrective lenses) | $0 co-pay; Routine eye examinations are covered once in a 12-month period; Frame services are limited up to 3 times for children up to 1 year of age, up to 4 times per year for children 1 through 3 years of age, one frame every 12 months for children 4-7 years of age and once every 24 months after 8 years of age. Safety frames are allowed for children through 7 years of age.<br>• Single vision and multifocal lens services are limited | Not covered | Not covered |

| | | | | |
|---|---|---|---|---|
| | | up to 3 times for children up to 1 year of age, up to 4 times per year for children 1-3 years of age, once every 12 months for children 4-7 years of age, once every 24 months after 8 years of age.<br>• Gas permeable contact lenses are limited as follow: up to 16 lenses for children up to 1 year of age, up to 8 lenses every 12 months for children 1-3 years of age, up to 6 lenses every 12 months for children 4-7 years of age, two lenses every 24 months for Members 8 years of age and over.<br>•Replacement of glasses that have been lost or damaged beyond repair are covered for adults age 21 and over is limited to once every 12 months. Replacement for lost or damaged glasses for children less than 21 years of age is not limited. | | |
| **Immunizations** | $0 co-pay | $0 co-pay | Not covered | $0 co-pay; **Not covered**: immunizations for travel |
| **Colorectal Cancer Screening** | Not covered | $0 co-pay | Not covered | $0 co-pay |
| **Screening Mammography** | Not covered | $0 co-pay | Not covered | $0 co-pay; One per year |
| **Hearing Exam (Adult)** | $0 co-pay | $2 co-pay | Not covered | $0 co-pay; Limit of one hearing exam per year |

| | | | | |
|---|---|---|---|---|
| **Hearing Exam (Child)** | $0 co-pay | $0 co-pay | Not covered | $0 co-pay |
| **Hearing Aids (Adult)** | $0 co-pay | $3 co-pay | Not covered | Not covered |
| **Hearing Aids (Child)** | $0 co-pay | $0 co-pay | Not covered | Not covered |
| **Diabetes – medically necessary equipment, supplies Education** | Not covered | $0 co-pay | Not covered | $0 co-pay |
| **Screening Pap tests** | $0 co-pay | $0 co-pay | $0 co-pay | $0 co-pay |
| **Gynecological exam** | $0 co-pay | $0 co-pay | $0 co-pay | $0 co-pay; One per year |
| **Prostate cancer screening** | Not covered | $0 co-pay | Not covered | $0 co-pay; One per year for men age 50-64 years |
| **Podiatry Services** | Not covered | $1 co-pay | Not covered | $0 co-pay; Must be related to medical condition, routine services are not covered |
| **Tobacco Cessation** | Not covered | $0 co-pay | Not covered | Not covered |
| **EPSDT** | $0 co-pay | $0 co-pay | Not covered | $0 co-pay; Covered for ages 19-20 |
| **Home and Community Based Waiver Services** (maximum dollars available per month as determined by level of care) | Not covered | $0 co-pay | Not covered | Not covered |

For additional information on Covered Services, refer to the Provider Manuals found on the Iowa DHS website at **http://dhs.iowa.gov/policy-manuals/medicaid-provider**

## Expanded Benefits

- Healthy Rewards -- Prepaid debit card which will be loaded with varying amounts for Members who meet specific preventative health metrics or other identified healthy behaviors
- Respite Care -- In-home and institutional respite for Home and Community Based Waiver Members
- Hypoallergenic Bedding -- Members receive up to $100 in hypoallergenic bedding to avoid asthma triggers for qualified Members

- Over-the-Counter (OTC) -- Allowance for $10 in OTC drugs (over and above the standard benefit) per household per month
- Weight Watchers -- Monthly membership for 6 months, for qualified Members age 13 and over
- Stay Connected -- Free cell phone for qualified Members engaged in a care management program that do not have a telephone. Cell phone would include unlimited text messaging and programmed numbers for the Members' doctor, case manager, social worker

**Non-Covered Services**

The following list is representative of Non-Covered Services and procedures, and is not meant to be exhaustive. (WellCare will review a treatment or service for medical necessity upon request)

- Services not considered to be medically necessary
- Any laboratory 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 laboratory service
- Investigational or experimental services such as new treatment that has not been accepted universally as a form of treatment
- 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 (e.g., the reversal of sterilization, in-vitro fertilization, etc.)
- All procedures listed in the CPT or HCPCS description as "unlisted" or "unspecified"
- Educational supplies; medical testimony; special reports; travel by the physician; no-show or canceled appointments; additional allowances for services provided after office hours or between 10 p.m. and 8 a.m. or on Sundays and holidays; calls, visits or consultations by telephone and other related services
- Biofeedback or hypnotherapy
- Services provided free of charge to Iowa Medicaid Members by county health departments, free clinics, or state laboratories, e.g., metabolic screens for Members younger than one year of age, etc.
- Services and/or procedures performed without regard to the policies contained in this manual
- Hospital visits if the hospital admission and/or length of stay are disallowed by WellCare
- Tubal anastomosis
- Penile prosthesis
- Infertility procedures and related services other than assessment
- Thermography
- Sensitivity training, encounter groups or workshops
- Sexual competency training
- Education testing and diagnosis
- Paternity testing
- Postmortem services

- Services, including but not limited to drugs, that are investigational, mainly for research purposes or experimental in nature
- Sterilization of a mentally incompetent or institutionalized Member
- Services provided in countries other than the United States
- Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Iowa Medicaid program regulations referenced herein
- Services for which the Member has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage

**Long-Term Services and Supports (LTSS)**

Home and Community-Based Services (HCBS):

- Adult day care
- Assisted living services
- Community Care Management Agency (CCMA) services
- Counseling and training
- Environmental accessibility adaptations
- Home-delivered meals
- Home maintenance
- Medical transportation
- Personal assistance services – Level I and Level II
- Personal Emergency Response Systems (PERS)
- Residential care including E-ARCH and CCFFH
- Respite care
- Skilled (or private-duty) nursing
- Specialized medical equipment and supplies
- Assistive devices
- Behavioral programming
- Chore
- Consumer-directed attendant care
- Family and community supports
- Home health aide
- In home family therapy
- Mental health outreach
- Nursing
- Nutritional counseling
- Home and vehicle modification
- IMMT
- Prevocational services
- Supported community living
- Supported employment
- Day habilitation
- Senior companion
- Transportation

- Institutional services:
  - Acute waitlisted ICF/SNF
  - Nursing facility (NF), skilled nursing facility (SNF), and Sub acute facility services
  - ICF/ID

- NF/MI
- PMIC
- MHI

Criteria for each of these services and State approval must be met in order to qualify.

For more information on HCBS Covered Services, refer to the Provider Manual on the DHS website at **dhs.iowa.gov/policy-manuals/medicaid-provider**

Consumer Choice Options

WellCare will ensure that each LTSS Provider's service delivery site or services meets all the applicable requirements of Iowa law and the Iowa Contract and have the necessary and current licenses, certification, accreditation, and/or designation approval per Iowa requirements. When individuals are not required to be licensed, accredited or certified, WellCare shall ensure, based on applicable Iowa licensure rules and/or program standards that they are appropriately educated, trained, qualified, and competent to perform their job responsibilities. In addition, WellCare shall ensure that all required criminal history record checks and child and dependent adult abuse background checks are conducted for LTSS Providers who are not employees of a Provider agency or licensed/accredited by a board that conducts background checks. Specifically, WellCare shall ensure criminal history checks and child and dependent adult background checks are conducted for non-agency affiliated self-direction service Providers such as Consumer Directed Attendant Care (CDAC) and Consumer Choices Options (CCO) employees. Each of Iowa's 1915(c) and 1915(i) HCBS waivers set forth the minimum Provider qualification for each Covered Service and each HCBS waiver Provider shall meet these qualification requirements.

**LTSS Eligibility**

Members are eligible for LTSS if they:

- Live in the WellCare service area;
- Meet the clinical eligibility requirements for nursing facility care, skilled care, or ICF/ID care for:
  - The below listed 1915(c) Waivers:
    - Aids/HIV
    - Brain injury
    - Elderly
    - Health and disability
    - Intellectual disability
    - Physical disability
  - Nursing facility care
  - Skilled care
  - ICF/ID care: For example - Member needs help with daily living like bathing, dressing, eating, or walking or they have a chronic condition requiring nursing services; and meet Medicaid financial eligibility requirements

**Non Covered Services - LTSS**

- Services included in the PACE program
- Dental services provided outside of a hospital setting

- MFP grant services
- Services provided in an Iowa Veteran's Home
- School-based services provided by the Areas Education Agencies or Local Education Agencies

**Early Periodic Screening, Diagnostic and Treatment (EPSDT) Covered Services**
EPSDT services include medically necessary health care, diagnostic services, preventive services, rehabilitative services, treatment and other measures, as described in the Definitions section, for all Members up to the age of 21.

For the most up-to-date information on Covered Services, refer to the Iowa DHS website at **http://dhs.iowa.gov**

**Cost Sharing**
Providers may not deny care or services to any Member because of his or her inability to pay the copayment. WellCare shall not hold Members liable for debt due to insolvency of WellCare or non-payment by the State to WellCare. Further, WellCare and all Providers and subcontractors shall not charge Members for missed appointments. Member's total cost sharing shall not exceed five percent of their quarterly household income. WellCare shall track Members' cost sharing to ensure that if the five percent quarterly limit is reached, cost sharing is no longer collected until the beginning of a new quarter and the Provider's reimbursement is adjusted accordingly; that is, any co-payment amounts are no longer deducted from claims reimbursement.

LTSS Members who are receiving facility or community based care, must contribute a predetermined financial participation to the cost of services prior to Medicaid reimbursement. Providers bill Members for their portion of the client participation. The Agency will notify WellCare of a Member's financial participation amount.

Providers may receive information the following in regard to cost sharing via this Provider Manual, the WellCare website at **www.wellcare.com/Iowa** or by calling Provider Services at **1-855-599-3811**:

- The groups of individuals subject to the cost sharing charges
- The consequences for non-payment
- The cumulative cost-sharing maximums
- Mechanisms for making payments for required charges
- A list of preferred drugs or a mechanism to access such a list, if drug copayments are applied by WellCare

**Provider Services**
Providers may contact the appropriate departments at WellCare by referring to the *Quick Reference Guide* which may be found on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid**

Provider Relations representatives are available to assist in many requests for participating WellCare Providers.

## Website Resources

WellCare's website, **https://www.wellcare.com/Iowa** , offers a variety of tools to assist Providers and their staff.

Available resources include:

- Provider Manual
- *Quick Reference Guide*
- Clinical Practice Guidelines
- Clinical Coverage Guidelines
- Forms and documents
- Pharmacy and Provider look-up (directories)
- Authorization look-up tool
- Training materials and guides
- Newsletters
- Member rights and responsibilities
- Privacy statement and notice of privacy practices

### Secure Provider Portal – Benefits of Registering

WellCare's secure online Provider Portal offers immediate access to an assortment of useful tools. Providers can create unlimited individual sub-accounts for staff members, allowing for separate billing and medical accounts.

All Providers who create a password using their WellCare Provider Identification (Provider ID) number have access to the following features:

- **Claims submission status and inquiry:** Submit a new claim, check the status of an existing claim, and customize and download reports.
- **Member eligibility and co-payment information:** Verify Member eligibility and obtain specific co-payment information.
- **Authorization requests:** Submit authorization requests, attach clinical documentation and check authorization status. Providers can also print and/or save authorization forms.
- **Pharmacy Services and utilization:** View and download a copy of WellCare's Preferred Drug List (PDL), see drug recalls, access pharmacy utilization reports and obtain information about WellCare pharmacy services.
- **Training:** Take required training courses and complete attestations online.
- **Reports:** Access reports such as active Members, authorization status, claims status, eligibility status, pharmacy utilization and more.
- **Provider news:** View the latest important announcements and updates.
- **Personal inbox:** Receive notices and key reports regarding claims, eligibility inquiries and authorization requests.

### How to Register

Please visit **https://www.wellcare.com/Iowa**, click on Login/ Register at the top of the page.

After registering on WellCare's website, Providers should retain username and password information for future reference.

For more information about WellCare's Web capabilities, please contact Provider Services or a Provider Relations representative.

# Section 2: Provider and Member 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 Participation Agreement (the Agreement) or contact a Provider Relations representative for clarification of any of the following.

Participating WellCare 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 approved DHS rules and regulations, and assist us in complying with corrective action plans necessary for us to comply with such rules and regulations
- Retain all agreements, books, documents, papers and medical records related to the provision of services to WellCare Members as required by state and federal laws
- Provide Covered Services in a manner consistent with professionally recognized standards of health care, as defined in the Iowa Contract
- Use physician extenders appropriately. Physician assistants (PAs) and advanced registered nurse practitioners (ARNPs) should provide direct Member care within the scope or practice established by the rules and regulations of the approved DHS and WellCare guidelines
- Assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations
- Clearly identify physician extender titles (examples: MD, DO, ARNP, PA) to Members and to other health care professionals
- Honor at all times any Member request to be seen by a physician rather than a physician extender
- Administer, within the scope of practice, treatment for any Member in need of health care services
- Maintain the confidentiality of Member 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
- Maintain accurate medical records and adhere to all WellCare's policies governing content and confidentiality of medical records as outlined in *Section 3: Quality Improvement* and *Section 8: Compliance*
- Ensure that:

  - All employed physicians and other health care practitioners and Providers comply with the terms and conditions of the Agreement between Provider and WellCare
  - To the extent physician maintains written agreements with employed physicians and other health care practitioners and Providers, such agreements contain similar provisions to the Agreement
  - Physician maintains written agreements with all contracted physicians or other health care practitioners and Providers, which agreements contain similar provisions to the Agreement
- 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 Member or the requesting party at no charge, unless otherwise agreed
- Preserve Member dignity and observe the rights of Members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen
- Not discriminate in any manner between WellCare Members and non-WellCare Members
- Ensure that the hours of operation offered to WellCare Members is no less than those offered to commercial Members or comparable Medicaid Fee-For-Service recipients if Provider serves only Medicaid recipients
- Not deny, limit or condition the furnishing of treatment to any WellCare Member on the basis of any factor that is related to health status, including, but not limited to, the following:
  - Inability to pay copayment
  - Medical condition, including mental as well as physical illness
  - Claims experience
  - Receipt of health care
  - Medical history
  - Genetic information
  - Evidence of insurability
  - Including conditions arising out of acts of domestic violence, or disability
- Freely communicate with and advise Members regarding the diagnosis of the Member's condition and advocate on Member's behalf for Member'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 Members that are in need of services related to children's health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation, substance abuse or other behavioral health issues. If indicated, Providers must refer Members to WellCare-sponsored or community-based programs
- Must document the referral to WellCare-sponsored or community-based programs in the Member's medical record and provide the appropriate follow-up to ensure the Member 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 specific transplant services, are administered outside of the managed care program.

For Medicaid, excluded services are defined as those services that Members may obtain through other applicable Medicaid programs, including the Medicaid Fee-For-Service system, and for which WellCare is not financially responsible. These services may be paid for by the Agency on a Fee-For-Service basis or other basis. Providers are required to determine eligibility and Covered Services prior to rendering services. In the event the service(s) is (are) excluded, Providers must submit reimbursement for services directly to the Agency. In the event the service(s) is (are) prohibited, neither WellCare nor the Agency is financially responsible. For more information on prohibited services, refer to the Agency's website at **http://dhs.iowa.gov**

## Identification and Reporting of Abuse, Neglect and Exploitation of Children and Vulnerable Adults

Providers are responsible for the screening and identification of children and vulnerable adults who are abused neglected or exploited. Providers are also required to report the identification of Members who fall into the above categories.

Suspected cases of abuse, neglect and/or exploitation must be reported to the state's Adult Protective Services Unit. Adult Protective Services (APS) are services designed to protect elders and vulnerable adults from abuse, neglect or exploitation. The Iowa Department of Aging and the Iowa Department of Human Services have defined processes for ensuring elderly victims of abuse, neglect or exploitation in need of home- and community-based services are referred to the aging network, tracked and served in a timely manner. Requirements for serving elderly victims of abuse, neglect and exploitation can be found in Iowa Code Ch. 235B.

Providers may be asked to cooperate with WellCare to provide services or arrange for the Member to change locations. Training regarding abuse, neglect and exploitation is on WellCare's website at
**https://www.wellcare.com/Iowa/Providers/Medicaid/Training** .

To report suspected abuse, neglect or exploitation of children or vulnerable adults, Providers should call the Iowa Abuse Hotline at **1-800-362-2178**. The toll-free number is available 24 hours a day. If a Provider sees a child or vulnerable adult in immediate danger, they should call **911**.

## 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 Member's needs.

WellCare shall monitor Providers against these standards to ensure Members can obtain needed health services within the acceptable appointment time frames, in-office waiting times and after-hours standards. Hours of operation offered for Medicaid beneficiaries must be no less than those offered to commercial Members or comparable Medicaid

Fee-For-Service recipients if the Provider serves only Medicaid recipients. Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare.

| Type of Appointment | Access Standard |
|---|---|
| Urgent (PCPs) | Within one day of the request |
| Routine (PCPs) | Within four to six weeks of the request |
| Persistent Symptoms (PCPs) | Within 48 hours of the request |
| Urgent (Specialists) | Within one day of the request |
| Routine (Specialists) | Within 30 days of the request |
| Optometry Urgent | Within 48 hours of the request |
| Optometry Regular | Within 3 weeks of the request |
| Lab Services Urgent | Within 48 hours of the request |
| Lab Services Regular | Within 3 weeks of the request |

PCPs must provide or arrange for coverage of services, consultation or approval for Referrals 24 hours a day, seven days a week. To ensure accessibility and availability, PCPs must provide one of the following:

- A 24-hour answering service that connects the Member to someone who can render a clinical decision or reach the PCP
- An answering system with the option to page the physician for a return call within a maximum of 30 minutes
- An advice nurse with access to the PCP or on-call physician within a maximum of 30 minutes

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

**Responsibilities of All Providers**

The following is a summary of responsibilities specific to all Providers who render services to WellCare Members. These are intended to supplement the terms of the Agreement, not replace them. In the event of a conflict between this Provider Manual and the Agreement, the Agreement shall govern.

**Provider Identifiers**

All participating Providers are required to have a National Provider Identifier (NPI). For more information on NPI requirements, refer to *Section 5: Claims*.

Providers who are not already enrolled with the Iowa Medicaid program, and who perform services for WellCare's Medicaid Members, must also obtain an Iowa Medicaid Provider ID. WellCare will register its Providers with the Iowa Medicaid program to ensure each Provider obtains a Provider ID. The Provider ID is used to submit Encounter Data for the services rendered under WellCare.

**Advance Directives**
Members 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 life. Living will and Advance Directive rights may differ between states.

Each WellCare Member (age 18 years or older and of sound mind) should receive information regarding living wills and Advance Directives. This allows them to designate another person to make a decision should they become mentally or physically unable to do so. WellCare provides information on Advance Directives in the Member Handbook.

Information regarding living wills and Advance Directives should be made available in Provider offices and discussed with the Members. Completed forms should be documented and filed in Members' medical records.

A Provider shall not, as a condition of treatment, require a Member to execute or waive an Advance Directive.

**Provider Billing and Address Changes**
Prior notice to a Provider Relations representative or Provider Services is required for any of the following changes:

- 1099 mailing address
- Tax Identification Number (Tax ID or TIN) or Entity Affiliation (W-9 required)
- Group name or affiliation
- Physical or billing address
- Telephone and fax number

**Provider Termination**
In addition to the Provider termination information included in the Agreement, Providers must adhere to the following terms:

- Any contracted Provider must give at least 90 days prior written notice 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 Members regarding the Provider's participation status with WellCare. Please refer to the Agreement for the 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
- Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month
- Members in active treatment may continue care when such care is medically necessary, through the completion of treatment of a condition for which the Member was receiving at the time of the termination or until the Member selects another treating Provider, not to exceed six months after the Provider termination. For pregnant Members who have initiated a course of general care, regardless of the trimester in which care was initiated, continuation shall be provided until the completion of postpartum care

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

Please note that WellCare will notify in writing all appropriate agencies and/or Members 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 Iowa Medicaid program requirements and/or regulations and statutes.

**Out-of-Area Member Transfers**
Providers should assist WellCare in arranging and accepting the transfer of Members 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.

**Members with Special Health Care Needs**
Members with special health care needs include Members with the following conditions:

- Intellectually disabled or related conditions
- Serious chronic illnesses such as 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
- Related populations eligible for SSI

The following is a summary of responsibilities specific to Providers who render services to WellCare Members who have been identified with special health care needs:

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

For more information on Utilization Management for Members with special health care needs, refer to *Section* 4: *Utilization Management, Care Management and Disease Management.*

**Responsibilities of Primary Care Physicians (PCPs)**

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

- Coordinate, monitor and supervise the delivery of primary care services to each Member
- See Members for an initial office visit and assessment within the first 90 days of enrollment in WellCare
- Coordinate, monitor and supervise the delivery of medically necessary primary and preventive care services to each Member, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for Members under the age of 21
- Maintain a ratio of Members to full-time equivalent (FTE) physicians as follows:
  - One physician FTE per 1,500 Medicaid Members
  - One advanced registered nurse practitioner (ARNP) FTE for every 750 Medicaid Members above 1,500
  - One physician assistant (PA) FTE for every 750 Medicaid Members above 1,500
- Provide appropriate referrals of potentially eligible women, infants and children to the Women, Infants, and Children (WIC) program for nutritional assistance
- Assure Members 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 Member or the Member receives a HEDIS® (Healthcare Effectiveness Data and Information Set) service
- Submit encounters. For more information on encounters, refer to *Section 5: Claims*
- Ensure Members utilize network Providers. If unable to locate a participating WellCare Medicaid Provider for services required, contact Clinical Services for assistance. Refer to the *Quick Reference Guide* on WellCare's website
- Comply with and participate in corrective action and performance improvement plan(s)

**Vaccines for Children Program**

Providers must participate in the Vaccines for Children Program (VFC). The VFC is administered by the Department of Health, Bureau of Immunizations. The VFC provides vaccines at no charge to physicians and eliminates the need to refer children to county health departments (CHDs) for immunizations. WellCare covers and reimburses participating Providers for immunizations covered by Medicaid, but not provided through VFC. Providers who are directly enrolled in the VFC program must maintain adequate vaccine supplies.

**Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**
Any Provider, including physicians, nurse practitioners, registered nurses, physician assistants and medical residents who provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening services are responsible for:

- Providing all needed initial, periodic and inter-periodic EPSDT health assessments, diagnosis and treatment to all eligible Members in accordance with the Agency's approved Medicaid administrative regulation Sect III C.9.b and the Periodicity Schedule provided by the American Academy of Pediatrics (AAP)
- Referring the Member 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 are required 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 Prior Authorization for medically necessary EPSDT special services in the event other health care, diagnostic, preventive or rehabilitative services, treatment or other measures required under I.A.C. 249A.2(7), that are not otherwise covered under the Iowa Medicaid Program
- 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
- Ensuring Members receive the proper referrals to treat any conditions or problems identified during the health assessment including tracking, monitoring and following up with Members to ensure they receive the necessary medical services
- Assisting Members with transition to other appropriate care for children who age-out of EPSDT services

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

Provider 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, refer to *Section 1: Welcome to WellCare*. For more information on the Iowa Medicaid EPSDT Periodicity Schedule, refer to the Agency's website at **https://dhs.iowa.gov**. For more information on the Periodicity Schedule based on the American Academy of Pediatrics guidelines, refer to the AAP website at **http://www2.aap.org/immunization/IZSchedule.html**.

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

- Support of the Provider Relations, Provider Services and Clinical Services departments, as well as the tools and resources available on WellCare's website at **https://www.wellcare.com/Iowa**
- Information on WellCare network Providers for the purposes of referral management and discharge planning

**Closing of Physician Panel**
When requesting closure of the Provider's panel to new Members and/or transferring WellCare Members, PCPs must:

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

**Covering Physicians/Providers**
In the event that participating Providers are temporarily unavailable to provide care or referral services to WellCare Members, Providers should make arrangements with another WellCare-contracted (participating) and credentialed Provider to provide services on their behalf, unless there is an emergency.

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

In nonemergency cases, should a Provider have a covering physician/Provider who is not contracted and credentialed with WellCare, he or she should contact WellCare for approval. For more information, refer to the *Quick Reference Guide* on WellCare's website.

**Termination of a Member**
A WellCare Provider may not seek or request to terminate his/her relationship with a Member, or transfer a Member to another Provider of care based on the Member's medical condition, amount or variety of care required, or the cost of Covered Services required by WellCare's Member.

Reasonable efforts should always be made to establish a satisfactory Provider and Member relationship in accordance with practice standards. The Provider should provide adequate documentation in the Member's medical record to support his/her efforts to develop and maintain a satisfactory Provider and Member relationship. If a satisfactory relationship cannot be established or maintained, the Provider shall continue to provide medical care for the WellCare Member until such time that written notification is received from WellCare stating that the Member has been transferred from the Provider's practice, and such transfer has occurred.

In the event that a participating Provider desires to terminate his/her relationship with a WellCare Member, the Provider should submit adequate documentation to support that although they have attempted to maintain a satisfactory Provider and Member

relationship, the Member's noncompliance with treatment or uncooperative behavior is impairing the ability to care for and treat the Member effectively.

The Provider should complete a "PCP Request for Transfer of Member Form", attach supporting documentation and fax the form to WellCare's Customer Service Department. A copy of the form is available on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid/Forms**

**Domestic Violence and Substance Abuse Screening**
PCPs should identify indicators of substance abuse or domestic violence and offer referral services to applicable community agencies.

**Smoking Cessation**
PCPs should direct Members who smoke and wish to quit smoking to call WellCare's Customer Service Department and ask to be directed to the Smoking Cessation program. A health coach will work with Members through tailored interactions based on their individual needs and health objectives associated with smoking cessation.

PCPs can also reference the Agency for Health Care and Research & Quality's Smoking Cessation *Quick Reference Guide* on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid** or by contacting a Provider Relations representative.

**Weight Loss**
Providers should direct Members with a high body mass index (BMI) and who wish to achieve a healthy weight to call WellCare's Customer Service Department and ask to be directed to the Medically Directed Healthy Weight program. A health coach will work with Members through tailored interactions based on their individual needs and health objectives associated with weight loss.

**Adult Health Screening**
An adult health Screening should be performed by a physician to assess the health status of all WellCare adult Members. The adult Member should receive an appropriate assessment and intervention as indicated or upon request.

## 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 Members, to ensure that the associates of WellCare value diversity within the organization, and to see that Members in need of linguistic services receive adequate communication support. In addition, WellCare is committed to having its Providers fully recognize and care for the culturally diverse needs of the Members they serve.

The objectives of the Cultural Competency program are to:

- Identify Members who have potential cultural or linguistic barriers for which alternative communication methods are needed

- Use culturally sensitive and appropriate educational materials based on the Member's race, ethnicity, and primary language spoken
- Make resources available to address the unique language barriers and communication barriers that exist in the population
- Help Providers care for and recognize the culturally diverse needs of the population
- Provide education to associates on the value of the diverse cultural and linguistic differences in the organization and the populations served
- Decrease health care disparities in the minority populations WellCare serves

Culturally and Linguistically Appropriate Services (CLAS) are health care services provided that are respectful of, and responsive to, cultural and linguistic needs. The delivery of culturally competent health care and services requires that health care Providers and/or their staff possess a set of attitudes, skills, behaviors, and policies which enable the organization and staff to work effectively in cross-cultural situations.

The components of WellCare's Cultural Competency program include:

- Data Analysis – WellCare analyzes data on the populations in each region it serves for the purpose of learning about that region's cultural and linguistic needs, as well as any health disparities specific to that region. 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 population
    - Demographic data available from the U.S. Census and any special studies done locally
    - Claims and Encounter Data to identify the health care needs of the population by identifying the diagnostic categories that are the most prevalent
    - Member requests for assistance, or Member grievances, to identify areas of opportunity to improve service to Members from a cultural and linguistic angle
    - Data on race, ethnicity and language spoken for Members can be collected both electronically from the state data received and through voluntary self-identification by the Member during enrollment/intake or during encounters with network Providers
- Community-Based Support: WellCare's success requires linking with other groups that share the same goals.
    - WellCare reaches out to community-based organizations that support racial and ethnic minorities, and the disabled, to ensure that existing community resources for Members who have special needs are used to their full potential. The goal is to coordinate the deployment of both community and WellCare resources, as well as to take full advantage of the bonds that may exist between the community-based entities and the covered population.
    - WellCare develops and maintains grassroots sponsorships that enhance its effort to reach low-income communities. WellCare also provides opportunities for building meaningful relationships that benefit all Members of the communities. These sponsorships are coordinated with Providers, community health fairs and public events.

- Diversity and Language Abilities of WellCare – WellCare recruits diverse talented staff 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 Members are hired for functional units that have direct contact with Members to meet the needs identified. Today, one-third 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. For example, in Georgia, approximately two-thirds of the Hispanic population is of Mexican origin. In Florida and New York City, the Puerto Rican population is predominant.
    - Where WellCare enrolls significant numbers of Members who speak languages other than English or Spanish, WellCare seeks to recruit staff Members 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. This information is made available in the Provider Directory so that Members can choose a Provider that speaks their primary language.
    - Providers are recruited to ensure a diverse selection of Providers to care for the population served.
- Linguistic Services
    - Providers will identify Members who have potential linguistic barriers for which alternative communication methods are needed and will contact WellCare to arrange appropriate assistance.
    - Members may receive interpreter services at no cost when necessary to access Covered Services through a vendor, as arranged by the Customer 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 are provided by vendors with such expertise and coordinated by WellCare's Customer Service Department.
    - Written materials are available for Members in large–print format, and certain non-English languages prevalent in WellCare's service areas.
- Electronic Media
    - Telephone system adaptations – Members have access to the TTY/TDD line for hearing-impaired services. WellCare's Customer Service Department is responsible for any necessary follow-up calls to the Member. The toll-free TTY/TDD number can be found on the Member identification card.
- Provider Education
    - WellCare's Cultural Competency Program provides a checklist to assess the cultural competency of Providers' offices

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

For more information about the Cultural Competency Program, registered Provider Portal users may access the Cultural Competency training on WellCare's secure website by logging in to **https://www.wellcare.com/Iowa**. A paper copy, at no charge, may be obtained upon request by contacting Provider Services or a Provider Relations representative.

**Cultural Competency Survey**
For more information on the Cultural Competency Program, registered Provider portal users may access the Cultural Competency training by logging in to **https://www.wellcare.com/Iowa**. A paper copy, at no charge, may be obtained upon request by contacting Customer Service or your Provider Relations representative.

## Member Administrative Guidelines

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

**Member Handbook**
All newly enrolled Members will receive a Member Handbook within five calendar days of receiving the notice of enrollment from WellCare. WellCare will mail all enrolled Members a Member Handbook.

**Enrollment**
WellCare must obey laws that protect from discrimination or unfair treatment. WellCare does not discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age or national origin.

Upon enrollment in WellCare, Members 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 disenrollment procedures
- Brochures describing certain benefits not traditionally covered by Medicaid and other value-added items or services, if applicable

**Member Identification Cards**
Member identification cards are intended to identify WellCare Members, the type of plan they have and to facilitate their interactions with health care Providers. Information found on the Member identification card may include the Member's name, identification number, plan type, PCP's name and telephone number, co-payment information, WellCare contact information and claims filing address. Possession of the Member identification card does not guarantee eligibility or coverage. Providers are responsible for ascertaining the current eligibility of the cardholder.

Note: Members who have Medicare or other health insurance as their primary insurance are not required to choose a PCP with WellCare and they will receive an ID card stating that a PCP is not required.

**Eligibility Verification**

A Member's eligibility status can change at any time. Therefore, all Providers should consider requesting and copying a Member's identification card, along with additional proof of identification such as a photo ID, and file them in the patient's medical record.

Providers may do one of the following to verify eligibility:

- Access the secure, online Provider Portal of the WellCare website at **https://www.wellcare.com/Iowa/Providers/Medicaid**
- Access WellCare's interactive voice response (IVR) system
- Contact Provider Services

Providers will need their Provider ID number to access Member eligibility through the avenues listed above. 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 Agreement for additional details.

**Member Engagement**

WellCare utilizes a number of engagement strategies to establish a relationship with its Members. Engagement begins with notification of Member enrollment. Notice of enrollment triggers an attempt to reach the Member by phone to complete the Health Risk Assessment (HRA) and to familiarize the Member with his or her plan benefits. A total of eight attempts are made to contact the Member. If the Member cannot be reached by telephone, the Member's name and address is referred to the community health worker (CHW) assigned to the Member's ZIP Code. Community health workers then make every attempt to connect with the Member and conduct a face-to-face session to complete the HRA. This interview, whether telephonic or in person, is a critical step to engaging Members in their own health management. WellCare's telephonic team and CHWs are trained in behavioral interviewing techniques which promote maximum engagement of the Member.

**Assessments for Members**

A Health Risk Assessment is completed with the Member within the first 90 days of enrollment. Members have several options for completing the HRA. A paper version is mailed to the Member with his or her enrollment materials. The Member can alternatively choose to take the HRA online via the Member portal. In addition, WellCare makes eight attempts to contact the Member telephonically to complete an HRA. If the telephonic attempts are not successful, Members are referred to WellCare's community health workers, who are assigned by ZIP Code, for completion of the HRA. Community health workers utilize every method at their disposal to make contact with a Member and to conduct a face-to-face interview to complete the HRA.

In the event that the HRA identifies a Member who requires a more comprehensive assessment, the Member is electronically referred to WellCare's Care Management Program for completion of a more comprehensive assessment. Case managers are either licensed registered nurses or social workers. Upon completion of the more

comprehensive assessment, a care plan is developed with input from the Member, the Provider and the case manager. The care plan is available for Providers to view via the Provider portal. Case managers collaborate with the Provider to ensure the most successful care plan is developed and implemented to effect positive outcomes for the Member.

**Member Rights and Responsibilities**

Members have the right:

- To get details about what WellCare covers and how to use its services and WellCare Providers
- To have their privacy protected
- To know the names and titles of doctors and others who treat them
- To talk openly about care needed for their health, no matter the cost or benefit coverage or risks involved
- To have this information shared in a way they understand
- To know what to do for their health after they leave the hospital or Provider's office
- To refuse to take part in research
- To create an Advance Directive
- To suggest ways WellCare can improve
- To file complaints or appeals about WellCare or the care it provides
- To have a say in WellCare's Member rights
- To have all these rights apply to the person who can legally make health care decisions for them
- To have all WellCare staff Members observe their rights
- To use these rights no matter what their sex, age, race, ethnic, economic, educational or religious background
- To receive information about WellCare, its services, its practitioners and Providers, and Members rights and responsibilities
- To participate with practitioners in making decisions about their health care
- To a candid discussion of appropriate or medical necessary treatment options for their conditions, regardless of cost or benefit coverage
- To make recommendations regarding Member rights and responsibilities
- To be treated with respect and with due consideration for dignity and privacy
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand
- To participate in decisions regarding health care, including the right to refuse treatment
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- To ask for and receive a copy of medical records, and ask that they be amended or corrected:
    - Requests must be received in writing from the Member or the person chosen to represent him or her
    - The records will be provided at no cost
    - The records will be sent within 14 days of receipt of the request

- To be responsible for cost sharing only as specified under Covered Services co-payments and to be responsible for cost sharing only as specified in the Iowa Contract

To be furnished health care services in accordance with federal and state regulations the state must make sure a Member is:

- Free to exercise their rights
- The exercise of those rights does not adversely affect the way WellCare and its Providers or the state agency treat the Member

Members have the responsibility:

- To know how their plan works by reading their handbook
- To carry their ID card and Medicaid Gold Card with them at all times and to present them when they get health care services
- To get nonemergency care from a primary doctor, to get referrals for specialty care, and to work with those giving them care
- To be on time for appointments
- To cancel or set a new time for appointments ahead of time
- To report unexpected changes to their Provider
- To respect doctors, staff and other patients
- To help set treatment goals that they and their doctor agree to
- To follow the treatment plan they and their Provider agree on
- To understand medical advice and ask questions
- To know about the medicine they take, what it is for, and how to take it
- To provide information needed to treat them
- To make sure their doctor has their previous medical records
- To tell WellCare within 48 hours, or as soon as they can, if they are in a hospital or go to an emergency room
- To supply information (to the extent possible) that WellCare and its practitioners and Providers need in order to provide care
- To understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible

**Assignment of Primary Care Provider**

Members enrolled in a WellCare plan must choose a PCP at the point of enrollment or they will be assigned to a PCP within WellCare's network. Members have 30 days from the date of enrollment to select another participating PCP. To ensure quality and continuity of care, the PCP is responsible for arranging all of the Member's health care needs from providing primary care services to coordinating referrals to specialists and Providers of ancillary or hospital services.

**Changing Primary Care Providers**

Members may change their PCP selection at any time by calling Customer Service. The requested change will be effective the first day of the following month of the request if the request is received after the tenth day of the current month.

**Women's Health Specialists**

PCPs may also provide routine and preventive health care services that are specific to female Members. If a female Member 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.

**Hearing-Impaired, Interpreter and Sign Language Services**

Hearing-impaired, interpreter and sign language services are available to WellCare Members through WellCare's Customer Service Department. PCPs should coordinate these services for WellCare Members and contact Customer Service if assistance is needed. For Provider Services telephone numbers, please refer to the *Quick Reference Guide* WellCare's website at **https://www.wellcare.com/Iowa**

# 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 health care and services. Strategies are identified and activities implemented in response to findings. The QI Program addresses the quality of clinical care and nonclinical aspects of service with a focus on key areas that include, but are not limited to:

- Quantitative and qualitative improvement in Member outcomes
- Coordination and continuity of care with seamless transitions across health care settings/services
- Cultural competency
- Quality of care/service
- Critical incidents
- Preventive health
- Service utilization
- Complaints/grievances
- Network adequacy
- Appropriate service utilization
- Disease and Case Management
- Member and Provider satisfaction
- Components of operational Service
- Regulatory/federal/state/accreditation requirements

The QI Program activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, Healthcare Effectiveness Data and Information Set (HEDIS®) measures, and/or medical record audits. The organization's Board of Directors has delegated authority to the Quality Improvement Committee (QIC) to approve specific QI activities, (including monitoring and evaluating outcomes, overall effectiveness of the QI Program, and initiating corrective actions plans when appropriate) when the results are less than desired or when areas needing improvement are identified.

**Medical Records**

Member medical records must be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to: medication lists, documentation of inpatient admissions, specialty consults appointment documentation, and other documentation sufficient to disclose the quantity, quality, appropriateness and timeliness of services provided under the Contract. The medical record shall be signed and dated by the Provider of service(s).

Confidentiality of Member 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 law. Providers should have procedures in place to permit the timely access and submission of medical records to WellCare upon request. WellCare follows state and federal law regarding the retention of records remaining under the care, custody and control of the physician or health care Provider. Information from the medical records review may be used in the re-credentialing process as well as quality activities.

For more information regarding confidentiality of Member information and release of records, refer to *Section 8: Compliance*.

The Member's medical record is the property of the Provider who generates the record. However, each Member or his or her representative is entitled to one free copy of his or her medical record. Additional copies shall be made available to Members at cost.

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

- Member/patient identification information on each page
- Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers of emergency contacts (if no phone, contact name), consent forms, identify language spoken, and guardianship information
- Date of data entry and date of encounter
- Late entries should include date and time of occurrence and date and time of documentation
- Provider identification by name and profession of the rendering Provider (e.g., M.D., D.O., O.D.)
- Allergies and/or adverse reactions to drugs shall be noted in a prominent location
- Past medical history, including serious accidents, operations and illnesses. For children, past medical history includes prenatal care and birth information, operations and childhood illnesses (i.e., documentation of chicken pox)
- Identification of current problems
- The consultation, laboratory and radiology reports filed in the medical record shall contain the ordering Provider's initials or other documentation indicating review
- A current list of immunizations pursuant to 42 CFR 456
- Identification and history of nicotine, alcohol use or substance abuse
- Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department of Public Health pursuant to 42 CFR 456
- Follow-up visits provided secondary to reports of emergency room care
- Hospital discharge summaries
- Advanced medical directives, for adults
- Documentation that Member has received the Provider's office policy regarding office practices compliant to HIPAA
- Record is legible to at least a peer of the writer and written in standard English. Any record judged illegible by one reviewer shall be evaluated by another reviewer

A Member's medical record shall include the following minimal detail for individual clinical encounters:

- 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
- Unresolved problems, Referrals and results from diagnostic tests including results and/or status of preventive screening (EPSDT) services are addressed from previous visits

- Plan of treatment including:
    - Medication history, current medications prescribed, including the strength, amount and directions for use and refills
    - Therapies and other prescribed regimen
- Follow-up plans including consultation and referrals and directions, including time to return
- Education and instructions whether verbal, written or via telephone

**Provider Participation in the Quality Improvement Program**

Network Providers are contractually required to cooperate with quality improvement activities. Providers are invited to volunteer for participation in the QI Program. Avenues for participation include committee representation, quality/performance improvement projects, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) assessments and feedback/input via satisfaction surveys, grievances and calls to Customer Service. Provider participation in quality activities helps facilitate integration of Service delivery and benefit management.

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

**Member Satisfaction**

On an annual basis, WellCare conducts a Member satisfaction survey of a representative sample of Members. Satisfaction with services, quality, and access 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.

**Patient Safety to Include Quality of Care (QOC) and Quality of Service (QOS)**

Programs promoting patient safety are a public expectation, a legal and professional standard and an effective risk-management tool. As an integral component of health care 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 health care 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.

Potential quality of care (PQOC) incidents are events where undesirable health outcomes for WellCare Members could have been avoided through additional treatment rendered by the Provider or through treatment delivered in a manner inconsistent with current medical standards of practice. They are classified in one of six categories:

- Death or serious disability
- Delay or omission of care
- Medication issue
- Patient safety
- Post-op complications
- Critical incidents

- Procedural issue

Adverse incidents are events involving situations where an event occurs while the Member is receiving health care services and there is an association, in whole or in part, with a medical intervention, rather than the condition for which such intervention occurred, even if there is no permanent effect of the Member.

## Critical Incidents

WellCare identifies, tracks, and analyzes critical incidents to address potential and actual quality of care and/or health and safety issues. We regularly review the number and type of incidents (including, for example, the number and type of incidents across settings, Providers, and Provider types) and findings from investigations. We also identify trends and patterns, identify opportunities for improvement, and develop and implement strategies to reduce the occurrence of incidents and improve the quality of care delivery in all delivery settings.
WellCare will provide training for all Providers on Critical Incidents and will offer periodic updates to training to ensure Providers are fully aware of how they should respond to these occurrences.

A critical incident is a distressing, traumatic event which can occur in a Nursing Facility or Skilled Care Nursing Facility (NF/SCNF) or home and community-based long-term care service (HCBS) delivery setting, community alternative residential settings, adult day care centers, other HCBS Provider sites, and a Member's home. Events are defined as, but are not limited to; the following categories:

- Major Incident – an occurrence involving a consumer during service provision that:
  - Results in a physical injury to or by the Member that requires a physician's treatment or admission to a hospital
  - Results in the death of any person
  - Requires emergency mental health treatment for the consumer
  - Requires the intervention of law enforcement
  - Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3
  - Constitutes a prescription medication error or a pattern of medication efforts
  - Involves a Member's location being unknown by Provider staff who are assigned protective oversight

WellCare will require its staff members and contracted Providers to report, respond to, and document critical incidents as specified by WellCare. WellCare's staff and contracted Providers will report critical incidents to WellCare in accordance with applicable requirements. WellCare will develop and implement a critical incident reporting process, including a form and/or IA database, to be used to report critical incidents and reporting timeframes. Information will include but not be limited to the following: Date of Occurrence; Date WellCare became aware of the incident; Type of Incident; Setting; Provider; Short description of the incident; Short description of the immediate actions taken and date incident investigation was completed.

## Early, Periodic, Screening, Diagnosis and Treatment (EPSDT)

EPSDT is a federally mandated Medicaid program for children. The EPSDT program was first created by Congress in 1969 and it remains today as the only health care program ever designed specifically for children. The role of EPSDT is to promote the

physical, mental, social, emotional and behavioral health of children from birth to age 21. The EPSDT program emphasizes the use of a regular schedule of recommended well-child health visits, called screenings, to provide preventative health care and identify medical, developmental and social-emotional concerns. The EPSDT program requires any medically necessary diagnostic and treatment services for problems that are detected as part of a well-child screening exam be provided.

Members should have EPSDT visits on or before the following:

- Initial visit, newborn, within the first week, one month, two months, four months, six months, nine months, one year, 15 months and 18 months
- Then once a year for two through 21 year olds
- A complete history and physical examination within the first 90 days of joining WellCare

The basic requirements of EPSDT which must include all of the following services:

- **Comprehensive health and developmental history** including assessment of physical health, mental health (social, emotional and behavioral issues), development and nutrition.
- **Comprehensive unclothed physical exam** including height, weight, head circumference (newborn to age 24 months) and blood pressure (starting at age three)).
- **Developmental Milestones** and, when needed, developmental screening and assessment using a recognized standardized developmental screening tool.
- **Appropriate immunizations** or documentation of immunizations when received elsewhere.
- **Laboratory tests** to be performed at the Provider's discretion include tuberculosis screening, dyslipidemia screening, urinalysis, cervical cancer screening and sickle cell testing. Tests that are required or recommended are listed below:
  - **Lead test** (prior to age 12 months and 24 months
  - **Hemoglobin and Hematocrit** testing is recommended for nine months to 12 months, 15 months to 18 months (as medically necessary) and when a medical need is identified.
- **Health education** consists of anticipatory guidance and injury prevention.
- **Vision and Hearing Screening** includes the Provider's subjective assessment and periodic objective vision and hearing screening using HFS-approved instruments. If the objective screening is not performed by the Provider, then a referral should be made for the objective screening(s).
- **Nutritional Assessment** can consist of health history, dietary evaluation, anthropometric measurements, biochemical measurements and clinical evaluations.
- **Risk Assessment** is essential in early identification of physical and mental problems in all ages. Areas that should be assessed include mental health, tobacco/substance abuse and perinatal depression.
- **Oral Screening** is part of the physical examination. Children should be referred to dentist for routine and periodic examination at least annually.
- **Referral** to WIC, family care management and other community agencies (as appropriate).

## Preventive Guidelines

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
- Tests for cholesterol, blood sugar, colon and rectal cancer, 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 Member's needs. Prevention activities are reviewed and approved by the Utilization Management Medical Advisory Committee with input from participating Providers and the Quality Improvement Committee. 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.

**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 Members and populations. The Clinical Practice Guidelines are based on peer-reviewed medical evidence and are relevant to the population served. Approval of the Clinical Practice Guidelines occurs through the Quality Improvement Committee. Clinical Practice Guidelines, to include preventive health guidelines, may be found on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Clinical-Guidelines/CPGs**

**Healthcare Effectiveness Data and Information Set**

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. The tool comprises 88 measures across 7 domains of care, including:

- Effectiveness of care
- Access and availability of care
- Satisfaction with the care experience
- Utilization and risk adjusted utilization
- Relative resource use
- *WellCare (health plan)* descriptive information
- Measures collected using electronic clinical data systems

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. 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, Members benefit from the quality and

effectiveness of care received and Providers benefit by delivering industry recognized standards of care to achieve optimal outcomes.

**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 **https://www.wellcare.com/Iowa**

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

## Utilization Management

**Overview**

WellCare's Utilization Management (UM) program is designed to meet contractual requirements with federal regulations, while providing Members access to high-quality, cost-effective medically necessary care. For purposes of this section, terms and definitions may be contained within this section, within *Section 13: Definitions* of this manual, 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 Member's diagnosis and level of care required
- Providing access to medically appropriate, cost-effective health care 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 health care behaviors and Member partnership
- Facilitating communication and partnerships among Members, families, Providers, delegated entities and WellCare in an effort to enhance cooperation and appropriate utilization of health care services
- Reviewing, revising and developing medical coverage policies to ensure Members have appropriate access to new and emerging technology
- Enhancing the coordination and minimizing barriers in the delivery of behavioral and medical health care services

**Medically Necessary Services**

The determination of whether a covered benefit or service is medically necessary complies with the requirements established in Iowa Administrative Code, within the Iowa Contract.

To be medically necessary or a medical necessity, a covered benefit shall meet the following conditions:

- Be appropriate and necessary for the symptons, diagnosis or treatment of the condition of the Member
- Be provided for the diagnosis or direct care and treatment of the Member's condition enabling the Member to make reasonable progress in treatment
- Within the standards of professional practice and given at the appropriate time and in the appropriate setting
- The most appropiate level of covered services, which can safely be provided
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker or the Provider

"Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a Provider has prescribed, recommended or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a Covered Service.

In accordance with the Iowa Contract, each medically necessary service must be sufficient in amount, duration and scope to reasonably achieve its purpose.

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 health care and services based on WellCare Members' 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. WellCare does not provide financial incentives to encourage or promote underutilization.

**Criteria for UM Decisions**

WellCare's UM program uses nationally recognized review criteria based on sound scientific medical evidence. Physicians with an unrestricted license in the state of Iowa and professional knowledge and/or clinical expertise in the related health care specialty actively participate in the discussion, adoption, application and annual review and approval of all utilization decision-making criteria.

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

- InterQual™
- WellCare Clinical Coverage Guidelines
- Medical necessity
- State Medicaid Contract
- State Provider Handbooks, as appropriate
- Local and federal statutes and laws
- Medicaid and Medicare guidelines
- Hayes Health Technology Assessment
- Level of Care Utilization System (LOCUS)
- Child Adolescent Service Intensity Instrument (CASII)
- American Society of Addition Medicine (ASAM)

The clinical reviewer and/or Medical Director involved in the UM process apply medical necessity criteria in context with the Member's individual circumstance and the capacity of the local Provider delivery system. When the above criteria do not address the individual Member's needs or unique circumstance, the Medical Director will use clinical judgment in making the determination.

The review criteria and guidelines are available to the Providers upon request. Providers may request a copy of the criteria used for specific determination of medical necessity by contacting the Utilization Management Department via Provider Services at the phone number listed at the bottom of this page,

## Utilization Management Process

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

- Notifications
- Referrals
- Prior Authorizations
- Concurrent review
- Retrospective review

Decision and notification time frames are determined by either 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 on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid/Forms**.

### Notification

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

- Prenatal services. This enables WellCare to identify pregnant Members for inclusion into the care coordination program for pregnant Members. OB Providers are required to notify WellCare of pregnancies via fax using the *Prenatal Notification Form* as soon as possible after the initial visit. This process will expedite case management and claims reimbursement.
- A Member's admission to a hospital. This enables WellCare to log the hospital admission and follow up with the facility on the following calendar day to receive clinical information. The notification should be received by fax or telephone and include Member demographics, facility name and admitting diagnosis.

### Referrals

For an initial referral, WellCare does not require authorization as a condition of payment. 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.

### Prior Authorization

Prior Authorization allows for efficient use of Covered Services and ensures that Members receive the most appropriate level of care, within the most appropriate setting. Prior Authorization may be obtained by the Member's PCP, treating specialist or facility.

Reasons for requiring Prior Authorization may include:

- Review for medical necessity
- Appropriateness of rendering Provider
- Appropriateness of setting
- Case and disease management considerations

Prior Authorization is **required** for select elective or non-emergency services as designated by WellCare. Guidelines for Prior Authorization requirements by service type may be found in the *Quick Reference Guide* on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid** or by calling WellCare Provider Services at the phone number listed on the bottom of this page.

Some Prior Authorization guidelines to note are:

- The Prior Authorization request should include the diagnosis to be treated and the CPT® Code describing the anticipated procedure. If the procedure performed and billed is different from that on the request, but within the same family of services, a revised authorization is not required.
- 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 and total number of visits requested and the expected duration of care.

The attending physician or designee is responsible for obtaining the Prior Authorization of the elective or nonurgent admission. Refer to the *Quick Reference Guide* which may be found on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid** for a list of services requiring Prior Authorization.

**Concurrent Review**

Concurrent review activities involve the evaluation of a continued hospital, Long-Term Acute Care (LTAC) hospital, skilled nursing or acute rehabilitation stay for medical appropriateness, utilizing appropriate criteria. The concurrent review nurse follows the clinical status of the Member through telephonic or on-site chart review and communication with the attending physician, hospital UM, care management staff or hospital clinical staff involved in the Member'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 Member, complexity, treatment plan and discharge planning activity. The continued length of stay authorization will occur concurrently based on InterQual™ criteria for appropriateness of continued stay 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
- Identify cases appropriate for care management

The concurrent review process incorporates the use of InterQual™ criteria to assess quality and appropriate level of care for continued medical treatment. Reviews are performed by licensed nurses under the direction of the WellCare Medical Director.

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

**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 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 Member to the appropriate level of care. An inpatient review nurse may refer an inpatient Member with identified complex discharge needs to care management for follow-up needs.

**Retrospective Review**

A retrospective review is any review of care or services that have already been provided. There are two types of retrospective reviews which 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.
- Retrospective review initiated by Providers
  - WellCare will review post-service requests for authorization of inpatient admissions or outpatient services. The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions, and taking into account the Member's needs at the time of service. WellCare will also identify quality issues, utilization issues and the rationale behind failure to follow WellCare's Prior Authorization/pre-certification guidelines.

WellCare will give a written notification to the requesting Provider and Member within 30 calendar days of receipt of a request for a UM determination. If WellCare is unable to make a decision due to matters beyond its control, it may extend the decision time frame once, for up to 14 calendar days of the post-service request.

The Member or Provider may request a copy of the criteria used for a specific determination of medical necessity by contacting the Utilization Management Department via Provider Services. Refer to the *Quick Reference Guide* which may be found on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid**

**Peer-to-Peer Reconsideration of Adverse Determination**

In the event of an adverse determination following a medical necessity review, peer-to-peer reconsideration is offered to the attending or ordering physician via fax notification. The attending or ordering physician is provided a toll-free number to the Medical Director Hotline to request a discussion with the WellCare medical director who made the denial determination. Peer-to-peer reconsideration is offered within seven business days from the decision date.

The review determination notification contains instructions on how to use the peer-to-peer reconsideration 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 Members including:

- Certain diagnostic tests and procedures considered by WellCare to routinely be part of an office visit, and plain film X-rays
- Clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories and physician offices under a Clinical Laboratory Improvements Amendments (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
    - Cytogenetic laboratory tests
- Certain tests described as CLIA-waived may be conducted in the physician's office if the Provider is authorized through the appropriate CLIA certificate, a copy of which must be submitted to WellCare.

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

**WellCare Proposed Actions**

A proposed action is an action taken by WellCare to deny a request for services or a reduction in the amount, duration and scope of services. In the event of a proposed action, WellCare will notify the Member and the requesting Provider in writing of the proposed action. The notice will contain the following:

- The action WellCare has taken or intends to take
- The reason(s) for the action
- The Member's right to appeal, and the process to do so
- The Member's right to request a state hearing or external review
- Procedures for exercising Member's rights to appeal or file a grievance
- Circumstances under which expedited resolution is available and how to request it
- The Member'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 Member may be required to pay the costs of these services

**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 Member of the health care team, a Member, 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 Member by a qualified health care professional within network, or a non-participating Provider if there is not a participating Provider with the expertise required for the condition.

In accordance with the Iowa Contract, WellCare shall comply with all Members requests for a second opinion from a qualified professional. If the Provider network does not include a Provider who is qualified to give a second opinion, WellCare shall arrange for the Member to obtain a second opinion from a Provider outside the network at no cost to the Member.

**Individuals with Special Health Care Needs**

Individuals with special health care needs are adults and children/adolescents who face physical, behavioral or environmental challenges daily that place at risk their health and ability to fully function in society. Factors include: (a) individuals with mental retardation or related conditions; (b) individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; (c) individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; and (d) children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to placement in foster care.

Physicians who render services to Members who have been identified as having chronic or life-threatening conditions should:

- Allow the Members needing a course of treatment or regular care monitoring to have direct access through standing authorization or approved visits, as appropriate for the Member's condition or needs:
  - To obtain a standing authorization, the Provider should complete the *Outpatient Authorization Request Form* and document the need for a standing authorization request under the pertinent clinical summary area of the form
  - The authorization request should outline the plan of care including the frequency, total number of visits and the expected duration of care
- Coordinate with WellCare to ensure that each Member has an ongoing source of primary care appropriate to his or her needs and a person
  or entity formally designated as primarily responsible for coordinating the health care services furnished to the Member
- Ensure that Members requiring specialized medical care over a prolonged period of time have access to a specialty care Provider
  - Members will have access to a specialty care Provider through standing authorization requests, if appropriate

## Service Authorization Decisions

| Type of Request | Decision | Extension |
|---|---|---|
| **Standard Pre-Service** | 7 calendar days | 14 calendar days |
| **Expedited Pre-Service** | 3 calendar days | 14 calendar days |
| **Urgent Concurrent** | 24 hours | 48 hours |
| **Post-Service** | 30 calendar days | 14 calendar days |

## Standard Service Authorization

WellCare will provide a service authorization decision as expeditiously as the Member's health condition requires and within state-established time frame which will not exceed seven calendar days. WellCare will fax an authorization response to the Provider fax number(s) included on the authorization request form. An extension may be granted for an additional 14 calendar days if the Member or the Provider requests an extension, or if WellCare justifies a need for additional information and the extension is in the Member's best interest.

## Expedited Service Authorization

In the event the Provider indicates, or WellCare determines, that following the standard time frame could seriously jeopardize the Member's life or health, WellCare will make an expedited authorization determination and provide notice within 3 calendar days of the request. An extension may be granted for an additional 14 Calendar Days if the Member or the Provider requests an extension, or if WellCare justifies a need for additional information and the extension is in the Member's best interest. **Requests for expedited decisions for Prior Authorization should be requested by telephone,** not fax or WellCare's secure, online Provider Portal. Please refer to the *Quick Reference Guide* to contact the UM Department via Provider Services, which may be found on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid**

Members and Providers may file a verbal request for an expedited decision.

**Urgent Concurrent Authorization**
An authorization decision for services that are ongoing at the time of the request, and that are considered to be urgent in nature, will be made within 24 hours of receipt of the request. An extension may be granted for an additional 48 hours.

**Emergency/Urgent Care and Post-Stabilization Services**
Emergency services are not subject to Prior Authorization requirements and are available to Members 24 hours a day, seven days a week. Urgent care services should be provided within one day. See *Section 13: Definitions* for definitions of “emergency” and “urgent”.

Post-stabilization services are services related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or improve, or resolve the Member’s condition. Post-stabilization services are covered without Prior Authorization up to the point WellCare is notified that the Member’s condition has stabilized.

**Continuity of Care**
WellCare will allow Members in active treatment to continue care with a terminated treating Provider, whether termination is voluntary or involuntary, when such care is medically necessary, through completion of treatment of a condition for which the Member was receiving care at the time of the termination, until the Member selects another treating Provider, or during the next open enrollment period. The transition of care period is 90 days.

WellCare will allow pregnant Members who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care with a terminated treating Provider until completion of postpartum care.

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**

**Transition Period-Out of Network Care:**
During the first 90 days of the Contract, with the exception of LTSS, residential services and certain services rendered to dual diagnosis populations, WellCare shall allow a Member who is receiving covered benefits from a non-network Provider at the time of Contractor enrollment to continue to accessing that Provider, even if the network has been closed due to the WellCare meeting the network access requirements.

WellCare is permitted to establish single case agreements or otherwise authorize non-network care past the initial 90 days of the Contract to provide continuity of care for Members receiving out- of network services.

WellCare shall make commercially reasonable attempts to contract the Providers from whom an enrolled Member is receiving ongoing care.

**Transitions during Inpatient Stays:**
WellCare shall provide care coordination after the Member has disenrolled from WellCare whenever the Member disenrollment occurs during an inpatient stay.

Acute inpatient hospital services for Members who are hospitalized at the time of disenrollment from WellCare shall be paid by WellCare until the Member is discharged from acute care or for 60 days after disenrollment, whichever is less, unless the Member is no longer eligible for Medicaid.

Services other than inpatient hospital services (e.g., physician services) shall be paid by the new program contractor as of the effective date of disenrollment.

When Member disenrollment to another program Contractor occurs during an inpatient stay, WellCare shall notify the new program Contractor of the inpatient status of the Member. WellCare shall also notify the inpatient hospital of the change in program Contractor enrollment, but advise the hospital that WellCare maintains financial responsibility.

**Long Term Services and Supports (LTSS):**
WellCare shall not reduce, modify or terminate LTSS services in the absence of an up-to-date assessment of needs that supports the reduction, modification, or termination.
WellCare shall ensure Members receiving LTSS will be permitted to see all current Providers on their approved service plan, when they initially enroll with WellCare, even on a non-network basis, until an updated service plan is completed, either agreed upon by the Member or resolved through the appeals or fair hearing process, and implemented.

WellCare shall honor existing exceptions to policy granted by the Director for the scope and duration designated.

WellCare shall extend the authorization of LTSS from a non-contracted Provider as necessary to ensure continuity of care pending the Provider's contracting with WellCare, or the Member's transition to a contract Provider.

WellCare shall facilitate a seamless transition to new services and/or Providers, as applicable, in the plan of care developed by WellCare, without any disruption in services.

**Residential Services:**

**Year one Operations:**
During the first year of the Contract, WellCare shall permit Members using a residential Provider at the time of enrolment with WellCare to access the residential Provider being utilized at the time of enrollment for up to one year, even on a non-network basis. For purposes of this requirement a residential Provider is defined as a: (i) nursing facility; (II) ICF.ID; and (iii) support for the Member to live in a residential setting either controlled by the Member or the Provider funded through 1915 (i) Habilitation waiver Provider or a 1915© HCBS waiver.

**Ongoing Operations:**
Effective one year after the Contract effective date, WellCare shall not transition Members using residential Providers to another residential Provider unless the following conditions are met: (i) the Member or his/her representative specifically requests to transition; (ii) the Member or his/her representative provides written consent to transition based on quality or other concerns raised by WellCare, which shall not include the residential Provider's rate of reimbursement; or (III) the residential Provider has chosen not to contract with WellCare.

If the residential Provider is a non-contract Provider, WellCare may: (i) authorize continuation of these services pending contracting with the Provider; (ii) authorize continuation of the services, for at least 30 days pending facilitation of the Member's transition to a contracted Provider, subject to the Member's agreement with such transition; or (III) Continue to reimburse services from the non-contract Provider.

If a Member is transitioned to a contract Provider, WellCare shall extend the authorization of services with the non-contracted Provider beyond the minimum 30 day requirements necessary to ensure continuity of care and the Member's seamless transition to a new Provider.

WellCare shall permit a Member with a dual diagnosis of a behavioral health condition and developmental disorder to remain in their residential Provider for at least one year or with their inpatient psychiatric Provider, regardless of network status, as long as the services continue to be medically necessary.

If, for whatever reason, a Member can no longer be served by his/her residential Provider WellCare shall find and make available to the Member an alternative residential Provider that can meet the Member's needs so there is no break in services.

**Pregnancy Continuity of Care:**
WellCare shall develop and implement a continuity of care policy to address Members who are pregnant at the time of enrollment with WellCare and are receiving services from an out- of network Provider.

**Dual Diagnosis Continuity of Care:**
Even if the Provider is not in-network with WellCare, WellCare shall permit Members with a dual diagnosis of a behavioral health condition and developmental disorder to remain with their Providers of all outpatient behavioral health services for a minimum of three months as long as the services continue to be medically necessary. WellCare may shorten this transition time frame only when the Provider of services is no longer available to service the Member or when a change in Providers is requested in writing by the Member or the Member's representative.

**Authorization Request Forms**
WellCare requests Providers use the standardized authorization request forms to ensure receipt of all pertinent information and enable a timely response to their request, including:

- *Inpatient Authorization Request Form* is used for services such as planned elective/non-urgent inpatient, observation, and skilled nursing facility and inpatient rehabilitation authorizations
- *Outpatient Authorization Request Form* is used for services such as follow-up consultations, consultations with treatment, diagnostic testing, office procedures, ambulatory surgery, radiation therapy, out-of-network services
- *Ancillary Authorization Request Form* is used for services such as durable medical equipment (DME), dialysis, home care services, and outpatient therapies including physical therapy (PT), occupational therapy (OT), speech therapy (ST). All Ancillary Authorization Request forms for non-urgent/elective ancillary services should be submitted via fax to the number listed on the form

To ensure timely and appropriate claims payment, all forms must:

- Have all required fields completed

- Be typed or printed in black ink for ease of review
- Contain a clinical summary or have supporting clinical information attached
- Behavioral health use authorization forms such as Discharge Summary Community Based Care Management, PHP/IOP Form, Inpatient/Sub-Acute/CSU Form Outpatient Services Request Form, Psychological/Neuropsychological, and Residential Services.

These forms among others can be found on WellCare's website at **https://www.wellcare.com/Iowa/**

If Prior Authorization is not granted, all associated claims will not be paid. See WellCare's *Clinical Coverage Guidelines* at **https://www.wellcare.com/Iowa/Providers/Clinical-Guidelines/CCGs** for additional information.

Providers must immediately notify WellCare of a Member's pregnancy. A *Prenatal Notification Form* should be completed by the OB/GYN or Primary Care Provider during the first visit and faxed to WellCare as soon as possible after the initial visit.

All forms are located on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid/Forms** All forms should be submitted via fax to the number listed on the form.

In no instance may the limitations or exclusions imposed by WellCare be more stringent than those specified in the Iowa Medicaid Handbooks.

**Special Requirements for Payment of Services**

The following services have special requirements from the state of Iowa

**Sterilizations**

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.

WellCare will not, and is prohibited from, making payment for sterilizations performed on any person who:

- Is under 21 years of age at the time he/she signs the consent
- Is not mentally competent
- Is institutionalized in a correctional facility, mental hospital or other rehabilitation facility

The required *470-0835 Consent Form* must be completed and submitted to WellCare.

For sterilization procedures, the mandatory waiting period between signed consent and sterilization is 30 calendar days.

The signed consent form expires 180 calendar days from the date of the Member's signature.

In the case of premature delivery or emergency abdominal surgery performed within 30 calendar days of signed consent, the physician must certify that the sterilization was performed less than 30 calendar days, but not less than 72 hours, after informed consent was obtained. Although these exceptions are provided, the conditions of the waiver will be subject to review.

A sterilization consent form must be properly filled out and signed for all sterilization procedures and attached to the claim at the time of submission to WellCare. The Member must sign the consent form at least 30 calendar days, but not more than 180 calendar days, prior to the sterilization. The physician must sign the consent form after the sterilization has been performed.

**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, verbally and in writing, prior to the hysterectomy that she would be permanently incapable of reproducing (this does not apply if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy)
- Prior to the hysterectomy, the Member/individual and the attending physician must sign and date the *Hysterectomy Acknowledgement Form*
- In the case of prior sterility or emergency hysterectomy, a Member is not required to sign the consent form
- The Provider submits the properly executed *Patient's Acknowledgement of Prior Receipt of Hysterectomy Information Form* with the claim prior to submission to WellCare

WellCare will deny payment on any claim(s) submitted without the required documentation or with incomplete or inaccurate documentation. WellCare does not accept documentation meant to satisfy informed consent requirements which has been completed or altered after the service was performed.

Regardless of whether the requirements listed above are met, a hysterectomy is considered a payable benefit when performed for medical necessity and not for the purpose of family planning, sterilization, hygiene or mental incompetence. The consent form does not need to be submitted with the request for authorization but does need to be submitted with the claim.

All forms are located on WellCare's website at
**https://www.wellcare.com/Iowa/Providers/Medicaid/Forms**

**Long Term Services and Supports Program (LTSS)**

Long Term Services and Supports (LTSS) is a program for managing long-term care services. Long-term care includes help doing everyday tasks that Members may no longer be able to do for themselves as they grow older or if they have a disability. These include bathing, dressing, getting around their home, preparing meals or doing household chores. Long-term care also includes care in a Member's own home or in the community as an option to a nursing home. These are called home- and community-based services, or HCBS. Long-term care services also include care in a nursing home.

WellCare of Iowa's LTSS program is built on the foundational idea that each Member has the ability to reach his or her own individualized goals with the right supports and services in place. Ultimately, we designed our program to be Member-centered so Member engagement drives the process because we believe that our success is only derived when Members are able to achieve their own optimal levels of self-management and independence.
To help our Members achieve these goals and ensure they are served in the community of their choice, we provide Members multiple layers of support that include:

- Conflict-free assessments
- A dedicated Community Based Care Manager
- A Member-centered interdisciplinary care team that includes, among others, the Member, his or her Primary Care Physician (PCP), other service Providers (including LTSS, behavioral and/or physical specialists) and any advocates, friends or family Members identified by the Member
- A detailed care plan developed by the Member with the assistance of his or her interdisciplinary care team that also includes a risk agreement, a service plan and emergency or back-up plan
- A robust statewide accessible network of service Providers to meet primary, secondary and tertiary needs including home and community-based service Providers, dedicated PCPs, LTSS Providers and specialists of all kinds
- Integrated community and natural supports and the power of WellCare of Iowa's community connections to draw upon those supports effectively
- Flexible funding to meet immediate and long term needs of Members to help them achieve independence in the least restrictive and appropriate setting when it can be made less costly than an institutional setting
- Constant and continuous monitoring at the individual Member and at the system level through the use of WellCare of Iowa's proprietary and comprehensive electronic tools and technologies, including our Member 360 view – a part of our care system platform that allows WellCare of Iowa to see every aspect of an individual Member's needs and be alerted should there be gaps or other barriers that require intervention for that Member to be successful

Each of these elements works seamlessly together to help Members receive services in the community of their choice.

**Eligibility**

Members are eligible for LTSS if they:

- Live in the WellCare service area;
- Meet the clinical eligibility requirements for nursing facility care, Skilled care, or ICF/ID care for:
    - The below listed 1915(c) Waivers:
        - Aids/HIV
        - Brain injury
        - Elderly
        - Health and disability
        - Intellectual disability
        - Physical disability
    - Nursing facility care
    - Skilled care
    - ICF/ID care; for example, you need help with daily living like bathing, dressing, eating, or walking or you have a chronic condition requiring nursing services; and meet Medicaid financial eligibility requirements

Members potentially appropriate for this program can be referred by the Member or family; physician or other Provider; via hospital staff or via claims data. When WellCare of Iowa receives the referral, a Field Assessment Nurse will conduct a conflict free assessment using the InterRAI-HC or Supports Intensity Scale, which will be transmitted to Iowa Department of

Health. The Member must make application for an HCBS waiver to the Department of Human Services. The Department of Human Services will determine level of care and approve/deny enrollment in the waiver program under the 1915 (c) Home and Community-Based Waiver program.

Waiver Members must reside home environment outside of a facility. If in a facility, the Community Based Care Manager (CBCM) will collaborate with the facility to ensure the Member will not be involuntarily discharged to a potentially more restrictive setting, as our goal is for the Member to be placed in the least restrictive, yet appropriate setting.

For more information on HCBS Covered Services, refer to the Provider Manual on the DHS website at **dhs.iowa.gov/policy-manuals/medicaid-provider**

## Case Management Program

WellCare offers comprehensive integrated Case Management services to facilitate Member assessment, planning and advocacy in order to improve health outcomes for Members. WellCare trusts Providers will help coordinate the placement and cost-effective treatment of Members who are eligible for WellCare Case Management Programs.

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

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

The Case Management process begins with Member identification and follows the Member until discharge from the Program. Members may be identified for Case Management by:

- Referral from a Member's Primary Care Provider or other specialist
- Self-referral
- Referral from a family member
- Referral after a hospital discharge
- After completing a Health Risk Assessment (HRA)
- Data mining for high-risk Members

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

**Clinical Assessment and Evaluation** – A comprehensive assessment of the Member is completed to determine where he or she is in the health continuum. This assessment gauges the Member's support systems and resources and seeks to align the Member with appropriate clinical needs.

**Care Planning** – Collaboration with the Member and/or caregiver, the PCP and other Providers involved in the Member'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 Member adherence with the plan of care. Activities may be as simple as reviewing the plan with the Member 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).
**Member Advocacy -** Advocating on behalf of the Member within the complex labyrinth of the health care system. Case Managers assist Members with seeking services to optimize their health. Case Management emphasizes continuity of care for Members through the coordination of care among physicians, CMHCs and other Providers. Members commonly identified for WellCare's Case Management program include those with:

**Catastrophic Injuries** – Traumatic injuries, i.e., 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 health care, i.e., Acquired Immune Deficiency Syndrome (AIDS).
**Transplantation** – Organ failure, donor matching, post-transplant follow-up.
**Complex Discharge Needs** – Members 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 Health Care Needs** – Children or adults who have serious medical or chronic conditions with severe chronic illnesses, physical, mental and developmental disabilities.

## Disease Management Program

Disease Management is a population-based strategy that involves consistent care across the continuum for Members with certain disease states. Elements of the program include education of the Member about the particular disease and self-management techniques, monitoring of the Member for adherence to the treatment plan and the consistent use of validated, industry-recognized, evidence-based *Clinical Practice Guidelines* by the treatment team as well as the Disease Manager.
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
- Smoking Cessation

WellCare's Disease Management Program educates Members 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 Members, improve health outcomes and decrease medical costs. In addition, WellCare makes available to Providers and Members general information regarding health conditions on WellCare's website at **https://www.wellcare.com/Iowa** .

**Candidates for Disease Management**

WellCare encourages referrals from Providers, Members, hospital discharge planners and others in the health care community.

Interventions for Members identified vary depending on their level of need and stratification level. Interventions are based on industry-recognized *Clinical Practice Guidelines*. Members 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 on WellCare's website at **https://www.wellcare.com/Georgia/Providers/Clinical-Guidelines/CPGs** .

**Access to Case and Disease Management Programs**

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

For more information on the Case Management Referral Line, refer to the *Quick Reference Guide* on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid**

**Case and Disease Management Referrals**

Members may be identified for case and disease management in several ways, including:

- Referral from their Primary Care Provider or specialist
- Self-referral
- Referral from a family member
- Referral after a hospital discharge
- Triggers after completing a Health Risk Assessment (HRA)
- Data mining for Members with health care risks or identified care needs

If a Provider would like to refer a WellCare Member as a potential candidate to the Case Management Program or Disease Management Program, or would like more information about one of the programs, they may call the WellCare Case Management Referral Line at the number listed on the *Quick Reference Guide* on WellCare's website.

**Delegated Entities**

WellCare delegates some utilization management, case management, and disease management activities to external entities. In these cases, WellCare performs oversight and monitoring activities to hold those entities accountable to State, Federal, and accreditation standards.

In order to receive a delegation status for utilization management, care management, and/or disease management activities, the delegated entity must demonstrate that ongoing, functioning systems are in place and meet the required WellCare, regulatory, and accreditation standards. There must be a mutually agreed upon written delegation agreement describing the responsibilities of WellCare and the delegated entities. The agreement must be approved by DHS, prior to implementation.

Delegation of select functions may occur only after an initial (pre-delegation) audit of the delegated activity has been completed and there is evidence that WellCare's delegation requirements are met. These requirements include:

- Maintaining a written program description of the specific delegated activity, i.e. Utilization Management, Case Management, and/or Disease Management
- Maintaining formal policies and procedures to support compliance with State, Federal, and accreditation standards
- Submitting monthly and quarterly reports
- Adhering to program evaluation mechanisms
- Remediating areas of non-compliance, up to termination of the delegated arrangement, if the delegated entity does not fulfill its obligations

On an annual basis, or more frequently based on monitoring mechanisms, formal audits and/or focused reviews of the delegated entity are performed to ensure compliance with WellCare's delegation requirements. For more information on Delegated Entities, refer to *Section 9: Delegated Entities.*

# 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 its Customer Service Department. For more information, refer to the *Quick Reference Guide,* which may be found on WellCare's website.

For Providers who are unaccustomed to submitting claims, WellCare provides detailed claims' submission procedures on its website. The *Medicaid Provider Resource Guide* on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid** provides information regarding how to submit both paper and electronic claims.

The claims submission address, telephone numbers for contacting Provider Services, how to file a claims dispute, and authorization information are located on the *Quick Reference Guide* which can be accessed on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid**

Additional information regarding reimbursement policies and *Claims Companion Guides* are located on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid**

## 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 not 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 **payspan.com.** Providers can also view PaySpan's webinar anytime at: **payspan.webex.com.** PaySpan Health Support can be reached via email at **providersupport@payspanhealth.com**, by phone at **1-877-331-7154** or on the Web at **payspanhealth.com**.

## Timely Claims Submission

Unless otherwise stated in the Provider Participation Agreement (the Agreement), Provider must submit claims (initial, corrected and voided) within ninety days (participating Providers) and 365 days (non-participating Providers). For COB claims, it is 90 days from the Medicaid or primary insurance payment date, whichever is later, from the date of Service for outpatient Services and the date of discharge for inpatient services (Hospital Services Manual Section IX Transmittal

#17 page 9.3). Unless prohibited by federal law or the Centers for Medicare & Medicaid Services (CMS), WellCare may deny or reject payment for any claims that fail to meet WellCare's submission requirements for Clean Claims (as defined in the Definition section) or that are received after the time limit in the Agreement for filing Clean Claims.

The following items can be accepted as proof that a claim was submitted timely:

- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by WellCare
- A Provider's electronic submission sheet with all the following identifiers, including patient name, Provider name, date of service to match Explanation of Benefits (EOB)/claim(s) in question, prior submission bill dates; and WellCare product name or line of business

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

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

**Tax Identification (TIN) and National Provider Identifier (NPI) Requirements**

WellCare requires the payer-issued Tax ID and NPI on all claims submissions. WellCare will reject claims without the Tax ID and NPI, with the exception of atypical Providers. Atypical Providers must pre-register with 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 **https://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/downloads/npifinalrule.pdf**

**Taxonomy**

Providers are required to submit claims with the correct taxonomy code consistent with Provider's specialty and services being rendered in order for appropriate adjudication. WellCare may reject the claim if the taxonomy code is incorrect or omitted.

**Pre-Authorization number**

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

**National Drug Codes (NDC)**

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

**Strategic National Implementation Process (SNIP)**

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 level V guidelines. Claims with invalid NDC codes will be rejected. If there are any State specific front end edits, WellCare of Iowa will also incorporate these edit modifications as well, including both removal and/or addition of certain edits.

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.

**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 requires all diagnosis coding to be ICD-10-CM, or its successor, as mandated by CMS. *Refer to Compliance section for additional information.* 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(is) 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.

When presenting a claim for payment to WellCare, the Provider is indicating an understanding that:

- The Provider has an affirmative duty to supervise the provision of, and be responsible for, the Covered Services claimed to have been provided
- To supervise and be responsible for preparation and submission of the claim
- To present a claim that is true and accurate and that is for WellCare Covered Services that:
    - Have actually been furnished to the Member by the Provider prior to submitting the claims
    - Are medically necessary

Providers using electronic submission shall submit all claims to WellCare or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 837 electronic format, or a CMS 1500 and/or CMS-1450 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 Member's medical record prior to the initial submission of any claim. The Provider also acknowledges and agrees that at no time shall Members be responsible for any payments to the Provider with the exception of Member expenses and/or Non-Covered Services. For more information on paper submission of claims, refer to the *Quick Reference Guide* WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid** For more information on Covered Services under WellCare's Medicaid plans, refer to WellCare's website at **https://www.wellcare.com/Iowa/Members/Medicaid-Plans/WellCare-of-Iowa** . For more information on claims submission requirements, refer to the Iowa Contract.

## 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* which may be found on WellCare's website at **https://www.wellcare.com/Iowa/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 clearinghouse(s),for information on the unique WellCare Payer Identification (Payer ID) numbers used to identify WellCare on electronic claims submissions, or to contact WellCare's EDI team, refer to the *Provider Resource Guide*, which may be found on WellCare's website at
**https://www.wellcare.com/Iowa/Providers/Medicaid**

**HIPAA Electronic Transactions and Code Sets**
*HIPAA Electronic Transactions and Code Sets* is a federal mandate that requires health care 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 on EDI implementation with WellCare, refer to the *WellCare Companion Guides* on WellCare's website at
**https://www.wellcare.com/Iowa/Providers/Medicaid**

**Paper Claims Submissions**
For timelier processing of claims, Providers are encouraged to submit electronically. Claims not submitted electronically may be subject to penalties as specified in the Agreement. For assistance in creating an EDI process, contact WellCare's EDI team by referring to the *Quick Reference Guide* on WellCare's website at
**https://www.wellcare.com/Iowa/Providers/Medicaid**

If permitted under the Agreement 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 forms
- 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 large, dark font such as, PICA, ARIAL 10-, 11- or 12-point type
        - In capital letters
    - **The typed information must not have:**
        - Broken characters
        - Script, italics or stylized font
        - Red ink
        - Mini font
        - Dot matrix font

## Claims Processing

### Readmission

WellCare follows the State of Iowa's 30-day readmission policy. WellCare may review hospital admissions on a specific Member if it appears that two or more admissions are related based on same or similar conditions. Based upon the claim review (including a review of medical records if requested from the Provider), WellCare will make all necessary adjustments to the claim, including recovery of payments which are not supported by the medical record. Providers who do not submit the requested medical records, or who do not remit the overpayment amount identified by WellCare, may be subject to a recoupment.

### Disclosure of Coding Edits

WellCare uses claims editing software programs to assist in determining proper coding for Provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule Database, the American Medical Association (AMA) and Specialty Society correct coding guidelines, and regulations. These software programs may result in claim edits for specific procedure code combinations. These claims editing software programs may result in an adjustment of the payment to the Provider for the services or in a request, prior to payment, for the submission for review of medical records that relate to the claim. Providers may request reconsideration of any adjustments produced by these claims editing software programs by submitting a timely request for reconsideration to WellCare. A reduction in payment 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

WellCare of Iowa will process clean claims within 30 calendar days and will apply interest in conjunction with the State's corresponding interest rate for claims processed beyond 30 days, in accordance with **I.A.C 191-15.32(2)**.

### Coordination of Benefits (COB)/ Third Party Liability (TPL)

WellCare shall coordinate payment for Covered Services in accordance with the terms of a Member's benefit plan, applicable state and federal laws and CMS guidance. Providers shall bill primary insurers for items and services they provide to a Member 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 as well as a copy of the primary payer's Explanation of Payment (EOP). The primary carrier's EOP should contain the name of the primary carrier, payment date, payment/denied amount, reason for denial, if applicable, billed charges and any remaining patient liability. WellCare utilizes the "lessor of" logic when processing COB claims. We will pay the Member's coinsurance, deductibles, co-payments and other cost-sharing expenses up to the allowed amount or, the difference between the primary payer's amount and WellCare's allowed amount, whichever is less. The Contractor's total liability **shall not exceed** the allowed amount minus the amount paid by the primary payer. WellCare may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services to the extent permitted by applicable laws. Providers shall follow WellCare policies and procedures regarding subrogation activity.

## Patient Liability/Cost-Sharing

All Member cost sharing amounts will be finalized via the explanation of payment or 835 process wherein Providers will be able to accurately identify any outstanding remaining balance owed to the Provider by the Member. This amount will be denoted via the patient responsibility section in the 835 file, or if the Provider so chooses, they can visit Payformance to download a paper remittance advice, which also demonstrates the final Member responsibility whether it be a cost share or co-pay.

## Encounters Data

### Overview

This section is intended to provide delegated vendors and Providers (IPAs) with the necessary information to allow them to submit Encounter Data to WellCare. If Encounter Data does not meet the Service Level Agreements (SLAs) for timeliness of submission, completeness or accuracy, the Agency 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 Agreement, delegated vendors and capitated Providers should submit complete and accurate encounter files to WellCare as follows:

- For initial submission, encounters will be submitted within 60 days from Service month
- For resubmission, encounters rejected by WellCare must be remediated and resubmitted 100 percent within seven calendar days from the date that the Provider receives the notification/response file from WellCare
- Encounters can be submitted to WellCare on a daily/weekly basis
- Providers must maintain a minimum of 95 percent acceptance rate for all encounters submitted within a calendar month
- All Providers must register and uniquely match against the State roster before WellCare accepts the encounters
- Encounter Compliance reports will be published to Providers on a monthly basis
- Providers who fail to comply with the Encounter SLAs are subject to be placed on a 90-day Corrective Action Plan

### Fines/Penalties

The following applies if the Provider is capitated or WellCare has delegated activities to the Provider pursuant to a separate delegation addendum: Provider shall reimburse WellCare for any fines, penalties or costs of corrective actions required of WellCare by governmental authorities caused by the Provider's failure to comply with laws or program requirements, including failure to submit accurate encounters on a timely basis or to properly perform delegated functions.

### Accurate Encounters Submission

All encounter transactions submitted via 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 or Provider encounter, the encounter is loaded into WellCare's Encounters System and processed. The encounter is 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 submitting encounters electronically, refer to the *WellCare Companion Guides* which may be found on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid/Claims**

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

**Encounters Submission Methods**
Delegated vendors and Providers may submit encounters using several methods: electronically, through WellCare's contracted clearinghouse(s), via Direct Data Entry (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 WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid/Claims/Electronic**

**Submitting Encounters Using Direct Data Entry (DDE)**
Delegated vendors and Providers may submit their encounter information directly to WellCare using WellCare's Direct Data Entry (DDE) portal. The DDE tool can be found on the secure online Provider Portal at **https://www.wellcare.com/Iowa** . For more information on free DDE options, refer to the Iowa Medicaid *Provider Resource Guide* on WellCare's website at https://www.wellcare.com/Iowa/Providers/Medicaid

**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
- 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, voided or a replaced/overlaid encounter. The definitions of the types of encounters are as follows:

- New Encounter – An encounter that has never been submitted to WellCare previously
- Voided Encounter – An encounter that WellCare deletes from the encounter file and is not submitted to the state
- Replaced or Overlaid Encounter – An encounter that is updated or corrected within the WellCare system

**Balance Billing**

Providers shall accept payment from WellCare for Covered Services provided to WellCare Members in accordance with the reimbursement terms outlined in the Agreement. Payment made to Providers constitutes payment in full by WellCare for covered benefits, with the exception of Member expenses. For Covered Services, Providers shall not balance bill Members any amount in excess of the contracted amount in the Agreement. 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 Members are to be held harmless for Covered Services. For more information on balance billing, refer to the Iowa Contract. Additionally, Providers shall not charge WellCare Members for missed appointments.

**Hold Harmless Dual-Eligible Members**

Those dual-eligible Members whose Medicare Part A and B Member expenses are identified and paid for at the amounts provided for by Iowa Medicaid shall not be billed for such Medicare Part A and B Member 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 Iowa Medicaid. Providers shall accept WellCare's payment as payment in full.

**Claims Appeals**

The claims appeal process is designed to address claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Claim payment disputes must be submitted to WellCare in writing within one year of the date of denial of the Explanation of Payment (EOP).

Documentation consists of: (a) Date(s) of Service; (b) Member name; (c) Member WellCare ID number and/or date of birth; (d) Provider name; (e) Provider Tax ID/TIN; (f) Total billed charges; (g) the Provider's statement explaining the reason for the dispute; and (h) Supporting documentation when necessary (e.g. proof of timely filing, medical records).

To initiate the process, Providers may mail to the address, or fax to the fax number, listed in the *Quick Reference Guide* located on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid**

Refer to the *Quick Reference Guide* at **https://www.wellcare.com/Iowa/Providers/Medicaid** for addresses and phone numbers to file claims disputes.

If the Provider's issue is not resolved, or if the Provider requests, any non-claims issue will be routed to the Grievance department. Please see *Section 7: Appeals and Grievances* for more information.

**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 to be replaced.)
- Example: REF✻F8✻Wellcare Claim number here~

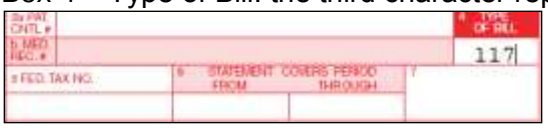
These codes are not intended for use for original claim submission or rejected claims.

**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:

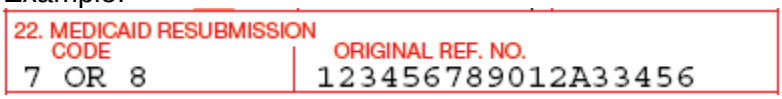
Box 4 – Type of Bill: the third character represents the "Frequency Code"




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

- For Professional claims, 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 for the newly submitted corrected claim.

**Reimbursement**

WellCare applies the CMS Site-of-Service payment differentials in its fee schedules for Current Procedural Terminology (CPT) codes based on the place of treatment (physician office services versus other places of treatment).

**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:

- 100 percent of maximum allowable fee for primary surgical procedure
- 50 percent of maximum allowable fee for secondary surgical procedure
- 25 percent of maximum allowable fee for all other surgical 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.

**Assistant Surgeon**

Assistant Surgeons (AS) are reimbursed 16 percent of the maximum allowable fee for the procedure code. Multiple surgical procedures for AS are reimbursed as follows:

- 16 percent of 100 percent of the maximum allowable fee for primary surgical procedure (first claim line)
- 16 percent of 50 percent of the maximum allowable fee for the second surgical procedure
- 16 percent of 25 percent of the maximum allowable fee for all other surgical procedures

WellCare uses the American College of Surgeons (ACS) as the primary source to determine which procedures allow an Assistant Surgeon. For procedures that the ACS lists as “sometimes”, CMS is used as the secondary source.

**Co-Surgeon**
Each Provider will be paid 60 percent of the maximum allowable fee for the procedure code. In these cases, each surgeon should report his/her 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.

**Modifier**
Pricing modifiers are used with the procedures listed in the fee schedule to affect the procedure code's fee or cause a claim to pend for review. The pricing modifiers are 22, 24, 25, 26, 50, 51, 52, 54, 55, 56, 59, 62, 66, 76, 77, 78, 79, 80, and 99, LT/RT, QK, QS, and TC.

For more information, refer to the Iowa Medicaid policy manuals located at:
**http://dhs.iowa.gov/policy-manuals/medicaid-provider**

**Allied Health Providers**
If there are no reimbursement guidelines on the Iowa 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 one-hundred percent payment quality but recognizes that a small percent 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 Iowa Administrative Code (IAC) 191-15.33 (507B) and limit its recovery effort to twenty-four (24) months from claim receipt date and will not pursue claims where billed charges are less than $25. 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 Members.

In all cases, WellCare, or its designee, will provide a written notice to the Provider explaining the reason for the overpayment and amount, contact information, and instructions on how to send the refund. The standard request notification provides 45 days for the Provider to send in the refund, request further information, appeal or dispute the retroactive denial.

Failure of the Provider to respond within the above timeframe will constitute acceptance of the terms in the letter and will result in offsets to future payments. The Provider will receive an Explanation of Payment (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 the Provider independently identifies an overpayment, they can either a) send a corrected claim (refer to the corrected claim section of this manual), b) contact WellCare Provider Services to arrange an off-set against future payments, or c) send a refund and explanation of the overpayment to:

**WellCare Health Plans, Inc.**
**P.O. Box 31584**
**Tampa, FL 33631-3584**

For more information on contacting Provider Services, refer to the *Quick Reference Guide* which may be found on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid**

**Benefits During Disaster and Catastrophic Events**
Refer to Provider Agreement.

# Section 6: Credentialing

**Overview**

Credentialing is the process by which the appropriate WellCare peer review bodies evaluate the credentials and training qualifications of practitioners including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/health care delivery organizations. For purposes of this Credentialing section, all references to “practitioners” shall include Providers providing 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/health care delivery organizations.

This review 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 health care
- 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 Members. WellCare will only register a participating Provider with DHS after a background screening has been completed.

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/health care delivery organizations are required to be credentialed in order to be network Providers of services to WellCare Members.
- Satisfactory site inspection evaluations are required to be performed in accordance with state, federal, state 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. In the event 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. The delegated entity's contract must first be approved by DHS prior to implementation.

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 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.

WellCare ensures credentialing shall be 90 percent completed within 30 calendar days, and 100 percent completed within 45 calendar days of submission.

**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 **credentialinginquiries@wellcare.com.** Upon receipt of a written request, WellCare will provide written information to the practitioner on 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**

The practitioner may review documentation submitted by him/her in support of the application/re-credentialing application, together with any discrepant information received from professional liability insurance carriers, State licensing agencies and certification boards, 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.

The Provider may not review peer review information obtained by WellCare.

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

In the event the credentials verification process reveals information submitted by the practitioner that differs from the verification information obtained by WellCare, the practitioner has the right to review the information that was submitted in support of his/her application, and has the right to correct the erroneous information. 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
- WellCare's review process

**Baseline Criteria**
Baseline criteria for practitioners to qualify for Provider network participation:

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

**Drug Enforcement Administration Certificate** – Practitioners 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 MD/DO/DPM/DDS/DMD).

**Work History** – Practitioners must provide a minimum of five years' 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 educational/training from an accredited training program in the specialty requested.

**Hospital-Admitting Privileges** – Specialist practitioners 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 Members.

**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. Providers are not eligible for participation if such 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 policy and procedure.

**New Providers** – A Provider is required to have a Iowa Medicaid Provider number as well as a National Provider Identifier (NPI) to participate in WellCare's network.

**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. Ongoing/quarterly monitoring of the opt-out website is performed by WellCare.

**Liability Insurance**
WellCare Providers (all disciplines) are required to carry and continue to maintain appropriate professional liability insurance limits in accordance with Iowa Contract.

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

**Site Inspection Evaluation (SIE)**

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
  - 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
- When 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 Member 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 onsite review.

**Covering Physicians**

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:

- Advanced registered nurse practitioners (ARNPs)
- Certified nurse midwives (CNMs)
- Physician assistants (PAs)
- Osteopathic assistant (OAs)

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

- Licensed clinical social workers
- Licensed behavioral health counselors
- Licensed marriage and family therapists
- Physical therapists
- Occupational therapists
- Audiologists
- Speech/language therapists/pathologists

**Ancillary Health Care Delivery Organizations**
Ancillary and organizational applicants must complete an application and, as applicable, undergo an 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, accreditation and WellCare policy and procedure, re-credentialing is required at least once every three years.

**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.

**Eligibility in the Medicaid Program**
All Providers must be eligible for participation in the Medicaid program. If a Provider is currently suspended or involuntarily terminated from the Iowa Medicaid program whether by contract or sanction, other than for purposes of inactivity, that Provider is not considered an eligible Medicaid Provider. Suspension and termination are described further in Executive Order 12549. If a Provider is found to be ineligible for participation in the Medicaid program, the Provider is subject to immediate termination from WellCare.

**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 policy and procedure. 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.

In the event 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 Members. 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, of whom at least one is a participating Provider and a clinical peer of the practitioner that 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 thereby 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
- 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 in which 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 his or her 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 there from, 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. In the event the findings are positive for the practitioner, the second-level review shall be waived.

In the event 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 his or her 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. In the event 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 he or she 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 *Section 9: Delegated Entities* section in this manual for further details.

# Section 7: Appeals and Grievances

## Appeals Process

### Provider

**Medicaid Provider on Behalf of Self Appeals Process**
A Provider may request an appeal regarding Provider payment or contractual issues on his or her own behalf by mailing a letter of appeal and/or an appeal form with supporting documentation, such as medical records to WellCare.

Providers have 90 calendar days from the original utilization management or claim denial to file a Provider appeal. Cases appealed after that time will be denied for untimely filing. If the Provider feels they have filed their case within the appropriate time frame, the Provider may submit documentation showing proof of timely filing. Acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of WellCare or similar receipt from other commercial delivery services.

WellCare has 60 calendar days to review the case for medical necessity and conformity to WellCare guidelines.

Cases received without the necessary documentation will be denied for lack of information. It is the responsibility of the Provider to provide the requested documentation within 60 calendar days of the denial to reopen the case. Records and documents received after that time frame will not be reviewed and the case 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 Member for copies of medical records provided for this purpose.

**Reversal of Denial of Provider on Behalf of Self Appeals**
If all of the relevant information is received, WellCare will make a determination within 60 calendar days. 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 overturned. The Provider will be notified of this decision in writing.

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

**Affirmation of Denial of Provider on Behalf of Self Appeals**
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 may be provided. The Provider may also request a copy of the clinical rationale used in making the appeal decision by sending a written request to the appeals address listed in the decision letter.

**Member**

For a Member appeal, the Member, Member's representative, or a Provider acting on behalf of the Member and with the Member's written consent, may file an appeal request verbally with Customer Service at the phone number below or on the back of the Member's ID card. An appeal may also be submitted in writing. All requests must be submitted within 90 calendar days from the date on the notice of action. WellCare shall acknowledge in writing within three business days of receipt of appeal except in the case of an expedited request.

The Member should send Medical appeal request to:

**WellCare Appeals**
**P.O. Box 31368**
**Tampa, FL 33631-3368**

Fax: **1-866-201-0657**
Telephone: **1-866-334-7927**
Hours of Operation: Monday–Friday, from 8 a.m. to 7 p.m. CST

If an appeal is filed verbally via WellCare's Customer Service department, the request must be followed up with a written, signed appeal request to WellCare within 10 calendar days of the verbal filing, except when an expedited resolution has been requested. For verbal filings, the time frames for resolution begin on the date the verbal filing was received by WellCare.

If the Member's request for appeal is submitted after 90 calendar days from the date on the notice of action, 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 Member did not personally receive the notice of action or received the notice late
- The Member was seriously ill, which prevented a timely appeal
- There was a death or serious illness in the Member's immediate family
- An accident caused important records to be destroyed
- Documentation was difficult to locate within the time limits
- The Member had incorrect or incomplete information concerning the appeal process

If the Member wishes to use a representative, he or she must submit a signed statement naming the person he or she wishes to represent him or her. For the Member's convenience, WellCare has an Appointment of Representative (AOR) statement form that can be used. The Member and the person who will be representing the Member must sign the AOR statement. The form is located on WellCare's website at
**https://www.wellcare.com/Iowa/Providers/Medicaid/Forms**

Members 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/TDD capability.

Members may also present evidence and allegation of fact or law, in person as well as in writing and prior to and after the appeal, review their case files. The timeframe to submit additional

documentation for expedited appeals is limited due to the short timeframe to process the request for expedited appeal.

Providers do not have appeal rights through the Member appeals process. However, Providers have the ability to file an authorization or claim-related appeal (dispute) on their own behalf. See *Medicaid Provider on Behalf of Self Appeals Process* above for more information.

The Member, Member's representative or a Provider acting on the Member's behalf with the Member's consent may file for an expedited, standard pre-service or retrospective appeal determination. The request can come from the Provider or office staff working on behalf of the Provider.

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

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

- Denial or limited authorization of a requested service, including the type or level of service as defined in the Iowa Contract
- 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 Agency
- The failure of WellCare to act within 60 calendar days or maximum of 90 calendar days if the grievance involves the collection of information outside of the service area; or 30 calendar days from the date WellCare receives a pre-service appeal or 45 calendar days for a retrospective appeal.
- For a resident of a rural area with only one managed care entity, the denial of a Member's request to exercise his or her right to obtain services outside the network

WellCare ensures that decision makers on appeals were not involved in previous levels of review or decision making. When deciding any of the following: (a) an appeal of a denial based on lack of medical necessity; (b) a grievance regarding denial of expedited resolution of an appeal; or (c) a grievance or appeal involving clinical issues. The appeal reviewers will be health care professionals with clinical expertise in treating the Member's condition/disease or have sought advice from Providers with expertise in the field of medicine related to the request.

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

- Expedited request: **72 hours**
- Standard pre-service request: **30 calendar days**
- Retrospective request: **45 calendar days**

The appeals determination periods noted above may be extended by up to 14 calendar days if the Member requests an extension or if WellCare justifies a need for additional information and documents how the extension is in the interest of the Member. If an extension is not requested by the Member, WellCare will provide the Member with written notice of the reason for the delay within two business days of the decision to extend the time frame. WellCare shall notify Members in their primary language of appeal resolutions.

## Expedited Appeals Process

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

Members who verbally request an expedited appeal are not required to submit a written appeal request as outlined in the appeals *Member* section.

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

### Denial of an Expedited Request

WellCare will provide the Member with prompt verbal notification by the end of business the day of the decision being made regarding the denial of an expedited appeal and the Member's rights, and will subsequently mail to the Member within two calendar days of the verbal notification, a written letter that explains:

- That WellCare will automatically transfer and process the request using the 30 calendar day time frame for standard appeals beginning on the date WellCare received the original request.

### Resolution of an Expedited Appeal

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

### Reversal of Denial of an Expedited Appeal

If WellCare overturns its initial action and/or the denial, it will issue authorization to cover the requested service and notify the Member verbally by end of business the day the decision is made, followed by written notification of the appeal decision.

### Affirmation of Denial of an Expedited Appeal

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

- Verbally notify the Member of the decision by end of business the day the decision is made
- Issue a notice of adverse action to the Member and/or appellant
- Include in the notice the specific reason for the appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based;
- Inform the Member:
    - Of their right to request a Medicaid Fair Hearing within 90 calendar days of receipt of the notice of resolution and how to do so
    - Of their right to representation
    - Of their right to continue to receive benefits pending a Medicaid Fair Hearing
    - That they may be liable for the cost of any continued benefits if WellCare's action is upheld

## Standard Pre-Service Appeals Process

A Member, a Member's representative or a Provider on behalf of a Member with the Member's written consent, may file a standard pre-service appeal request either verbally or in writing within 90 calendar days from the date on the notice of action.

If an appeal is filed verbally through Customer Service, the request must be followed up with a written, signed appeal to WellCare within 10 calendar days of the verbal filing. For verbal filings, the time frames for resolution begin on the date the verbal filing was received.

Members are also provided reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing.

### Reversal of Denial of a Standard Pre-Service Appeal

If upon standard appeal, WellCare overturns its adverse organization determination denying a Member's request for a service (pre-service request), then WellCare will issue an authorization for the pre-service request.

WellCare will issue an authorization for the disputed services of the decision if the services were not furnished while the appeal was pending and the decision is to reverse a decision to deny, limit or delay services. WellCare will also pay for the disputed services if the services were furnished while the appeal was pending and the disposition reverses a decision to deny, limit or delay services.

### Affirmation of Denial of a Standard Pre-Service Appeal

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

- Issue a notice of adverse action to the Member and/or appellant
- Include in the notice the specific reason for the appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, as well as informs the Member:
    - Of their right to request a Medicaid Fair Hearing within 90 calendar days of receipt of the notice of resolution and how to do so
    - Of their right to representation
    - Of their right to continue to receive benefits pending a Medicaid Fair Hearing
    - That they may be liable for the cost of any continued benefits if WellCare's action is upheld

## Standard Retrospective Appeals Process

**Post-Service Appeals** are typically requests for payment for care or services that the Member has already received. Accordingly, a post-service appeal would never result in the need for an expedited review.

A Member, or a Member's representative, may file a standard retrospective appeal request either verbally or in writing within 90 calendar days from the date on the notice of action. Members are also provided reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing.

For more information on Appointment of Representative (AOR) statements and verbal filings requirements, see *Member Appeals* section.

**Reversal of Denial of Standard Retrospective Appeal**
If, upon appeal, WellCare overturns its adverse organization determination denying a Member's request for payment, then WellCare will issue its reconsidered determination and send payment for the service.

WellCare will also pay for appealed services if the services were furnished while the appeal was pending and the disposition reverses a decision to deny, limit or delay services.

**Affirmation of Denial of a Standard Retrospective Appeal**
If WellCare affirms its initial action and/or denial (in whole or in part), it will:

- Issue a notice of adverse action to the Member and/or appellant;
- Include in the notice the specific reason for the appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, as well as informs the Member:
    - Of their right to request a Medicaid Fair Hearing within 90 calendar days of receipt of notice of resolution and how to do so
    - Of their right to representation
    - Of their right to continue to receive benefits pending a Medicaid Fair Hearing
    - That they may be liable for the cost of any continued benefits if WellCare's action is upheld

**Medicaid Fair Hearing for Medicaid Members** A Medicaid Member has the right to request a a State Fair Hearing if he or she is dissatisfied with an action that has been taken by WellCare, within 90 days of the final appeal decision by WellCare. The Member must first exhaust WellCare's appeals process prior to requesting a State Fair Hearing.

A Provider must have a Member's written consent before requesting a Medicaid Fair Hearing on behalf of a Member. The parties to a Medicaid Fair Hearing include WellCare, as well as the Member, his or her representative or the representative of a deceased Member's estate and the state. Requests should be sent to:

**Department of Human Services**
**Appeal Section**
**1305 E. Walnut Street, 5th Floor**
**Des Moines, IA 50319**
Phone: **1-515-281-3094**
Fax: **1-515-564-4044**
Email: **appeals@dhs.state.ia.us**

**Continuation of Benefits while the Appeal and Medicaid Fair Hearing are Pending**
As used in this section, "timely" means filing on or before the later of the following:

- Within 10 days of WellCare mailing the notice of adverse action
- Intended effective date of WellCare's proposed action, whichever is later

WellCare will continue the Member's benefits if: (a) the Member, or the Member's authorized representative files the appeal timely; (b) the appeal involves the termination, suspension or reduction of a previously authorized course of treatment; (c) the services were ordered by an authorized Provider; (d) the original period covered by the original authorization has not expired; and (e) the Member requests extension of the benefits.

If, at the Member's request, WellCare continues or reinstates the Member's benefit while the appeal or Medicaid Fair Hearing is pending, the benefits will be continued until one of the following occurs:

- The Member withdraws the appeal or request for the Medicaid Fair Hearing
- Ten days pass after WellCare mails the notice of adverse action, unless the Member, within 10 days, has requested a Medicaid Fair Hearing with continuation of benefits until a Medicaid Fair Hearing decision is reached
- A Medicaid Fair Hearing officer issues a hearing decision adverse to the Member
- 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 Member (i.e., WellCare's decision was upheld), WellCare may recover from the Member the cost of the services furnished to the Member while the appeal was pending, to the extent that they were furnished solely because of the requirements of the contract

## Grievance Process

**Provider Complaints**

Providers have the right to file a formal written complaint with the Grievance department for issues that are non-claims related no later than 60 calendar days from the date the Provider becomes aware of the issue generating the complaint. Written resolution will be provided by WellCare to the Provider within 45 calendar days from the date the formal written complaint is received by WellCare. Providers with complaints unresolved during Provider Service Resolution (PSR) process, or if the Provider makes his request known, may request to file a formal written Provider complaint.

A Provider may file a complaint in writing regarding dissatisfaction or dispute with WellCare's policies, procedures, or administrative functions, by mailing or faxing a *Complaint Request Form* with supporting documentation, to WellCare's Grievance department.

A written Provider grievance shall be mailed directly to WellCare's Grievance department.

For more information on how to contact the Grievance department, refer to the *Quick Reference Guide* which may be found on WellCare's website at **https://www.wellcare.com/Illinois/Providers/Medicaid** .

A Provider may not file a grievance on behalf of the Member without written consent from the Member, as the Member's representative.

WellCare will give all Providers written notice of the Provider grievance procedures at the time they enter into contract.

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

**Member**

The Member, or Member's representative acting on the Member's behalf, may file a grievance. 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 Member's rights
  - Quality of care/services provided
  - Refusal to see Member (other than in the case of patient discharge from office)
  - Office conditions
- Services provided by WellCare including, but not limited to:
  - Hold time on telephone
  - Rudeness of staff
  - Involuntary disenrollment from WellCare
  - Unfulfilled requests
- Access availability including, but not limited to:
  - Difficulty getting an appointment
  - Wait time in excess of one hour
  - Handicap accessibility

A Member, a Member's representative or any Provider acting on behalf of the Member with written consent, may file a standard and/or expedited grievance within 60 calendar days of the incident, or when the Member was made aware of the incident.

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

If the Member wishes to use a representative, then he or she must submit a signed statement naming the person he or she wishes to represent him or her. For the Member's convenience, WellCare has an Appointment of Representative (AOR) statement form that can be used. The Member and the person who will be representing the Member must sign the AOR statement. The form is located on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid/Forms** . Members are provided reasonable assistance in completing forms and other procedural steps for a grievance, including, but not limited to, providing interpreter services and toll-free telephone numbers with TTY/TDD capability.

**Grievance Submission**
A verbal grievance request can be filed, toll-free, with WellCare Customer Service. A verbal request may be followed up with a written request by the Member, but the time frame for resolution begins the date the verbal filing is received by WellCare.

The Member should send the grievance request to:

**WellCare Grievances**
**P.O. Box 31384**
**Tampa, FL 33631-3384**

Phone: **1-866-334-7927**
Fax: **1-866-388-1769**
Hours of Operation: Monday–Friday, from 8 a.m. to 7 p.m. CST

**Grievance Resolution**

WellCare will acknowledge the Member's standard grievance in writing within three business days from the date the grievance is received by WellCare. Upon the grievance resolution, a letter will be mailed to the Member: (a) within 30 calendar days from the date the standard 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 of the grievance.

The acknowledgement letter includes:

- Name and telephone number of the Grievance Coordinator
- Request for any additional information, if needed to investigate the issue

The resolution letter includes:

- The results/findings of the resolution
- All information considered in the investigation of the grievance
- The date of the grievance resolution
- Member rights on Medicaid Fair Hearing

WellCare shall notify Members in their primary language of grievance resolutions.

# 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 sub-contractors and their employees, are required to comply with WellCare Compliance Program requirements. WellCare's compliance-related 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 implement disciplinary actions to address violations
- HIPAA Privacy and Security Training
  - Summarizes privacy and security requirements in accordance with the federal standards established pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act
  - Training includes, but is not limited to, discussion on:
    - Proper Uses and Disclosures of Protected Health Information (PHI)
    - Member Rights
    - Physical and technical safeguards
- Fraud, Waste and Abuse (FWA) Training
  - Must include, but not limited to:
    - Laws and regulations related to fraud, waste and abuse (i.e., 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 for employees and subcontractors who report suspected fraud, waste and abuse
    - 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 Members 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 Members. Reports may be made anonymously through the WellCare fraud hotline at **1-866-678-8355**.

Details of the corporate ethics and compliance program may be found on WellCare's website at **https://www.wellcare.com/Iowa/Corporate/About-Us/Compliance**

**Provider Education and Outreach**

Providers may:

- Display state-approved WellCare-specific materials in-office
- Announce a new affiliation with a health plan
- Make available and/or distribute marketing materials as long as the Provider and/or the facility distributes, or makes available, marketing materials for all Managed Care Plans with which the Provider participates
- Co-sponsor events such as health fairs and advertise indirectly with a health plan via television, radio, posters, fliers and print advertisement

Providers are prohibited from:

- Verbally, or in writing, comparing benefits or Providers 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, such as WellCare, or any other entity
- Assisting with health plan enrollment or disenrollment

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

**Provider-Based Marketing Activities**

Providers may:

- Make available and/or distribute marketing materials as long as the Provider and/or the facility distributes or makes available marketing materials for all Managed Care Plans with which the Provider participates. If a Provider agrees to make available and/or distribute Managed Care Plan marketing materials it should do so knowing it must accept future requests from other Managed Care Plans with which it participates
- Display posters or other materials in common areas such as the Provider's waiting room

Providers must comply with the following:

- To the extent that a Provider can assist a recipient in an objective assessment of his/her needs and potential options to meet those needs, the Provider may do so
- May engage in discussions with recipients should a recipient seek advice. However, Providers must remain neutral when assisting with enrollment decisions

Providers are prohibited from:

- Offering marketing/appointment forms

- Making phone calls to direct, urge or attempt to persuade recipients to enroll in the Managed Care Plan based on financial or any other interests of the Provider
- Mailing marketing materials on behalf of the Managed Care Plan
- Offering anything of value to induce recipients/Members to select them as their Provider
- Offering inducements to persuade recipients to enroll in the Managed Care Plan
- Conducting health Screening as a marketing activity
- Accepting compensation directly or indirectly from the Managed Care Plan for marketing activities
- Distributing marketing materials within an exam room setting
- Furnishing to the Managed Care Plan lists of their Medicaid patients or the Membership of any Managed Care Plan

Providers may also:

- Provide the names of the Managed Care Plans with which they participate
- Make available and/or distribute Managed Care Plan marketing materials
- Refer their patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office
- Share information with patients from the Agency's website or CMS' website

Provider Affiliation Information:

- Providers may announce new or continuing affiliations with the Managed Care Plan through general advertising (e.g., radio, television, websites)
- Providers may make new affiliation announcements within the first 30 Calendar Days of the new Provider Agreement
- Providers may make one announcement to patients of a new affiliation that names only the Managed Care Plan when such announcement is conveyed through direct mail, email, or phone
- Additional direct mail and/or email communications from Providers to their patients regarding affiliations must include a list of all Managed Care Plans with which the Provider contracts
- Any affiliation communication materials that include Managed Care Plan-specific information (e.g., benefits, formularies) must be prior approved by the Agency
- Multiple Managed Care Plans can either have one Managed Care Plan submit the material on behalf of all the other Managed Care Plans, or have the piece submitted and approved by the Agency prior to use for each Managed Care Plan. Materials that indicate the Provider has an affiliation with certain Managed Care Plans and that only list Managed Care Plan names and/or contact information do not require Agency approval
- Providers may distribute printed information provided by the Managed Care Plan to their patients comparing the benefits of all of the different Managed Care Plans with which the Providers contract. The Managed Care Plan shall ensure that:

  (i) Materials do not "rank order" or highlight specific Managed Care Plans and include only objective information

  (ii) Such materials have the concurrence of all Managed Care Plans involved in the comparison and are approved by the Agency prior to distribution

  (iii) The Managed Care Plans identify a lead Managed Care Plan to coordinate submission of the materials

**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 all 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 **www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx** for specific codes.

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

## 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. WellCare's Code of Conduct and Business Ethics policy can be found at **https://www.wellcare.com/Iowa/Corporate/About-Us/Compliance** .

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 operate in accordance with the laws and regulations governing its 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 suspected Fraud, Waste and Abuse by calling the WellCare FWA Hotline at **1-866-678-8355**.

**Fraud, Waste and Abuse**

WellCare is committed to the prevention, detection and reporting of health care fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements. 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 health care Service use, including overutilization, unbundling, upcoding, misuse of modifiers and other common schemes.

WellCare is committed to identifying, investigating and remedying fraud, waste and abuse (FWA), as further detailed in the Company's FWA Policy. To this end, WellCare continues to implement policies and procedures to detect fraud, particularly regarding claim coding, to ensure that are practices are consistent with the highest industry standards.

WellCare's goal is to process claims consistently and in accordance with best practice standards. If a claim coding is identified as contrary to AMA, CMS, FDA and State Medicaid guidelines, the Provider will be notified of the same, and WellCare will seek to remedy the issue. Providers will receive notification that claim coding error was detected based on edits that

include, but are not limited to, AMA, CMS, FDA and state Medicaid guidelines. That includes high dollar claims, unbundled procedures, modifiers, Correct Coding Initiatives edits, duplicates, maximum units, multiple surgeries, and bilateral procedures, all of which WellCare actively monitors for FWA.

Federal and state regulatory agencies, law enforcement, and WellCare vigorously investigate incidents of suspected fraud and abuse. 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), the Healthcare 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 Providers and their employees must complete an annual FWA training program. (See Iowa Contract)

To report suspected fraud and abuse, please refer to the *Quick Reference Guide* on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid** or call the confidential and toll-free WellCare compliance hotline. Details of the corporate ethics and compliance program, and how to contact the WellCare fraud hotline, are on WellCare's website at **https://www.wellcare.com/Iowa/Corporate/About-Us/Compliance** .

To report suspected Medicaid and Welfare fraud to the state call **1-800-831-1394**, available Monday – Friday 7 a.m. to 6 p.m. Suspected fraud may also be reported to the US Department of Health and Human Services at the **Office of Inspector General website** (**https://forms.oig.hhs.gov/hotlineoperations/nothhsemployeeen.aspx**).

## Confidentiality of Member 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. All consultations or discussions involving the Member or his/her case should be conducted discreetly and professionally, in accordance with all applicable state and federal laws, 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 confidentiality of Members' medical records and other Protected Health Information (PHI), and the practice is following those procedures and/or obtaining appropriate authorization from Members 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.

Every Provider practice is required to provide Members with information regarding their privacy practices and to the extent required by law, with their Notice of Privacy Practices (NPP). The NPP advises Members how the Provider practice may use and share a Member's PHI and how a Member can exercise his or her health privacy rights. HIPAA provides for the release of Member medical records to WellCare for payment purposes and/or health plan operations. HIPAA regulations require each covered entity, such as health care Providers, to provide a NPP to each new patient or Member. Employees who have access to Member records and other confidential information are required to sign a Confidentiality Statement.

Some examples of confidential information include:

- Medical records
- Communication between a Member and a Provider regarding the Member's medical care and treatment
- All personal and/or protected health information (PHI) as defined under the federal HIPAA privacy regulations, and/or other state or federal laws
- Any communication with other clinical persons involved in the Member's health, medical and behavioral care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number (SSN), etc.
- Member transfer to a facility for treatment of drug abuse, alcoholism, behavioral or psychiatric problem
- Any communicable disease, such as Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (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 Member health records for the purposes of treatment, payment and health care activities.

**Disclosure of WellCare Information to WellCare Members**

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

For more information on how to request this information, Members may contact WellCare's Customer Service using the toll-free telephone number found on the Member's ID card. Providers may contact WellCare's Provider Services by referring to the *Quick Reference Guide* on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid**

# Section 9: Delegated Entities

**Overview**

WellCare oversees the provision of services provided by the delegated entity and/or sub-delegate, and is accountable to the federal and state agencies, including the Agency, 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.

**Compliance**

WellCare's compliance responsibilities extend to delegated entities, including, without limitation:

- Compliance Plan
- HIPAA Privacy and Security
- Fraud, Waste and Abuse Training
- Cultural Competency Plan
- Disaster Recovery and Business Continuity

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

WellCare ensures compliance through the delegation oversight process and the Delegation Oversight Committee (DOC). The DOC and its committee representatives:

- Ensure that all delegated entities are eligible for participation in the Medicaid and Medicare programs
- Ensure that WellCare has written agreements with each delegated entity that specifies the responsibilities of the delegated entity and WellCare, reporting requirements and delegated activities in a clear and understandable manner
- Ensure that the appropriate WellCare associates have properly evaluated the entity's ability to perform the delegated activities prior to delegation
- Provide formal, ongoing monitoring of the entity's performance at least annually, including monitoring to ensure quality of care and quality of Service is not compromised by financial incentives
- Impose sanctions up to and including the revocation and/or termination of delegation if the delegated entity's performance is inadequate
- Assure the delegated entity is in compliance with the requirements in in the Iowa Contract. Assure that each delegated subcontract:
    - Identifies the population covered by the delegated subcontract
    - Specifies the amount, duration and scope of services to be provided by the delegated subcontractor
    - Specifies the term and the procedures and criteria for termination
    - Specifies that delegated subcontractors use only Agency-participating Medicaid Providers in accordance with the Iowa Contract
    - Makes full disclosure of the method and amount of compensation or other consideration to be received from WellCare
    - Provides for monitoring by WellCare of the quality of services rendered to Members, in accordance with the Iowa Contract

- Provides that the Agency and Department of Health and Human Services (DHHS) may evaluate through inspection or other means the quality, appropriateness and timeliness of services performed
- Provide for inspections of any records pertinent to the Iowa Contract by the Agency and DHHS
- Requires that records be maintained for a minimum of no less than 10 years from the close of the Iowa Contract and after final payment is made under the Iowa contract. If an audit, litigation or other action involving the records is started before the end of the 10-year period, the records must be retained until all issues arising out of the action are resolved. (Prior approval for the disposition of records must be requested and approved by WellCare if the subcontract is continuous.)
- Where the delegated subcontractor agrees to provide Covered Services, contain no provision that provides incentives, monetary or otherwise, for the withholding from Members of medically necessary Covered Services
- Contains a prohibition on assignment, or on any further subcontracting, without the prior written consent of the subcontractor
- Specifies that delegated subcontractor agrees to submit encounter records in the format specified by the Agency so that WellCare can meet the Agency's specifications required by the Iowa Contract
- Incorporates all the provisions of the Iowa Contract to the fullest extent applicable to the service or activity delegated pursuant to the delegated subcontract, including without limitation, the obligation to comply with all applicable federal and Agency laws and regulations
- Provides for WellCare to monitor the delegated subcontractor's performance on an ongoing basis, including those with accreditation; the frequency and method of reporting to WellCare, the process by which WellCare evaluates the delegated subcontractor's performance; and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually
- Specifies that a delegated subcontractor with NCQA®, URAC or other national accreditation shall provide WellCare with a copy of its current certificate of accreditation together with a copy of the survey report
- Provides a process for the delegated subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action
- Specifies the remedies, up to and including revocation of the delegated subcontract available to WellCare if the delegated subcontractor does not fulfill its obligations
- Contains provisions that require suspected fraud and abuse be reported to WellCare

# Section 10: Behavioral Health

**Overview**

WellCare provides a behavioral health benefit for Medicaid Members. All provisions contained within the Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Members may refer themselves for behavioral health services and do not require a Referral from their PCP.

Some behavioral health services may require Prior Authorization, including all services provided by non-participating Providers. WellCare uses InterQual, Level of Care Utilization System (LOCUS), and Child Adolescent Service Intensity Instrument (CASII) criteria for behavioral health and American Society for Addiction Medicine (ASAM) criteria, for substance abuse. These criteria are well-known and nationally accepted guideline for assessing level of care criteria for behavioral health.

For complete information regarding benefits and exclusions, or in the event a Provider needs to contact WellCare's Customer Service for a Referral to a behavioral health Provider, refer to the *Quick Reference Guide*, which may be found on WellCare's website. at **https://www.wellcare.com/Iowa/Providers/Medicaid**

**Behavioral Health Program**

WellCare does not require Prior Authorization for standard outpatient services. WellCare encourages community-based services and Member treatment at the least restrictive level of care, whenever possible.

Prior Authorization is required for psychological testing, intensive outpatient, partial hospital programs, residential treatment programs and inpatient hospital services. Prior Authorization request forms for all levels of care are made available to Providers online or upon request. For complete information regarding authorization requirements please visit the behavioral health link on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid/Behavioral-Health**

**Continuity and Coordination of Care between Medical Care and Behavioral Health Care**

PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Conversely, behavioral health Providers may provide physical health care services if and when they are licensed to do so within the scope of their practice. Behavioral health Providers are required to use the ICD-10 or current version of the DSM when assessing the Member for behavioral health services and document the diagnosis and assessment/outcome information in the Member's medical record.

Behavioral health Providers are required to submit, with the Member's or Member's legal guardian's consent, an initial and quarterly summary report of the Member's behavioral health status to the PCP. 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 Members identified PCP noting any changes in the treatment plan on the day of discharge.

WellCare strongly encourages open communication between PCPs and behavioral health Providers to help guide and ensure the delivery of safe, appropriate, efficient and quality clinical health care. If a Member'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.

Effective communication of care is dependent upon clear and timely communication and allows for better decision making regarding treatment interventions, decreases the potential for fragmentation of treatment and improves Member health outcomes.

To maintain continuity of care, patient safety and Member well-being, communication between behavioral health Providers and medical Providers is critical, especially for Members with comorbidities receiving pharmacological therapy. Fostering a culture of collaboration and cooperation will help sustain a seamless continuum of care between medical and behavioral health and thus impact Member outcomes.

**Responsibilities of Behavioral Health Providers**

WellCare monitors Providers against these standards to ensure Members 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 Member 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 | Access Standard |
|---|---|
| **BH Provider – Urgent Non-Emergency** | < 1 hour of presentation at service site or within 24 hours of telephonic contact |
| **BH Provider – Persistent Symptoms** | < 48 hours of reporting symptoms |
| **BH Provider – Routine** | ≤ 3 weeks if the request |
| **BH Provider – Non-Life Threatening emergency** | < 6 hours |
| **BH Provider – Emergency** | < 15 minutes of presentation/request |
| **BH Provider – Mobile Crisis** | < 1 hour of request |
| **BH Provider – Substance Use Disorder & Pregnancy** | < 48 hours of seeking treatment |
| **BH Provider – Intravenous Drug Use** | ≤ 14 days of the request or 120 days after request if no program has the capacity |

All Members 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.

Behavioral health Providers are expected to assist Members in accessing emergent, urgent, and routine behavioral health services as expeditiously as the Member's condition requires. Members also have access to a toll-free behavioral crisis hotline that is staffed 24 hours a day. The behavioral crisis phone number is available on WellCare's website and the Member handbook.

For information about WellCare's Case Management and Disease Management programs, including how to refer a Member for these services, please see *Section 4: Utilization Management, Case Management and Disease Management.*

# Section 11: Pharmacy

**Overview**

Iowa'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 Members. The utilization management tools that are used to optimize the pharmacy program include:

- Preferred Drug List (PDL)
- Step Therapy (ST)
- Quantity Limit (QL)
- Age Limit (AL)
- Coverage Determination Review Process
- Pharmacy Lock-In Program
- Network Improvement Program (NIP)
- Exactus™ Pharmacy Solutions

These processes are described in detail below. In addition, prescriber and Member involvement is critical to the success of the pharmacy program. To help your patient get the most out of their pharmacy benefit please 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) 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

To contact WellCare's Pharmacy department, please refer to the *Quick Reference Guide* which may be found on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid** .

**Preferred Drug List**

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 Pharmaceutical and Therapeutics Committee (P&T Committee). WellCare shall provide all prescription drugs listed in the Agency's Medicaid Preferred Drug List (PDL). The PDL denotes any of the pharmacy utilization management tools that apply to a particular pharmaceutical.

Iowa's PDLs can be found on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid/Pharmacy** .

Any changes to the list of pharmaceuticals and applicable pharmaceutical management procedures are communicated to Providers via the following:

- Quarterly updates in Provider newsletters
- Website updates, including the link to Iowa P&T PDL changes

- Links to Pharmacy and Provider communication that detail any major changes to a particular therapy or therapeutic class will be updated 30 days prior to changes

All FFS pharmacy PA and PDL changes are communicated by the State Iowa following the meetings with an allowance for a 30 day implementation period.

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.

**Step Therapy**
Step therapy programs are developed by the Iowa 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 drugs are recognized as safe, effective and economically sound treatments. The first-line drugs on Iowa's PDL have been evaluated through the use of clinical literature and are approved by the corresponding 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 Food and Drug Administration (FDA) approved dosing guidelines. Quantity limits are also used to help prevent billing errors.

Please refer to the PDL to view drugs with quantity limits.

**Age Limits**
Some drugs have an age limit associated with them. WellCare utilizes age limits to help ensure proper medication utilization and dosage, when necessary.

Medications with age limits are identified on the PDL.

**Injectable and Infusion Services**
Select self-injectable and infusion drugs are covered under the Iowa outpatient pharmacy benefit.

Some self-injectable products and infusion drugs listed on the PDL will require a Coverage Determination Request Review using the Injectable Infusion Form approved by the state of Iowa.

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.

Refer to WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid/Pharmacy** for more information.

**Coverage Limitations**

WellCare covers all drug categories currently available through the Iowa Medicaid Fee-For-Service program. The following is a list of non-covered (i.e., excluded from the Medicaid benefit with the exception of Members affected by EPSTD guidelines) drugs and/or categories:

- Drugs used to cause anorexia, weight gain or weight loss
- Drugs used for cosmetic purposes or hair growth
- Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed in section B.7
- Drugs used for fertility purposes or for male sexual enhancement
- Drugs prescribed for a use other than the drug's medically accepted use
- Drugs classified as less than effective by the Centers for Medicare and Medicaid Services
- Drugs marketed by manufacturers that have not signed a Medicaid rebate agreement
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or designee
- Prescription drugs for Medicaid Members who also qualify for Medicare (referred to as "dual eligibles") are paid through Medicare Part D effective January 1, 2006. Medicaid does not cover any drugs covered under Medicare Part D for these Members

WellCare follows EPSTD guidelines. Providers may submit a coverage determination request form for Members effected by the guidelines.

- Non-controlled medications that are lost, stolen or destroyed after delivery to the Member are limited to a one time override allowance per 12 month period
- Requests exceeding the one time override allowance for non-controlled medications that are lost, stolen or destroyed after delivery to the Member may be considered with additional documentation. Such requests involving stolen medications must include a copy of a police report
- Override of refill too soon will not be allowed for controlled substances and/or tramadol containing products that are lost, stolen, or destroyed after delivery to the Member
- Override of refill limits will not be allowed for Members residing in a long term care (LTC) facility

**Smoking Cessation therapy - Oral**

WellCare will provide Members who want to quit smoking with nicotine replacement therapy covered on the Iowa PDL.

Prior authorization is required for varenicline (Chantix™) or bupropion SR that is FDA approved for smoking cessation. Requests for authorization must include:

- Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling.

- Confirmation of enrollment and ongoing participation in the Quitline Iowa counseling program is required for approval and continued coverage.

Approvals will be granted only for patients 18 years of age or older.

- The duration of therapy is initially limited to 12 weeks within a 12-month period
- For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment will be considered with a prior authorization request. The maximum duration of approvable therapy is 24 weeks within a 12-month period
- Requests for varenicline to be used in combination with bupropion SR that is FDA-indicated for smoking cessation or nicotine replacement therapy will not be approved.
- The 72-hour emergency supply rule does not apply for drugs used for the treatment of smoking cessation

**Over-the-Counter (OTC) Medications**

OTC items listed on the Iowa PDL require a prescription and in some cases a Prior Authorization. Examples of OTC items listed on the PDL include:

- Multivitamins/multivitamins with iron
- Iron
- Non-sedating antihistamines
- Diphenydramine
- Insulin
- Topical antifungals
- Ibuprofen
- Meclizine

For a complete listing of covered OTC medications, please refer to the PDL on WellCare's website at **www.wellcare.com/Iowa/Providers/Medicaid/Pharmacy**

**Member Co-Payments**

- $0 co-payment for WellCare Members in accordance with the Iowa Contract.

**Coverage Determination Review Process (Requesting Prior Authorization)**

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 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 (administered in the home)
- Drugs not listed on the PDL
- Drugs that have an age edit
- Drugs listed on the PDL but still require Prior Authorization
- Non-preferred brand-name drugs when a generic exists
- Drugs that have a step therapy edit and the first-line therapy is inappropriate

Providers may request an exception to WellCare's PDL verbally or in writing. For written requests, Providers should complete a *Coverage Determination Request Form*, supplying pertinent Member medical history and information. A Coverage Determination Request form

may be accessed on WellCare's website at
**https://www.wellcare.com/Iowa/Providers/Medicaid/Pharmacy**

To submit a request, orally, refer to the contact information listed on your *Quick Reference Guide* on WellCare's website at **https://www.wellcare.com/Iowa/Providers/Medicaid**

Upon receipt of the Coverage Determination Request, a decision is completed within 24 hours . If authorization cannot be approved or denied, and the drug is medically necessary, up to a 24-hour emergency supply of the non-preferred drug can be supplied to the Member. This does not apply to Prior Authorization categories that are exempt from the 72-hour override.

For WellCare, a decision is completed within 24 hours for both standard and expedited requests.

**Medication Appeals**
To request an appeal of a Coverage Determination Review decision, contact the Pharmacy Appeals department via fax, mail, in person or phone. The *Medication Appeals Form* is located on the website at **https://www.wellcare.com/Iowa/Providers/Medicaid/Pharmacy**

For contact information, refer to the *Quick Reference Guide* on WellCare's website at **https://www.wellcare.com/Illinois/Providers/Medicaid** .

Once the appeal of the Coverage Determination Review decision has been properly submitted and obtained by WellCare, the request will follow the appeals process described in *Section 7: Appeals and Grievances* section of this Manual.

**Pharmacy Management – Network Improvement Program (NIP)**
The Pharmacy Network Improvement Program (NIP) 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 practice guidelines and cost-effective therapeutic options. These reports are delivered by the WellCare of Iowa State Pharmacy Director and/or Clinical Pharmacy Manager to physicians identified for the program.

**Member Pharmacy Access**
WellCare maintains a comprehensive network of pharmacies to ensure that pharmacy services are available and accessible to all Members 24 hours a day.

For areas where there are no pharmacies open 24 hours a day, Members may call CVS Caremark for information on how to access pharmacy services. Contact information is located on the *Quick Reference Guide* on WellCare's website at
**https://www.wellcare.com/Illinois/Providers/Medicaid**

**Exactus Pharmacy Solutions**
WellCare offers specialty pharmacy services to Members who are taking medications to treat long-term, life-threatening or rare conditions. The Exactus Pharmacy Solutions team has expertise in the special handling, storage and administration that injectables, infusibles, orals and other medications require. This team knows the insurance process and the Member's plan benefits. This means less chance of delays in a Member receiving their needed medication(s). Prescription within 24 to 48 hours after contacting an Exactus Pharmacy Solutions

representative. The actual ship date depends on whether or not Provider discussion is needed about the prescription.

To learn more about the conditions covered under Exactus Pharmacy Solutions, or how to contact them, refer to the Exactus Pharmacy Solutions website at **https://www.wellcare.com/Iowa/Providers/Exactus-Specialty-Pharmacy .**

# Section 12: Definitions

The following terms as used in this Provider Manual shall be construed and/or interpreted as follows, unless otherwise defined in the WellCare Participation Agreement.

**Action** means, pursuant to 42 CFR 438.400(b). the denial or limited authorization of a requested Service, including the type or level of Service; the reduction, suspension or termination of a previously authorized Service; the denial, in whole or in part, of payment for a Service; the failure to provide services in a timely manner, as defined by the state; or the failure of WellCare to act within 90 days from the date WellCare receives a grievance, or 45 days from the date WellCare receives an appeal. For a resident of a rural area with only one managed care entity, the denial of an enrollee's request to exercise the right to obtain services outside the network.

**Advance Directive** means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.

**Agency or DHS** means state of Iowa, Department of Human Services.

**American Indian/Alaska Native Healthcare Provider** as defined in the Iowa Contract means a health care program, including Providers of contract health services, operated by the American Indian/Alaska Native Health Service (IHS) or an American Indian/Alaska Native Tribe, Tribal Organization or Urban Indian Organization as defined in Section 4 of the American Indian/Alaska Native health Care Improvement Act (25 U.S.C. 1603)

**Appeal** means, as defined in the Iowa Contract, a request from a Member for review of an action taken by WellCare. It is a clear expression by the Member, or the Member’s authorized representative, following a decision by WellCare that the Member wants the decision reconsidered and reviewed.

**Authorization** means an approval request for payment of services. An authorization is provided only after WellCare agrees the treatment is necessary.

**Benefit Plan** means a schedule of health care services to be delivered or other health Covered Service 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.

**Business Days** means traditional workdays, which are Monday–Friday. Federal and/or state holidays may be excluded.

**Calendar Days** means all seven days of the week.

**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 behavioral health, radiology, laboratory, dental, vision or hearing services.

**Centers for Medicare & Medicaid Services (CMS)** means the agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the State Children's Health Insurance Program under Title XXI of the Social Security Acts.

**Child Health Check-Up-Program (CHCUP)** means a set of comprehensive and preventive health examinations provided on a periodic basis to identify and correct medical conditions in children/adolescents. Refer to the "EPSDT" definition for more information.

**Children/Adolescents** means Members under the age of 21. For purposes of the provision of Behavioral Health services, means Members under the age of 18 as defined by the Agency.

**Clean Claim** means a claim for Covered Services that is (i) received timely by Health Plan, (ii) is on a completed, legible CMS 1500 form or UB 04 electronic or paper billing instrument (iii) is true, complete, accurate, and includes all necessary supporting documentation and relevant information to determine payor liability, (iv) has no defect or impropriety or particular circumstances requiring special treatment that prevents timely payment of the claim, (v) is not subject to coordination of benefits, pre-existing condition investigations or subrogation, and (vi) is not under review for Medical Necessity. A Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse.

**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.

**Code of Federal Regulation (C.F.R.)**. As defined in the Iowa Contract, the C.F.R. is the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government. The requirements from applicable C.F.R. references cited in the Iowa Contract, including without limitation Medicaid Managed Care Regulations are made a part of the Provider Manual.

**Co-Surgeon** means one of multiple surgeons who work together as primary surgeons performing distinct part(s) of a surgical procedure.

**Covered Services** means Medically Necessary items and services covered under a Benefit Plan.

**Code of Federal Regulation (C.F.R.)**. As defined in the Iowa Contract, the C.F.R. is the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government. The requirements from applicable C.F.R. references cited in the Iowa Contract, including without limitation Medicaid Managed Care Regulations are made a part of the Provider Manual.

**Emergency Medical Condition** As defined in the Iowa Contract, a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) 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; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part.

**Emergency Services and Care** As defined in the Iowa Contract, Covered Services (inpatient and outpatient) that are as follows: (i) furnished by a Provider that is qualified to furnish these services, and (ii) needed to evaluate or stabilize an Emergency Medical Condition.

**Encounter Data** As defined in the Iowa Contract, records of medically-related services rendered by a Provider to a Member on a specified date of service. The data is inclusive of all services for which WellCare has any financial liability to a Provider.

**Grievance** means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a Provider or WellCare employee or failure to respect the enrollee's rights.

***hawk-i* Program** as defined in the Iowa Contract means the Healthy and Well Kids in Iowa, the Iowa program to provide health care coverage for uninsured children of eligible families as authorized by Title XXI of the federal Social Security Act.

**ICD-10-CM** means *International Classification of Diseases, 10th Revision, Clinical Modification*

**Home and Community Based Services (HCBS)** means services that are provided as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) or to delay or prevent placement in a nursing facility.

**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.

**I.A.C.** means the Iowa Administrative Code.

**Iowa Contract** means the Iowa Department of Human Services MCO Contract-MED 16-021 with WellCare and includes the collective documentation memorializing the terms of the agreement between the Agency and WellCare identified in the Contract Declarations and Execution Section and includes in addition to this section, the General Terms for Services Contracts, the Special Terms, and any Special Contract Attachments, as documents may be amended from time to time for WellCare to provide services to the Iowa Medicaid, Iowa Health and Wellness Plan, and Healthy and Well Kids in Iowa (hawk-i) programs.

**LTAC** means a Long-Term Acute Care hospital.

**Long Term Care (LTC) or Long Term Services and Supports (LTSS)** means the services of a nursing facility (NF), an Intermediate Care Facility for ICF/ID, State Resources Centers or services funded through 19515(c) HCBS waivers.

**Member** means an individual properly enrolled in a Benefit Plan and eligible to receive Covered Services at the time such services are rendered.

**Member Expenses** means co-payments, coinsurance, deductibles or other cost share amounts, if any, that a Member is required to pay for Covered Services under a Benefit Plan.

**Members/Individuals with Special Health Care Needs** means Members with special needs are 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.

**Out-of-Network** means a Provider is not contracted with WellCare.

**Periodicity** means the frequency with which an individual may be screened or re-screened.

**Periodicity Schedule** means the schedule which defines age-appropriate services and timeframes for Screenings within the Early and Periodic Screening, Diagnosis and Treatment services (EPSDT) program and applies to well-child visits and immunizations for children enrolled in the hawk-i Program.

**Preferred Drug List (PDL)** means a list of drugs that has been put together by doctors and pharmacists.

**Primary Care Provider (PCP)** means a primary care physician or other licensed health practitioner practicing in accordance with Iowa law who is responsible for providing preventative and primary health care to patients; for initiating referrals for specialists care; and for maintaining the continuity of patient care

**Prior Authorization** means the act of authorizing specific services before they are rendered.

**Provider** means a person or entity eligible to provide Medicaid services and that has a contractual agreement with WellCare to provide services under the Iowa Contract
**Referral** means a request by a PCP for a Member to be evaluated and/or treated by a specialty physician.

**Routine Care** means the level of care that can be delayed without anticipated deterioration in the Member’s condition.

**Screening** means an Assessment of an enrollee's physical or mental condition to determine evidence or indications of problems and need for further evaluation.

**Service** means health care, treatment, a procedure, supply, item or equipment.

**Service Location** means any location at which a Member may obtain any health care Service covered by WellCare under the terms of the Provider Contract.

**Urgent Care** means services for conditions, which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain, etc.) or could substantially restrict an enrollee's activity (e.g., infectious illnesses, flu, respiratory ailments, etc.).

**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.

# Section 13: WellCare Resources

**Forms and Documents**
https://www.wellcare.com/Iowa/Providers/Medicaid/Forms

**Quick Reference Guide**
https://www.wellcare.com/Iowa/Providers/Medicaid

**Clinical Practice Guidelines**
https://www.wellcare.com/Iowa/Providers/Clinical-Guidelines/CPGs

**Clinical Coverage Guidelines**
https://www.wellcare.com/Iowa/Providers/Clinical-Guidelines/CCGs

**Job Aids and Resource Guides**
https://www.wellcare.com/Iowa/Providers/Medicaid

**Provider Orientation**
https://www.wellcare.com/Iowa/
Provider must be a registered user of WellCare's secure online Provider Portal to access.