Medicare Advantage Provider Manual

2026

For more than 20 years, Wellcare has offered a range of Medicare products, which offer affordable coverage beyond Original Medicare. Beginning Jan. 1, 2022, our affiliated Medicare brands, including Allwell and ʻOhana Health Plan, transitioned to a newly refreshed and unified Wellcare brand. If you have any questions, please contact Provider Relations.

wellcare™ wellcare® By Allwell wellcare® By ʻOhana Health Plan

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Partners in Quality Care

Dear Provider Partner:

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

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

Wellcare's dedication to quality means that we are also committed to supporting you. We want to make sure that you have the tools you need to succeed. We will work with you and your staff to identify members with outstanding care gaps, and we will reward you for closing those gaps.

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

Thank you again for being a trusted Wellcare Provider partner!

Sincerely,

Wellcare

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- Responsibilities of all Providers
- Access Standards

Section 3
- Member Rights and Responsibilities

Section 4
- Quality Improvement
- Cultural Competency Program and Plan

Section 6
- Prior Authorization
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- Coordination of Care Between Medical and Behavioral Health Providers

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2026 Medicare Advantage Provider Manual Revision Table

Date	Section	Sub-Header	Comments
1/1/2026	1: Welcome to Wellcare	Wellcare Products	Availity partnership; Provider Services Phone Numbers
1/1/2026	2: Provider Administrative Guidelines	Deductible Access Standards Sample Member ID Card Special Supplemental Benefits for the Chronically Ill (SSBCI): Provider Attestation Website	Updated language; updated member ID card sample; Updated language
1/1/2026	4: Quality Improvement	Overview Member Experience Cultural Competency Diamond Designation™ Program Medical Record Review	Removed BH ECHO survey; updated language; updated language
1/1/2026	5: Medicare Star Ratings	Value Based Providers	New section
1/1/2026	6: Utilization Management, Care Management and Disease Management	Prior Authorizations Evolent Authorizations Organizational Determinations Retrospective Review Initiated by Wellcare	Added Availity details; Evolent name change; TAT changes; updated language
1/1/2026	7: Claims and Encounters	Provider Portal Overpayment Recovery Claim Payment Disputes Form & Submission Process	Added section to include Availity and provider portal links; updated language; removed mailing addresses
1/1/2026	9: Participating Provider Reconsiderations (Appeals)	Reconsideration Request Form & Submission Process	Clarified fax options, moved codes to Section 7: Claims and Encounters;

			updated submission paths
1/1/2026	13: Special Needs Plan (SNP) Members	Payments and Billing	Updated list
1/1/2026	14: Behavioral Health	Responsibilities of Behavioral Health Providers	Updated Access Standards chart
1/1/2026	15: Pharmacy	Obtaining a Coverage Determination Request	Removed MMP chart
1/1/2026	16: Definitions and Abbreviations	Abbreviations	New acronyms added
4/7/2026	9: Participating Provider Reconsiderations (Appeals)	Reconsideration Request Form & Submission Process	Added chart to separate Appeals mailing addresses

Section 1: Welcome to Wellcare

Wellcare is the Medicare brand for Centene Corporation, a leading healthcare enterprise committed to helping people live healthier lives. Today, Wellcare is proud to offer access to quality, affordable, and culturally sensitive healthcare to more than 1 million Medicare Advantage Members and 4.1 million PDP Members across all 50 states. Wellcare's experience and exclusive commitment to these programs enable the company to serve its Members and Providers as well as manage its operations effectively and efficiently.

Mission and Vision

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

- Enhance its Members' health and quality of life.
- Partner with Providers and government entities to provide quality, cost-effective healthcare solutions.
- Create a rewarding and enriching environment for its associates.

Wellcare's core values include:

- Partnership – Members are the reason Wellcare is in business; Providers are partners in serving 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 employees must be responsible for the commitments Wellcare makes and the results it delivers.
- One Team – With fellow employees, Wellcare can expect – and is expected to demonstrate – a collaborative approach in the way it works.

Purpose of This Manual

This manual is designed for Providers who are contracted with Wellcare to deliver high-quality healthcare services to Members enrolled in one of our Medicare Advantage (MA) plans.

This manual serves as a guide to Providers and their staff to comply with the policies and procedures governing the administration of Wellcare's Medicare Advantage Benefit Plans and is an extension of, and supplements, the contract under which a Provider participates in Wellcare's network for Medicare Advantage Benefit Plans (the Agreement). This document serves as the initial edition of the Provider Manual for Plan Year 2026 and is effective as of January 1, 2026.

This manual is available on Wellcare's website, go.wellcare.com. Select your state from the drop-down menu and click on *Providers* > *Overview*. If the Member has one of our Wellcare By Allwell plans,

please visit our website, go.wellcare.com, select your state from the drop-down menu. Under the Wellcare By Allwell banner, click on *View Wellcare By Allwell Plans*.

A paper copy of this manual is available at no charge to Providers upon request.

In accordance with the Agreement, Participating Providers must abide by all applicable provisions contained in this manual.

Revisions to this manual reflect changes made to Wellcare's policies and procedures. As policies and procedures change, Wellcare will issue updates in the form of Provider Bulletins that will be incorporated into subsequent versions of this manual. Unless otherwise provided in the Agreement, Wellcare will communicate changes to the manual through a Table of Revisions in the front of the manual, Provider Bulletins posted to the Provider portal on Wellcare's website, or in the quarterly Provider Newsletter. Additionally, Wellcare will abide by any additional requirements in the Agreement regarding communication of changes, if required by the Agreement. Wellcare may release Provider Bulletins that are state-specific and may override the policies and procedures in this manual for that specific state only.

Wellcare Medicare Advantage (MA)

As a Medicare Advantage managed care organization, Wellcare administers coverage that includes all of the benefits traditionally covered by Medicare plus added benefits identified in the Benefit Plan's coverage documents. Such additional benefits may include*:

- No or low monthly health plan premiums with predictable copays for in-network services.
- Outpatient prescription drug coverage.
- Routine dental, vision and hearing benefits.

*Subject to change. Availability varies by plan and county/parish and is governed by the applicable Benefit Plan.

Wellcare Products

Wellcare's products are designed to offer enhanced benefits to its Members. Wellcare's products are offered in selected markets to allow flexibility and offer a distinct set of benefits to fit Member needs in each area. For more information on Wellcare's products, visit go.wellcare.com.

Health Maintenance Organization (HMO) –Traditional MA plan. All services must be provided within the Wellcare network unless an emergency or urgent need for care arises, or such a service is not available in-network. Some services require prior authorization by Wellcare, or its designee.

Plan-directed care is a service that a Member believes that they were instructed to obtain by a health plan representative or a contracted Provider. Except for items or services that are clearly never covered, or in cases when a Member is individually notified in writing of an adverse coverage decision in advance, CMS requires plans to pay for **all** plan-directed care, and beneficiaries may never be made liable for more than their in-network cost sharing. Consequently, network Providers must obtain

authorization from Wellcare prior to referring Members to out-of-network Providers. If a network Provider refers a Member to a non-contracted Provider without obtaining prior authorization, Wellcare may hold the referring Provider liable for the cost of the Member's out-of-network care.

HMO with Point-of-Service Option (HMO-POS) – The point-of-service (POS) benefit allows Members to access some covered services from non-network Providers, and they are entitled to use their POS option anywhere in the United States. However, they may pay more to access services outside the network via their POS benefit, and no guarantee can be made that non-network Providers will accept Wellcare insurance for non-emergency services. Services available under the POS benefit are outlined in plan materials, such as the Evidence of Coverage (EOC).

Plan-directed care is a service a Member believes that they were instructed to obtain by a health plan representative or a contracted Provider. Except for items or services that are clearly never covered, or in cases when a Member is individually notified in writing of an adverse coverage decision in advance, CMS requires plans to pay for **all** plan-directed care, and beneficiaries may never be made liable for more than their in-network cost sharing. Consequently, network Providers must obtain authorization from Wellcare prior to referring Members to out-of-network Providers. If a network Provider refers a Member to a non-contracted Provider without obtaining prior authorization, Wellcare may hold the referring Provider liable for the cost of the Member's out-of-network care.

Preferred Provider Organization (PPO) – A Medicare PPO Benefit Plan operates similarly to an HMO Benefit Plan, but allows Members to use doctors, hospitals, and specialists outside of the Benefit Plan's network. A PPO Benefit Plan still maintains a network of Providers who have agreed to contractually specified reimbursement for covered benefits. However, Members can opt to visit an out-of-network Provider without an authorization at a higher cost share. PPO Benefit Plans offer coverage of all services covered under Medicare Parts A/B and provide for some reimbursement of all Covered Services, regardless of whether the Covered Services are rendered within the plan's network of Providers.

Special Needs Plan (SNP) – SNPs are Medicare Advantage coordinated care plans that provide targeted care and limit enrollment to special needs individuals. SNPs are designed to go beyond the basic provisions of Medicare Parts A/B services and standard care coordination that are required of all traditional Medicare plans. Wellcare has Chronic Special Needs Plans (C-SNP) and Dual-Eligible Special Needs Plans (D-SNP).

Chronic Special Needs Plan (C-SNP) – A C-SNP restricts enrollment to special needs individuals with specific severe or disabling chronic conditions who live within the designated service area. Individuals eligible for C-SNPs have one or more comorbid and medically complex chronic conditions that are substantially disabling or life threatening; have high risk of hospitalization or other significant adverse health outcomes; require specialized delivery systems across domains of care; and live within the plan service area. Wellcare's C-SNPs cover cardiovascular disease, congestive heart failure and diabetes mellitus.

Dual-Eligible Special Needs Plans (D-SNP) – A D-SNP provides more focused healthcare for people who have Medicare and Medicaid who live within the plan service area. These plans provide a coordinated Medicare and Medicaid benefit package that offers more integrated or aligned care than regular Medicare Advantage plans or Original Medicare. All services must be provided within the network unless an emergency or urgent need for care arises, or if such a service is not available in network.[1] Some services require prior authorization by Wellcare or its designee. The authorization look-up tool is at wellcare.com/Authorization-Lookup.

PFFS Plans – Wellcare offers Private Fee-for-Service Plans (PFFS). These plans provide coverage for all Medicare-covered Part A and Part B services received from a broad network of in-network Providers yet allow Members to use Providers outside of the plan's network without prior authorization. Services received from an out-of-network Provider may have higher out-of-pocket costs. An out-of-network Provider may treat a PFFS Member by accepting our terms and conditions of payment as long as they are a Medicare Provider.

Providers can help Members with questions about benefits and Covered Services by referencing the Member's Evidence of Coverage (EOC). Members can find their EOC and formulary information at go.wellcare.com. From there, the Member should select Find My Plan, under the Members drop down, select the plan type, (*Medicare*), enter their ZIP code and click on *Go to my plan details*.

Note: All Members who receive renal dialysis services while temporarily outside their service area will pay the in-network cost- share regardless of the Provider's network affiliation.

WellCare Self-Service Tools for Providers

Availity Provider Portal: Key Features and Benefits of Registering

WellCare partners with Availity Essentials, a multi-payer portal, to offer select secure provider portal services. Availity Essentials is the fastest way to get help with routine tasks. Our current secure provider portal will continue to remain active and available to you, including a convenient and easy way to Chat with an agent.

Log in to Availity Essentials to access the following features for Wellcare members:

- Submit eligibility & benefits inquiries with access to member ID card.
- Manage authorizations and referrals.
- Use InterQual within your authorization workflow to help facilitate the authorization review process.
- Submit claims and encounters.
- Get real-time responses on professional and facility claims, along with encounters
- EDI reporting (as needed for your organization)
- Make claim corrections and view remittance advice.

[1] This rule applies to HMO D-SNPs only.

- Access clinical applications - Clinical Quality Validation (CQV) and PCP notifications.
- Access Centene Clinical Action (CCA) via Applications in Payer Spaces to view assigned members' HEDIS measures status, procedures, and more. Applications may also be used in CoC+ to render Appointment Agendas
- Look for additional functionality in the payer space on Availity Essentials and use the heart icon to add apps to **My Favorites** in the top navigation bar. Our current secure portal will still be available for other functions you may use today.
- Availity Essentials Administrators and Administrator Assistants can utilize Manage My Organization to add associated providers to your organization, for easy Select a Provider options when submitting transactions.

If you are new to Availity Essentials, your designated Availity administrator will determine who needs access to Availity Essentials on behalf of your organization and will add user accounts. Visit Register and Get Started with Availity Essentials to enroll for training and access other helpful resources.

Secure Provider Portal: Key Features and Benefits of Registering

Wellcare's secure online Provider portal offers immediate access to what Providers need most. Participating Providers who create an account and are assigned the appropriate role/permissions can use the following features:[2]

- **Claims Submission, Status, Appeal, Dispute –** Submit a claim, check status, appeal or dispute claims, and download reports.
- **Member Eligibility, Copay Information and More –** Verify Member eligibility, and view copays, benefit information, demographic information, care gaps, health conditions, visit history and more.
- **Authorization Requests –** Submit authorization requests, attach clinical documentation, check authorization status and submit appeals. Providers may also print and/or save copies of the authorization.
- **Pharmacy Services and Utilization –** View and download a copy of Wellcare's preferred drug list (PDL), access pharmacy utilization reports, and obtain information about Wellcare pharmacy services.
- **Visit Checklist/Appointment Agenda –** Download and print a checklist for Member appointments, then submit online to get credit for Partnership for Quality (P4Q).
- **Secure Inbox –** An inbox to receive general messages from the health plan.
- **Provider Training** – View the latest available training for Providers and submit attestations.

Provider Registration Advantage

The secure Provider portal lets Providers have one username and password for use with multiple practitioners or offices. Administrators can easily manage users and permissions. Once registered for Wellcare's portal, Providers should retain username and password information for reference.

[2] Feature availability varies by health plan.

How to Register

To create an account, please refer go.wellcare.com for more information. For more information about Wellcare's web capabilities, please call Provider Services or contact Provider Relations to schedule a website in-service training.

Additional Resources

Additional resources are available at go.wellcare.com. To find the correct materials, follow the steps below based on the Medicare Advantage brand:

For Wellcare:

- Go to go.wellcare.com.
- Select your state from the drop-down menu.
- Hover over the *Providers* tab and click Overview under the *Medicare* section.

For Wellcare By Allwell:

- Go to go.wellcare.com.
- Select your state from the drop-down menu.
- Under the Wellcare By Allwell header, click View Wellcare By Allwell Plans.
- A message will appear: "This link will leave Wellcare.com, opening in a new window." Click Continue.
- On the new page, select For Provider to access plan-specific resources.

The following resources are available on the provider websites:

- Quick Reference Guide: contains key contact information, including addresses, phone and fax numbers, and prior authorization requirements.
- Supporting Guides: Includes detailed information on claims and billing procedures, authorization process, appeals, and other operational policies.

Website Resources

Wellcare offers a variety of tools to assist Providers and their staff. Available resources may include:[3]

- Provider manuals
- Quick Reference Guides
- Clinical Practice Guidelines (CPGs)
- Clinical Policies (Clinical Coverage Guidelines (CCGs))
- Wellcare Companion Guide
- Forms and documents
- Pharmacy and Provider lookup (directories)
- Authorization look-up tool
- Training materials and job aids

[3] Certain resources may be limited or unavailable across lines of business.

- Newsletters and bulletins
- Member rights and responsibilities
- Privacy statement and notice of privacy practices

Using Chat: Get to Know the Benefits of Chat[4]

Faster than email and easier than phone calls, chat is a convenient way for Providers to ask simple questions and receive real-time support from agents. Chat support can help Providers and their staff with multi-session functionality, web support assistance and real-time claim adjustments. Explore the benefits of chat:

- Convenience
    - Chat offers the ease of getting help and answers without a phone call.
- No Waiting on Hold
- Documentation of Interaction
    - Chat logs provide transparency and proof of contact. Our Chat software gives Providers the option of receiving a transcription of the conversation.
- Access Chat through the Provider portal

The Chat Support icon is located in several areas of our secure portal:

- Login to Provider.wellcare.com.
- Chat is available on the login page, registration pages, home page, claims lookup area, and more.
- Providers can also access chat via the Help section after selecting a topic and choosing their state and plan.
- After a chat inquiry is submitted, the receiving Chat agent can assist with numerous issues.
- If the Chat agent is unable to resolve the issue, it will be routed to the right team for further assistance.
-

Interactive Voice Response (IVR) System IVR system

- New technology to expedite Provider verification and authentication within the IVR
- Provider or Member account information is sent directly to the agent's desktop from the IVR validation process, so Providers do not have to re-enter information
- Full speech capability lets Providers speak the information or Providers can use the touch-tone keypad

Self-Service Features

- Ability to receive Member copay benefits
- Ability to receive Member eligibility information
- Ability to request authorization and/or status information
- Unlimited claims information on full or partial payments
- Receive status for multiple lines of claim denials
- Automatic routing to the PCS claims adjustment team to dispute a denied claim
- Rejected claims information

[4] All features and benefits are not applicable for all lines of business.

TIPS for using IVR

Providers should have the following information available with each call:

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

Benefits of using Self-Service

- 24/7 data availability
- No hold times
- Providers may work at their own pace
- Access information in real time
- Unlimited number of Member claim status inquiries
- Direct access to PCS – no transfers

The *Phone Access Guide* is at go.wellcare.com under *Overview* in the Providers section of each state-specific page.

Providers may contact the appropriate departments at Wellcare by referring to the state-specific *Quick Reference Guides* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu. Wellcare Provider Relations representatives are also available to help. Please contact the local market office for assistance.

Provider Services Phone Numbers and Other Key Contacts

To ensure timely support and accurate care coordination, always refer to the Member's ID card for the appropriate Provider Services phone number. The ID card contains the most current and plan-specific contact details for your patients.

Why this matters:

- Contact information on the Member's ID card is the best source for accurate routing and quick assistance.
- Using the number on the ID card helps avoid delays and ensures you reach the correct team for your patient's plan.

National Contacts:

Certain resources have national phone numbers that apply across all markets. These numbers are listed in the manual for your convenience and do not vary by state or plan.

Department	Phone Number
Availity Essentials	1-800-AVAILITY (282-4548) website: www.availity.com
PaySpan	1-877-331-7154 website: www.payspanhealth.com

Department	Phone Number
Fraud, Waste, and Abuse	1-866-685-8664
Ethics & Compliance Hotline	1-800-345-1642

Additional Contact Information

For more information specific to a particular state and/or health plan, please contact Provider Services using the appropriate phone number listed above, or refer to the state-specific Quick Reference Guides (QRGs) at go.wellcare.com. For Wellcare, select your state from the drop-down menu and click Overview under Medicare in the Providers section. For Wellcare By Allwell, select your state from the drop-down menu, click View Wellcare/Wellcare By Allwell Plans, then select For Providers and Provider Resources.

For inquiries related to Member Services, Pharmacy, Vision, Dental, and other benefit areas, contact Provider Services or refer members to Member Services at the number printed on their ID card. This ensures timely assistance and accurate routing to the appropriate department.

Authorizations At-A-Glance

To ensure timely access to medically necessary services and medications, Wellcare offers multiple streamlined options for submitting authorization and coverage determination requests. Providers may initiate requests through secure online portals (Availity Essentials is our preferred portal), fax, or phone, depending on the type of service and urgency. This section outlines the preferred submission methods for authorization of medical services - including inpatient, outpatient, DME, and therapy services - as well as pharmacy coverage determinations. For state-specific contact details and tools, providers should refer to the Quick Reference Guide and Authorization Lookup available at go.wellcare.com.

Authorization Requests	• Submit to Availity Essentials (**fastest option**) • Submit to the Secure Provider portal at go.wellcare.com • Fax a properly completed Inpatient, Outpatient, Durable Medical Equipment (DME) and Orthotic and Prosthetic, or Home Health and Skilled Therapy Services Authorization Request Form • Contact Wellcare via phone for inpatient notifications and urgent outpatient services

For the appropriate contact information, per the above options, refer to the state-specific *Quick Reference Guide* on go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.	
Providers may access the authorization look-up tool by going to go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Authorization Lookup* under *Tools* in the *Providers* drop-down menu.	
Pharmacy Coverage Determination Request	Complete a *Coverage Determination Request Form online, or call, fax or mail the form* to the Pharmacy Department.
The Coverage Determination Request Form is located at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Pharmacy* under *Medicare* in the *Providers* drop-down menu.	

Non-Wellcare Provider Resources

Wellcare understands that Members may elect to visit Providers that are not part of Wellcare's Provider Network. If a Provider is not in-network, the Provider will still need to know how to file claims and understand any policies and procedures that may affect the Provider and Wellcare-Member patients.

To learn more about online resources available to non-participating Providers or how to join the Wellcare network of providers, visit go.wellcare.com select the appropriate state from the drop-down menu, click on "Provider," then select "Non-Wellcare Providers."

Section 2: Provider Administrative Guidelines

Provider Administrative Overview

In accordance with generally accepted professional standards, participating Providers must:

- Meet the requirements of all applicable state and federal laws and regulations, including without limitation, 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 MA contract(s) and/or MA rules and regulations and assist Wellcare in complying with corrective action plans necessary 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 healthcare.
- Use physician extenders appropriately. Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNPs) should provide direct Member care within the scope of practice established by the rules and regulations of the state 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 their title (examples: M.D., D.O., ARNP, PA) to Members and to other healthcare professionals.
- Honor at all times any Member request to be seen by a physician rather than a physician extender.
- Administer treatment for any Member in need of healthcare services they provide.
- Respond within the identified timeframe to Wellcare's requests for medical records to comply with regulatory requirements.
- Maintain accurate medical records and adhere to all Wellcare policies governing the content and confidentiality of medical records as outlined in *Section 4: Quality Improvement* (QI) and *Section 11: Compliance and Regulatory Requirements*.
- Allow Wellcare to use Provider performance data for quality improvement activities.
- Cooperate with QI activities.
- Ensure that to the extent the Provider maintains written agreements with employed physicians and other healthcare practitioners, such agreements are consistent with and require adherence 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 MA Members and MA Members who are not Wellcare Members. The hours of operation offered to Wellcare Members are no less than those offered to patients with commercial insurance.
- Not deny, limit, or condition the furnishing of treatment to any Wellcare MA Member on the basis of any factor that is related to health status, including, but not limited to the following:
    - Medical condition, including behavioral as well as physical illness
    - Claims experience
    - Receipt of healthcare
    - Medical history
    - Genetic information
    - Evidence of insurability, including conditions arising out of acts of domestic violence
    - Disability
- Freely communicate with and advise Members regarding the diagnosis of the Member's condition and advocate on the Member's behalf for the 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 who need services related to domestic violence, smoking cessation or substance abuse. If indicated, Providers must refer Members to Wellcare-sponsored or community-based programs.
- 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.

Responsibilities of All Providers

The following is a summary of responsibilities of all Providers who render services to Wellcare Members.

Compliance in Connection with Marketing Medicare Advantage Plans

Medicare Advantage plan marketing is regulated by the Centers for Medicare and Medicaid Services (CMS). Providers should familiarize themselves with CMS regulations and the CMS *Medicare Managed Care manual*. For more information, refer to *Section 11: Compliance and Regulatory Requirements* in this manual.

Maximum Out-of-Pocket

For MA Benefit Plans, Member Expenses are limited by a maximum out-of-pocket (MOOP) amount. If a Member has reached the maximum out-of-pocket amount for that particular Member's Benefit Plan,

a Provider should not collect any additional out-of-pocket amounts from the Member for Medicare Covered Services and should not apply or deduct any Member Expenses from that Provider's reimbursement. Providers may determine a Member's accumulated out-of-pocket amount via the Wellcare Provider portal or by contacting Wellcare's Provider Services Department. If a Provider collects an out-of-pocket amount that causes a Member to exceed their annual maximum out-of-pocket, Wellcare will notify the Provider that the amount collected from the Member was in excess of the maximum out-of-pocket, and the Provider shall promptly reimburse the Member for that amount.

If Wellcare determines that the Provider did not reimburse the amount in excess of the maximum out-of-pocket amount to the Member, Wellcare may pay the overage amount to the Member directly and recoup the amount directly from the Provider. If Wellcare erroneously deducts an amount from the Provider's reimbursement as a result of a Member's payment of a cost-share amount that does not exceed maximum out-of-pocket, Wellcare will reimburse the Provider for the amount deducted in error.

Wellcare may audit the Provider's compliance with this section and may require the Provider to submit documentation to Wellcare demonstrating that the Provider reimbursed Members for amounts in excess of the maximum out-of-pocket amounts.

Deductible

Some Medicare Benefit Plans require Members to meet a deductible each year for certain services before they may receive any payment from the health plan. Members who enroll after January of a given year may have already met their deductible for that year at another health plan. When Providers become aware that this has occurred, they should notify Wellcare and provide documentation illustrating that the Member has met their deductible. For example, a Provider might submit a remittance from another health plan illustrating that the Member met the Member's deductible previously. If appropriate documentation is submitted and approved, Wellcare will readjudicate the claim and pay the Provider.

When the Member's Benefit Plan includes a deductible, that deductible will be applied to payments that would otherwise be made for the following services:

- Cardiac rehabilitation services
- Intensive cardiac rehabilitation services
- Pulmonary rehabilitation services
- SET for PAD services
- Partial hospitalization
- Intensive Outpatient Program Services
- Chiropractic services
- Occupational therapy services
- Physician specialist services
- Mental health specialty services (individual and group sessions)

- Medicare covered podiatry services
- Other healthcare professional
- Psychiatric services (individual and group sessions)
- Physical therapy and speech-language pathology services
- Additional telehealth services
- Opioid treatment services
- Diagnostic procedures/tests
- Diagnostic radiological services
- Therapeutic radiological services
- Outpatient X-ray services
- Outpatient hospital services
- Observation services
- Ambulatory surgical center (ASC) services
- Outpatient substance abuse (individual and group sessions)
- Outpatient blood services
- Ground ambulance services
- Air ambulance services
- Durable medical equipment (DME)
- Prosthetic devices
- Medical supplies
- Dialysis services
- Kidney disease education services

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. Advance Directives may differ among states.

Each Member (age 18 years or older and of sound mind) should receive information about Advance Directives. These directives allow the Member to designate another person to make medical decisions on the Member's behalf should the Member become incapacitated.

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

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

Provider Billing and Address Changes

Providers are required to give prior notice per the terms of their Agreement for any of the following changes. Please contact us to report changes to your:

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

Failure to notify Wellcare prior to these changes will result in a delay in claims processing and payment.

To maintain the integrity of Provider Directory data, Wellcare may rely on information independently verified by a third party and may take appropriate actions to remove inaccurate Provider data from the directory.

Provider Termination

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

- Unless a different notice period is expressly stated in the Agreement, a Provider must give at least 90 days' prior written notice (180 days, if Provider is a hospital) to Wellcare before terminating their relationship with Wellcare "without cause," unless otherwise agreed to in writing. This ensures adequate notice may be given to Wellcare Members regarding the Provider's participation status with Wellcare.
- Unless otherwise provided in the termination notice, the effective date of termination will be on the last day of the month.

Please refer to *Section 8: Credentialing* of this manual for specific guidelines regarding rights to appeal a plan termination (if any).

Wellcare will notify in writing all appropriate agencies and/or Members prior to the termination effective date of a participating PCP, hospital, specialist or significant ancillary Provider within the service area, as required by Medicare Advantage program requirements and/or regulations and statutes.

Out-of-Area Member Transfers

Providers should help Wellcare arrange and accept the transfer of Members receiving care out of the service area if the transfer is considered medically acceptable by a Provider and the out-of-network Provider.

Members with Special Healthcare Needs

A Member with "special healthcare needs" is a Member who has one or more of the following conditions:

- Intellectual disability or related conditions.
- Serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia, or degenerative neurological disorders.
- Disabilities resulting from chronic illness such as arthritis, emphysema or diabetes.
- Environmental risk factors such as homelessness or family problems that may lead to the need for placement in foster care.

Providers who render services to Members with special healthcare needs shall:

- 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.
- Develop plans of care that 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 their needs, and a person or entity formally designated as primarily responsible for coordinating the healthcare services furnished.
- Coordinate services with other third-party organizations to prevent duplication of services and share results on identification and assessment of the Member's needs.
- Ensure the Member's privacy is protected as appropriate during the coordination process.

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 will monitor Providers against the standards below to help Members obtain needed health services within acceptable appointment times, in-office waiting times, and after-hours standards. Providers not in compliance with these standards will be required to implement corrective actions.

Members can access care according to the following standards:

- Emergency care: immediate or less than 24 hours
- Services that are not an emergency but do require medical attention: within one week
- Routine and preventive care: within 30 days

Type of Appointment	Access Standard
PCP – Adult Urgent Visit	≤ 24 hours
PCP – Adult Sick Visit	≤ 7 business days
PCP- Adult Routine Visit	≤ 30 business days
PCP - Wait Time	≤ 30 minutes
Oncology	≤ 30 business days
Oncology – Wait Times	≤ 30 minutes
Gynecology	≤ 30 business days
Gynecology – Wait Times	≤ 30 minutes
All Other Specialists	≤ 30 business days
All Other Specialists – Wait Times	≤ 30 minutes
Non – Prescriber BH – Urgent Care	≤ 48 hours
Non-Prescriber BH – Non-Life-Threatening Emergency Care	≤ 6 hours
Prescriber BH Sick Visit	≤ 7 business days
Prescriber BH Routine Well Care	≤ 10 business days
Prescriber BH Routine Follow-Up Visit	≤ 30 business days
After-hours Care	≤ 24 hours per day, 7 days per week

In-office wait times for all standards shall not exceed 30 minutes.

Telephone Arrangements

PCPs must provide or arrange for coverage of services, consultation, or approval for referrals 24 hours per day, seven days per week. To ensure access and availability, PCPs must provide one of the following after-hours services:

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

A medical professional who will answer after-hours calls and provide the Member with access to the PCP or on-call physician within a maximum of 30 minutes.

Responsibilities of Primary Care Providers

The following is a summary of responsibilities specific to PCPs who render services to Wellcare Members. PCPs coordinate, monitor and supervise the delivery of primary care services to each Member by doing the following:

- See Members for an initial office visit and assessment within the first 90 days of enrollment in Wellcare.
- Ensure Members are aware of the availability of public transportation where applicable.
- Provide access to Wellcare or its designee to examine thoroughly the primary care offices, books, records and operations of the PCP and any organization that (a) owns or controls the PCP's operation; or (b) has a financial relationship with the PCP or renders services to the PCP's office.
- Submit an encounter to Wellcare for each visit in which the Provider sees the Member and the Member receives a Healthcare Effectiveness Data and Information Set (HEDIS®) service. For more information on encounters, refer to *Section 7: Claims and Encounters* in this manual.
- Ensure Members use network Providers. If unable to locate a Wellcare-participating Medicare Advantage Provider for services required, PCPs should call the Clinical Services Department phone number listed in the *Quick Reference Guide* on Wellcare's website for assistance.
- Implement corrective action and performance improvement plan(s) when required by Wellcare.

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 resources:

- Support of Wellcare's Provider Relations, Provider Services and Clinical Services.
- The tools and resources at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.
- Information on Wellcare network Providers for the purposes of referral management and discharge planning.

Closing of Provider Panel

When requesting closure of their 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.
- Keep the panel open for Wellcare Members who were provided services before the closing of the panel.
- Notify Wellcare when reopening the panel and provide the effective date.

- Request may be submitted via Wellcare's secure Provider portal or by contacting your Provider Relations representative.

Covering Physicians/Providers

If a PCP's covering Provider is temporarily unavailable, the PCP should make arrangements with another Provider who participates in Wellcare's Medicare Advantage program. In the event of an emergency, Members may seek care from any Provider, regardless of whether the Provider is contracted with Wellcare.

In non-emergency cases, Providers should contact Wellcare for approval of any covering physician/Provider who is not contracted with Wellcare or has not been credentialed by Wellcare. For more information, refer to the state-specific *Quick Reference Guides* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

Assignment of Primary Care Provider

Most Members will choose a PCP or will have one assigned to them by Wellcare. (Private Fee-for-Service [PFFS] Members do not select a PCP or have one assigned to them.)

Verifying Member Benefits, Eligibility and Cost Shares

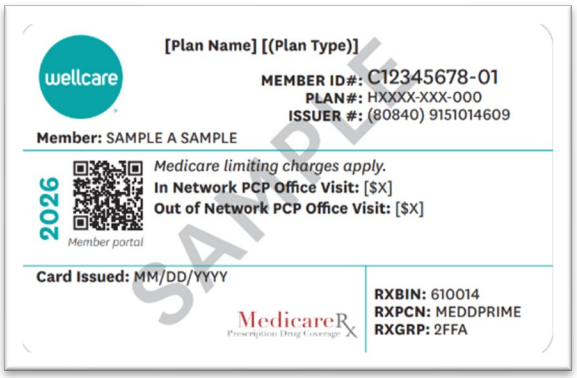
A Member's eligibility status may change at any time. Therefore, all Providers should verify eligibility, benefits, and cost sharing prior to each scheduled appointment. Providers should also request Members to present their ID card, along with additional proof of identification such as a photo ID (if applicable), at each encounter. If there are any differences between the Member's ID card and/or the Provider's eligibility report, Providers should contact Provider Services at the appropriate number listed.

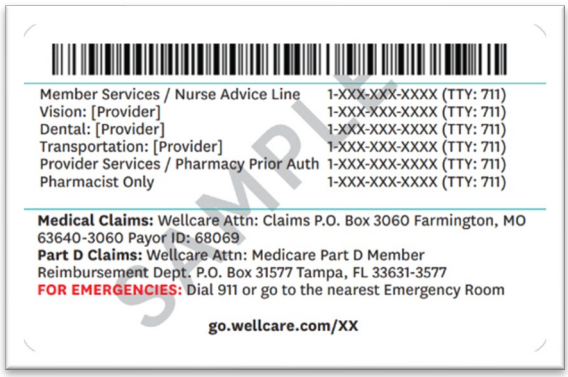
Providers may do one of the following to verify eligibility:

- Access Availity Essentials at https://www.availity.com/
- Access the Provider portal at go.wellcare.com
- Access Wellcare's Interactive Voice Response (IVR) system
- Contact Wellcare's Provider Services Department

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. 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.

Sample Member ID Card





Special Supplemental Benefits for the Chronically Ill (SSBCI): Provider Attestation Website

Starting in 2026, newly enrolled members may qualify for Special Supplemental Benefits for the Chronically Ill (SSBCI) through provider attestation. These benefits are designed to support individuals living with qualifying chronic conditions by offering additional services beyond standard Medicare coverage.

How to Determine Eligibility

To begin the SSBCI manual eligibility process, members must schedule an in-person office visit *or* contact their healthcare provider to request that the attestation be completed. If an office visit is required to complete the attestation, during this visit the provider will evaluate the member's health status and determine if they meet SSBCI criteria.

Provider Instructions for SSBCI Attestation

Providers should follow these steps to complete the attestation:

1. Visit ssbci.rrd.com
2. **Review the eligibility criteria** and evaluate the patient accordingly.
    1. Members must meet all three criteria to qualify for SSBCI benefits:
        i. **Patient must have an active diagnosis for one or more qualifying chronic conditions**. (Qualifying conditions are listed on the attestation website.)
            1. To qualify, the condition must be life threatening or must significantly limit your health or function.
        ii. **Patient must have a need for intensive care management.**
            1. To qualify, the patient must have frequent use of outpatient services or specialty care and/or, evidence of poor disease control or medication adherence and/ or, social or behavioral factors impacting health outcomes.
        iii. **Patient must be at high risk for an unplanned hospital visit.**

1. To qualify, the patient must have a history of frequent hospitalizations or ED visits.

3. **Submit an attestation** through the website confirming the patient meets SSBCI eligibility requirements.
4. **Submit a claim** from the office visit that includes the appropriate diagnosis codes indicating the member has one or more qualifying chronic conditions listed on ssbci.rrd.com.

What Happens Next?
Once the attestation is received:

- The member will receive an **approval or denial letter within 10 business days**.
- If approved, the letter will include details about the **specific SSBCI benefits** available and instructions on how to access them.

Termination of a Member

A Provider may not seek or request to terminate his or 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 the Member.

Reasonable efforts should always be made to establish a satisfactory Provider and Member relationship in accordance with practice standards. If a Provider desires to terminate his or her relationship with a Member, the Provider must complete a *PCP Request for Transfer of Member* form and attach documentation of the Member's non-compliance with treatment or uncooperative behavior that is impairing the ability to care for and treat the Member effectively. The form should be faxed or emailed to Wellcare's Provider Services Department. The Request for transfer of Member form is at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Forms* under *Medicare* in the *Providers* drop-down menu.

Once the form has been submitted, the Provider shall continue to provide medical care for the Member until such time that written notification is received from Wellcare confirming that the Member has been successfully transferred to another Provider.

Domestic Violence and Substance Abuse Screening

Providers are expected to stay current with domestic violence and substance abuse training, as well as follow state laws in regard to serving as mandatory reporters. For adult patients where domestic violence is suspected, or stated by the patient, Providers are expected to provide education and community resources to the patient. In addition, if the adult patient gives consent for law enforcement involvement, the Provider should contact law enforcement officials.

Resources related to substance abuse can be located at go.wellcare.com. Select the appropriate state from the drop-down menu, then select Provider/Medicare/Forms.

Smoking Cessation

PCPs should direct Members who wish to quit smoking to call Wellcare's Customer Service Department and ask to be directed to the Care Management Department. A care manager will educate the Member on national and community resources that offer assistance, as well as smoking-cessation options available to the Member through Wellcare.

Annual Wellness Visit

An annual wellness visit should be completed to assess the health status of all Wellcare MA Members. The adult Member should receive an appropriate assessment and intervention as indicated or upon request. Please refer to the adult preventive health guidelines and the Member physical screening tool, both located at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Clinical Guidelines, then Clinical Practice Guidelines* under *Tools* in the *Providers* drop-down menu.

Section 3: Member Administrative Guidelines

Overview

Wellcare will make information available to Members on the role of the PCP, how to obtain care, what to do in an emergency or urgent medical situation, and the Members' rights and responsibilities. Wellcare will convey this information through various methods including an *Evidence of Coverage* booklet.

Evidence of Coverage Booklet

All Members have access to an *Evidence of Coverage* booklet no later than 10 calendar days from receipt of CMS confirmation of enrollment or by the last day of the month prior to the effective date, whichever is later, and annually thereafter.

Enrollment

Wellcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy and sexual orientation). Upon enrollment with Wellcare, Members are provided the following:

- Terms and conditions of enrollment
- Description of covered non-emergency services in-network and out-of-network, if applicable
- Information regarding coverage of out-of-network emergency or urgent care services
- Information about PCPs, such as location, telephone number, and office hours
- Grievance and disenrollment procedures
- Brochures describing certain benefits not traditionally covered by Medicare and other value-added items or services, if applicable

Member Identification Cards

Member identification cards are intended to identify Wellcare Members, including the type of plan they have, and facilitate their interactions with healthcare Providers. Information found on the Member identification card may include the Member's name, identification number, plan type, PCP's name and telephone number, health plan 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. Below are pictures of sample Member identification cards for Wellcare, Wellcare By Allwell, and Wellcare By Ohana Health Plan.

Member Rights and Responsibilities

Wellcare Members have specific rights and responsibilities when it comes to their care. The Member rights and responsibilities are provided to Members in the Member's *Evidence of Coverage* booklet and are outlined below. Providers will deliver care to Members in accordance with these rights and responsibilities. In the case of a conflict between the *Evidence of Coverage* booklet applicable to a given Member and the provisions below, the *Evidence of Coverage* booklet governs.

Members have the right to:

- Have information provided in a way that works for them, including information that is available in alternate languages and formats.
- Be treated with fairness, respect, and dignity.
- See Wellcare Providers, get Covered Services, and get their prescriptions filled in a timely manner.
- Have privacy and to have their protected health information (PHI) protected.
- Receive information about Wellcare, its network of Providers and practitioners, their Covered Services, and Member rights and responsibilities.
- Know their treatment choices and participate in decisions about their healthcare.
- Use advance directives (such as a living will or a durable healthcare power of attorney).
- Make complaints about Wellcare or the care provided and feel confident it will not adversely affect the way they are treated.
- Appeal medical or administrative decisions Wellcare has made by using the appeals process.
- Receive a copy of Member rights and responsibilities and make recommendations about Wellcare's Member rights and responsibilities policies.
- Talk openly about care and treatment options needed for their health, regardless of cost or benefit coverage, as well as the choices and risks involved. The information must be given to Members in a way they understand.

Members also have certain responsibilities. These include the responsibility to:

- Become familiar with their coverage and the rules they must follow to get care as a Member.
- Tell Wellcare and Providers if they have any additional health insurance coverage or prescription drug coverage.
- Tell their PCP and other healthcare Providers that they are enrolled in Wellcare.
- Give their PCP and other Providers complete and accurate information to care for them, and to follow the treatment plans and instructions that they and their Providers agree upon.
- Understand their health problems and help set treatment goals that they and their doctor agree to.
- Ask their PCP and other Providers questions about treatment if they do not understand.
- Make sure their Providers know all of the drugs they are taking, including over-the-counter drugs, vitamins and supplements.

- Act in a way that supports the care given to other patients and helps the smooth running of their Provider's office, hospitals, and other offices.
- Pay their plan premiums and any copayments or coinsurance they owe for the Covered Services they get. Members must also meet their other financial responsibilities as described in the *Evidence of Coverage* booklet.
- Inform Wellcare if they move.
- Inform Wellcare of any questions, concerns, problems, or suggestions by calling the Member Services department listed in the *Evidence of Coverage* booklet.

Changing Primary Care Providers

Members may change their PCP at any time by calling Wellcare's Member Services department.

Women's Health Specialists

PCPs may also provide routine and preventive healthcare 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 Members through Wellcare Member Services. PCPs should coordinate these services for Members and contact Member Services if assistance is needed. For Provider Services phone numbers, please refer to the state-specific *Quick Reference Guides* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

Section 4: Quality Improvement

Overview

Wellcare's Quality Improvement (QI) Program is comprehensive, systematic, and continuous. It applies to all Member demographic groups, care settings, and types of services afforded to Medicare Advantage Members, including the Special Needs Plan Membership. The QI Program addresses the quality of clinical care and non-clinical aspects of service. Key areas of focus include, but are not limited to:

- Utilization Management
- Population Health Management (including Care Management/Disease Management/Chronic Care Improvement Program, Preventive and Clinical Health and Model of Care)
- Coordination/Continuity of Care
- Cultural Competency
- Credentialing and Peer Review
- Patient Safety and Quality of Care
- Appeals, Grievances and Complaints
- Member Experience and Retention
- Provider Experience
- Components of operational service (including customer service/claims, etc.)
- Contractual, regulatory and accreditation reporting requirements
- Behavioral Health Services
- Clinical Indicators and initiatives (including HEDIS®, HOS, and Star Ratings)
- Member Record Review
- Delegation
- Pharmacy and Therapeutics
- Provider Satisfaction
- Appointment Access and Availability
- Network Adequacy and Accessibility®
- Confidentiality and Ethics

The QI Program reflects a continuous quality improvement (CQI) philosophy and mode of action. The QI Program Description, the QI Work Plan, and the National Medicare and SNP Quality Improvement and Utilization Management Program Evaluation are completed at least annually and describe CQI processes and are approved by the applicable committees. The Organization uses the CQI methodology to improve and accomplish identified goals and processes. The QI Program Description defines program structure, accountabilities, scope, responsibilities, and available resources. The Organization uses the Plan-Do-Study-Act (PDSA) method of CQI throughout the organization where multiple indicators of quality of care and service are reviewed and analyzed against benchmarks of quality clinical care, evidence-based medicine, and service delivery. When variations are noted, root cause analysis, action plans, and remeasurement occur to ensure progress toward established goals.

The strategy of PDSA incorporates the continuous tracking and trending of quality indicators to ensure that outcomes are measured and goals attained. Quality of care interventions and outcomes are monitored through nationally recognized quality standards such as HEDIS performance measures and CAHPS® surveys, while also utilizing current knowledge and clinical experience to monitor external quality review studies, periodic medical record reviews, clinical management, and quality initiatives. Action Plans are issued annually based on market and corporate performance with each measure within the Work Plan.

The National Medicare and SNP QI and UM Work Plan identifies specific activities and initiatives carried out by the Plan and the performance measures for analysis throughout the year. Work Plan activities align with contractual, accreditation, and regulatory requirements and identify measurements to accomplish goals.

The National Medicare and SNP QI and Utilization Management Program Evaluation describes the level of success achieved in realizing set clinical and service performance goals through quantitative and qualitative analysis and trending as appropriate. The Program Evaluation describes the overall effectiveness of the QI Program by including:

- A description of ongoing and completed QI activities and initiatives.
- Trended clinical care and service performance measures as well as the desired outcomes and progress toward achieving goals.
- An analysis and evaluation of the effectiveness of the QI Program and its progress toward influencing the quality of clinical care and service.
- A description of any barriers to accomplishing quality clinical care or achieving desired outcomes.
- Current opportunities for improvement with recommendations for interventions.
- Regular follow-up on action items identified in the National Medicare Quality Improvement and Utilization Management Committee (QIUMC) forum.

Network Practitioners and Providers are contractually required to cooperate with all Quality Improvement (QI) activities to improve the quality of care and services and Member experience. This includes the collection and evaluation of performance data and participation in the Wellcare Health Plan's, under Centene Corporation, QI programs. Practitioner and Provider contracts, or a contract addenda, also require that Practitioners and Providers allow Centene Corporation, of which Wellcare Health Plan is a part of, use of their performance data for quality improvement activities. To obtain a copy of the National Medicare and SNP Quality Improvement and Utilization Management Program Evaluation contact: MedicareQIProgramOperations@centene.com.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Appointment Access and Availability Monitoring

Wellcare monitors geographic access through the production of reports and maps. Reports are generated using the specific access standards per regulatory agencies and accrediting bodies to ensure compliance and that the needs of all Members are met.

Wellcare monitors the timeliness of access to care within its Provider networks via appointment accessibility and after-hours telephone surveys per requirements outlined by regulatory agencies, contractual requirements, and accrediting bodies. Wellcare requires that all network Providers, both first tier and downstream Providers, offer hours of operation that are no less than the hours of operation offered to commercial and fee-for-service patients.

Maps and accessibility reports are developed and reviewed for targeted lines of business that adhere to regulatory agencies, accrediting bodies, and company requirements. On at least a semi-annual basis, Wellcare completes analysis to evaluate compliance to geographic access standards and take action as appropriate. Results of the reports are reported into the appropriate committees.

In addition, average speed of answer, service level, and call abandonment rates are monitored on an ongoing basis to ensure adequate access to Wellcare personnel for Members and Providers. Access and availability are also monitored on an annual basis via the Member satisfaction survey. Network availability data is reported to the National Medicare Quality Improvement and Utilization Management Committee (QIUMC) on a semiannual basis.

Appeals, Concerns, Complaints, and Grievances

Appeals and Grievance activities are reported to the National Medicare Quality Improvement and Utilization Management Committee (QIUMC).

Within the Appeals and Grievance department, quality goals are outlined and aim to:

- Resolve 95% of complaints within compliance and/or accreditation time frames
- Improve quality of data to facilitate reporting, tracking and trending, and analysis
- Achieve acceptable scores on accreditation, and internal and external audits
- Reduce the volume of appeals
- Improve compliance and efficiency through automation whenever possible

Issues are documented in a common database to enable appropriate classification, timely investigation, and accurate reporting of issues to the appropriate Quality committee. Trended data is reviewed on a periodic basis to determine if a need for further action exists, be it Plan, practitioner, or Provider-focused. This data, as well as any identified trends or problem areas, and mitigation strategies to eliminate top reasons for dissatisfaction are reported through the National Medicare Quality Improvement and Utilization Management Committee (QIUMC) on a quarterly basis.

For additional information pertaining to Appeals and Grievances, see *Sections 9 and 10*.

Member Experience

The Member experience data collected through the CAHPS® survey addresses leading indicators of Member satisfaction including *Getting Needed Care*, *Getting Appointments and Care Quickly*, *Customer Service*, *Care Coordination*, *Rating of Drug Plan*, *Getting Needed Prescription Drugs*, *Flu Vaccination*, *Rating of Healthcare Quality*, and *Rating of Health Plan*. Wellcare identifies opportunities for improvement based on the information collected through the CAHPS® survey, appeals, and grievances.

Wellcare contracts with a NCQA-certified survey vendor to conduct the CAHPS survey on an annual basis, using NCQA-required survey techniques and specifications required by NCQA and CMS. CAHPS results are presented to the National Medicare Quality Improvement and Utilization Management Committee (QIUMC) for review of the committee including the external Providers that participate.

Member retention analysis and reporting is also a part of the Member experience evaluation process. The Member Experience and Retention Department strives for excellent Member satisfaction and uses voluntary disenrollment performance as the basis for monitoring success and performing root cause analyses for continual improvement of Member satisfaction.

Please refer to *Section 5: Medicare Stars Rating* for additional information regarding CAHPS®.

Provider Experience

The Provider network is formally surveyed by a certified vendor on an annual basis to assess Provider satisfaction with the Plan. Results are analyzed and an action plan is developed and implemented to address the areas identified as needing improvement. The results and action plan are presented to the National Medicare Quality Improvement and Utilization Management Committee (QIUMC) for approval and recommendations.

Behavioral Health Services

Behavioral health is integrated in the overall care model. The goals and objectives of the behavioral health activities are congruent with the Population Health Solutions health model and are incorporated into the overall care management model program description.

Special populations such as serious and persistent mental illness (SPMI) adults may require additional services and attention, which may lead to the development of special arrangements and procedures with our Provider network to arrange for and provide certain services including:

- Coordination of services for Members after discharge from state and private facilities to integrate them back into community. This includes coordination to implement or access services with network behavioral health Providers or Community Mental Health Clinics (CMHCs).

- Targeted care management by community mental health Providers for adults in the community with a severe and persistent mental illness.

The goals of the Behavioral Health Program mirror those of the Utilization and Care Management programs. The program is intended to decrease fragmentation of healthcare service delivery; facilitate appropriate utilization of available resources; and optimize Member outcomes through education, care coordination and advocacy services for the compromised populations served. It is a collaborative process using a multidisciplinary, Member-centered model that integrates the delivery of care and services across the care continuum. It supports the Institute for Healthcare Improvement's Triple Aim objectives, which include:

- Improving the patient experience of care (including quality and satisfaction).
- Improving the health of populations.
- Reducing the per-capita cost of healthcare.

Population Health Management

Population Health Management (PHM) allows for the assessment of the characteristics and needs of the entire Membership with the goal of determining actionable categories for appropriate intervention. The results of the assessment and stratification of Members allow the Plan to develop its strategy to improve the quality of life of its Members. The population assessment is conducted annually by collecting, stratifying, and integrating various data sets and programs to assess Member's needs across the entire Membership. The population assessment is used to:

- Assess the characteristics and needs of its Member population including social determinants of health.
- Identify and assess the needs of relevant Member sub-populations.
- Assess the needs of child and adolescent Members, if applicable.
- Assess the needs of Members with disabilities.
- Assess the needs of Members with serious and persistent mental illness (SPMI).
- Assess the needs of Members of racial or ethnic groups.
- Assess the needs of Members with LEP.

The population assessment is presented to the National Medicare Quality Improvement and Utilization Management Committee (QIUMC) on, at least, an annual basis.

Providers can reference information pertaining to Utilization Management and Care Management within this manual in *Section 6: Utilization Management/Care Management/Disease Management*.

Special Needs Plans (SNP) Model of Care

The Model of Care (MOC) provides the basic framework under which Wellcare will meet the needs of our Medicare Advantage Special Needs Plan (SNP) Members. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each Member are identified and addressed through the plan's care management practices.

Wellcare identifies, supports, and engages our most vulnerable Members at any point in their healthcare continuum to help them achieve an improved health status. Wellcare provides services in a Member-centric fashion. Wellcare's objectives for serving Members with complex and special needs include, but are not limited to:

- Conducting population assessments during Model of Care renewal cycles to identify the needs of the population and subpopulations, so Care Management processes and resources can be updated to address Member needs.
- Promoting preventive health services and the management of chronic diseases through care management programs that encourage the use of services to decrease future morbidity and mortality in Members.
- Conducting comprehensive health assessments that identify Member needs and barriers to care.
- Coordinating transitions of care for Members with complex and special needs to assist in navigating the complex healthcare system and accessing Provider, public and private community-based resources.
- Improving access to primary and specialty care for Members with complex health conditions so they receive appropriate services.
- Consulting with appropriate specialized healthcare personnel when needed such as medical directors, pharmacists, social workers and behavioral health professionals, etc.
- Ensuring that Members' socioeconomic barriers are addressed.

Effectiveness of the Model of Care Program is evaluated through the identification of objective, measurable, and population-specific quality indicators. Indicator data is collected on a routine and ad hoc basis, outcomes are analyzed, opportunities are identified, interventions are implemented for goal attainment, and reports are generated for ongoing monitoring. Data collection follows protocols established in approved policies and/or program designs. Data sources include administrative data such as claims, survey data, medical record documentation, or a combination of sources. There is a documented systematic step sequence for administrative data collection. Standardized tools are developed for utilization with any manual data collection such as extraction of data from medical records. Statistically valid sampling techniques are used as appropriate.

Wellcare has established performance outcomes for SNP plans to evaluate and measure the quality of care, quality outcomes, service, and access for Members. For each metric, benchmarks have been established based on evidenced-based medicine found in current literature, standards, and guidelines. Root cause analysis is conducted, and interventions identified for each indicator that falls below the desired value. The analysis, process improvement plan, implementation of interventions, and improvements are reported to the National Medicare Quality Improvement and Utilization Management Committee (QIUMC) for review, feedback, and approval.

Patient Safety

The QI Program places emphasis on patient safety. The goals for incorporation of patient safety into the QI Program are to:

- Prevent harm to Members in healthcare delivery.
- Develop organization-wide standards, definitions, processes, and norms.
- Promote evidence-based policies and practices.
- Disseminate training and re-training of case management/utilization management (both medical and behavioral health) in identifying and reporting potential quality of care issues.
- Encourage all employees/Providers to report potential quality-of-care issues.
- Strengthen efforts in providing safer and sustainable healthcare systems.
- Reduce Member instances of potential quality of care issues which put patient safety at risk.

In focusing on patient safety, the Plan aims to:

- Inform Members and Providers regarding Wellcare's patient safety initiatives.
- Encourage the practitioner and Provider community to adopt processes to improve safe clinical practices.
- Motivate Members to be participants in the delivery of their own safe healthcare.
- Communicate patient safety best practices.
- Develop clear policies, sound organizational leadership, and meaningful data to drive safety improvements.

The scope of the Patient Safety/Quality of Care (QOC) program encompasses review of medical, behavioral health, pharmaceutical care, and administrative issues in Provider and Member interactions. All Member demographic groups, care settings, and types of services are included in patient safety activities. The sources of data used to monitor aspects of patient safety include, but are not limited to:

- Practitioner-to-practitioner communication
- Office site visit review results
- Medical record review findings
- Clinical Practice Guideline compliance
- Potential QOC (PQOC) tracking/trending
- Concurrent review during the Utilization Management process
- Identification of potential trends in underutilization and overutilization
- Case and Disease Management Program participation
- Pharmaceutical management practices
- Member communication
- Provider/practitioner actions to improve patient safety

The Patient Safety Work Group was established to serve as a proactive, interactive team consisting of Quality Improvement Specialists/Nurse Reviewers and Medical Directors from all markets. The group's aim is to build cohesiveness in the PQOC process from identification and investigation to action taken and reporting. The group meets eight times annually, and action plans and minutes are generated and reviewed by the physician champion and the National Medicare Quality Improvement and Utilization Management Committee (QIUMC) for approval.

Preventive Health and Clinical Practice Guidelines

Wellcare uses Clinical Practice Guidelines (CPGs) to help practitioners and Members make decisions about appropriate healthcare for specific clinical circumstances and behavioral health services.

Wellcare also adopts CPGs to provide consistent quality healthcare to Members. While clinical judgment may supersede the CPGs, the guidelines aid Providers with guiding principles centered on procedures, pre-appraised resources and informational tools to help apply evidence from research in the care of individual Members and populations. The CPGs are based on medical evidence and are relevant to the population served. The guidelines support quality and efficiency of care by establishing guidance to improve care for behavioral health, chronic disease, and preventive care. The CPG grid is reviewed at least annually or upon significant new scientific evidence or changes in national standards.

Wellcare adopts guidelines from recognized sources or feedback of board-certified practitioners from appropriate specialties that would use the guideline. Evidence of appropriate specialties involvement may also come through:

- Participation on a committee (e.g. Physical Health Clinical Policy Committee, Behavioral Health Clinical Policy Committee, Quality Committee, etc.)
- Consideration of comments from practitioners to whom guidelines were circulated.

When there are differing opinions noted by national organizations, Wellcare will default to the Member's benefit structure as deemed by Medicare and other applicable regulations. If guidelines from a recognized source cannot be found, Wellcare's Physical Health Clinical Policy Committee or Behavioral Health Clinical Policy Committee is consulted for assistance in guideline sourcing or development.

The CPG grid is posted on the Wellcare website in the Provider section under Clinical Guidelines, then under CPGs. Mechanisms to notify and distribute guidelines may also include:

- New practitioner orientation materials
- Provider and Member/enrollee newsletters
- Member/enrollee handbook
- Special mailings

Medical Record Review

Consistent, current, and complete documentation in the medical record is an essential part of quality patient care. Medical record review is one aspect of Provider oversight conducted to assess and improve the quality of care delivered to Members and the documentation of such care. The review process allows for identification of the Provider's level of compliance achieved with contractual, accreditation, and regulatory standards.

Medical records maintained by Providers must be comprehensive and reflect all aspects of care for each Member. Records are to be maintained in a secure location. Documentation in the Member's

medical record is to be completed in a timely, legible, current, detailed, and organized manner that conforms to good professional medical practice. Records must be maintained in a manner that permits effective, professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Medical records must be signed and dated.

Complete medical records include, but are not limited to:

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

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 must be granted to Wellcare or its representatives without a fee and on or before the date reasonably requested by Wellcare to the extent permitted by state and federal law and the applicable Provider agreement. Wellcare may request medical records for its own audit and overview activities as well as in response to government audits. Providers must have procedures in place to permit the timely access and submission of medical records to Wellcare in order for Wellcare to meet such audit timelines.

Except as otherwise provided by applicable law, the Member's medical record is the property of the Provider who generates the record. Barring applicable statutes or regulations to the contrary, the Member or their representative is entitled to one free copy of the Member's medical record. Additional copies shall be made available to Members upon request, and Providers may assess a reasonable cost.

Wellcare follows state and federal laws regarding the retention of records remaining under the care, custody and control of the physician or healthcare Provider. Information from the medical records review may be used in the recredentialing process as well as quality activities.
For more information on medical records compliance, including but not limited to, confidentiality of Member information and release of records, refer to *Section 11: Compliance and Regulatory Requirements* of this manual.

Cultural Competency

Wellcare views Cultural Competency as the measure of a person or organization's willingness and ability to learn about, understand, and provide quality customer service across all segments of the population. It is the active implementation of a system-wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization, and at all service levels the organization engages in outside of the organization.

A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of healthcare delivery, Cultural Competency is the promotion of sensitivity and responsiveness to the needs of patients and incorporates cultural considerations that include, but are not limited to the following: race, ethnicity, primary language, age, geographic location, gender identity/diversity, sexual orientation, English proficiency, physical abilities/limitations, spiritual beliefs and practices, economic status, family roles, literacy, and diverse populations. It accommodates the patient's culturally based attitudes, beliefs and needs within the framework of access to health care services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions, and systems practices among Providers and staff to ensure that services are delivered in a culturally responsive manner.

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

As part of Wellcare's Cultural Competency Program, Providers must:

- Facilitate Member access to Cultural and Linguistic Services, including informing Members of their right to access free, quality medical interpreters, and signers, accessible transportation, and TDD/TTY 711 services.
    - To support informing Members of their right to access no cost language services, it is recommended that Providers post nondiscrimination notices and language assistance taglines in lobbies and on websites. Language assistance taglines notify individuals of the availability of language assistance for the top 15 languages utilized in the state as identified by Section 1557 of the ACA and should include at least one tagline in 18-point font.
- Provide medical care with consideration of the Members' primary or preferred language, race ethnicity, and culture.
- Participate in cultural competency training annually and ensure that office staff routinely interact with Members have also been given the opportunity to participate in, and have participated in, cultural competency training.
- Ensure that treatment plans are developed with consideration of the Member's race, country of origin, preferred language, social class, religion, mental or physical abilities, heritage,

acculturation, age, gender, gender identity or diversity, sexual orientation, and other characteristics that may influence the Member's perspective on health care.

- Ensure an appropriate mechanism is established to fulfill the Provider's obligations under the Americans with Disabilities Act, including that all facilities providing services to Members must be accessible to persons with disabilities. Additionally, no Member with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public facility, or be subjected to discrimination by any such facility.

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

- Denying a Member a covered service or availability of a facility.
- Providing a Wellcare Member a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay Members (examples: separate waiting rooms, delayed appointment times).

Providers may take cultural competency training, located on the Provider portal, to meet annual cultural competency training requirements. Providers are able to participate in training opportunities administered by the State, nationally recognized organizations, or training provided by other organizations. For additional information regarding resources and trainings, visit:

- On the Office of Minority Health's website, you will find "A Physician's Practical Guide to Culturally Competent Care." By taking this course online, you can earn up to nine CME credits, or nine contact hours for free. The course may be found at cccm.thinkculturalhealth.hhs.gov.
- Think Cultural Health's website includes classes, guides, and tools to assist you in providing culturally competent care. The website is cccm.thinkculturalhealth.hhs.gov.
- The Agency for Healthcare Research and Quality website, which offers a toolkit as a way for primary care practices to assess their services for health literacy considerations, raise awareness of their entire staff, and work on specific areas. The toolkit can be found at
- ahrq.gov/health-literacy/improve/precautions/toolkit.html.

Language Services

In accordance with Title VI of the Civil Rights Act, Prohibition Against National Origin Discriminations, the President's Executive Order 131166, Section 1557 of the Patient Protection and Affordable Care Act, the Health Plan and its Providers must make language assistance available to persons with Limited English Proficiency (LEP) at all points of contact during all hours of operation. Language services are available at no cost to Wellcare Members and Providers without unreasonable delay at all medical points of contact. The Member has the right to file a complaint or grievance if cultural and linguistic needs are not met.

Language services include:

- Telephonic interpretation
- Oral translation (reading of English material in a Members preferred language)

- Face-to-face non-English interpretation
- Sign language
- Auxiliary aids, including alternate formats such as large print and Braille
- Written translations for materials that are critical for obtaining health insurance coverage and access to healthcare services in non-English prevalent languages

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

To obtain language services for a Member, contact Wellcare Provider Services. Face-to-face and American Sign Language services should be requested as soon as possible, or at least seven days before the appointment and 10 days for medical interpretation. All Providers (Medical, Behavioral, Pharmacy, etc.) can request language services by calling our Provider Services at the appropriate number for the service market.

Restrictions Related to Interpretation or Facilitation of Communication

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

For more information, call Provider Services toll-free.

Americans with Disabilities Act (ADA)

Title III of the ADA mandates that public accommodations, such as a Provider's office, be accessible to those with disabilities. The provisions of the ADA protect qualified individuals with a disability from:

1. Exclusion from participation in the benefits of services, programs, or activities of a public entity.
2. Denial of the benefits of services, programs, or activities of a public entity.
3. Discrimination by any such entity. Wellcare Providers must provide physical access, accommodations, and accessible equipment for Members with physical or mental disabilities as required by 42 CFR Section 438.206(c)(3).

Providers are required to comply with all federal and state disability access laws and regulations (including, but not limited to, the Medicaid/CHIP Managed Care final rule provisions noted above, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act). Wellcare must inspect the office of any Provider who provides services on-site at the Provider's location and who seeks to participate in the Provider Network to determine whether the office is architecturally and programmatically accessible to persons with disabilities. Physical access," also referred to as "architectural access," refers to a person with a disability's ability to access buildings, structures, and the environment. "Programmatic access" refers to a person with a disability's ability to access goods, services, activities, and equipment.

If any disability access barriers are identified, the Provider agrees, in writing, to remove the barrier to make the office, facility, or services accessible to persons with disabilities within 180 days after Wellcare has identified the barrier.

Providers are also required to:

- Provide Interpretation Services in all languages, including Sign Language, at all key points of contact through a variety of formats, including but not limited to: an in-person interpreter upon a Member's request; telephone, relay, or video remote interpreting 24 hours per day, seven days per week; or through other formats, such as real-time captioning or augmentative and alternative communication devices that ensure effective communication.
- Provide Member-Informing Materials (print documents, signage, and multimedia materials such as websites) translated into the currently identified threshold or concentration standard languages and provided through a variety of other means. This may include but is not limited to: oral interpretation for other languages upon request; accessible formats (e.g. documents in Braille, large print, audio format, or websites with captioned videos and/or ASL versions) upon request; and easy-to-understand materials provided in a manner that takes into account different levels of health literacy.
- Provide Reasonable Accommodations that facilitate access for Members. This includes but is not limited to accessible: medical care facilities, diagnostic equipment, and examination tables and scales; and modification of policies, practices, and procedures (e.g., modify policies to permit the use of service animals or to minimize distractions and stimuli for Members with mental health or developmental disabilities).
- Inform Members of the availability of these cultural, linguistic, and disability access services at no cost to Members on brochures, newsletters, outreach and marketing materials, and other materials that are routinely disseminated to Members, and at Member orientation sessions and sites where Members receive covered services.

- Wellcare and participating Providers shall also facilitate access to these services and document a request and/or refusal of services in CRM or the Provider's Member data system.

Providers should call their Provider Relations Representative for more information.

Important Points to Remember: Word Choice

Avoid words with negative connotations like "handicapped," "afflicted," "crippled," "victim," "sufferer," etc. Do not refer to individuals by their disability. A person is not a condition.

Emphasize "person first" terminology:

- Handicapped (PERSON with a disability)
- Deaf (A PERSON who is deaf)
- Mute (A PERSON without speech)
- Confined/Wheelchair-Bound (A PERSON who uses a wheelchair)

If a Member does not have a disability at this time in their life, that DOES NOT make them "normal" or "able-bodied." It makes them "non-disabled."

The term "disability" means, with respect to an individual, any substantial limitation of one or more of a person's daily life activities that may be present from birth or may occur during a person's lifetime. Any individual meeting any of these conditions is considered to be an individual with a disability for purposes of coverage under the Americans with Disabilities Act.

Programmatic access to healthcare means that policies and practices that are part of the delivery of healthcare do not hinder the ability of Members with disabilities to receive the same quality of care as other persons.

Common Methods to Ensure Equal Communication and Access to Information:

1. Provisions for intake forms to be completed by persons who are blind or with a low visual disability with the same confidentiality afforded other Members.
    a. Use of large print forms, electronic or online web-based forms, or in-person staff assistance in a private location.
2. Provision for a presence of sign language interpreters to enable full communication with deaf or hard of hearing Members who use sign language.
3. Provision for making auditory information (e.g., automated messages) available via alternative means.
    a. Written communication or secure web-based methods may be used as possible substitutes.
4. Provision for communicating with deaf or hard of hearing Members by telephone.
    a. Use of telephone relay services (TRS), video relay services (VRS), a TDD, or use of secure electronic means.

Policies for Scheduling and Waiting:

1. Policies that allow scheduling additional time for the duration of appointments for Members with disabilities who may require it.

    a. Members may require more time than the standard because of multiple complexities. More time may be needed to conduct the examination or for communication through an interpreter as well as other communication issues.
2. Policies to enable Members who may not be able to tolerate waiting in a reception area to be seen immediately upon arrival,
    a. Members with cognitive, intellectual, or some psychiatric disability may be unable to wait in a crowded reception area without becoming agitated or anxious.
3. Policies to allow flexibility in appointment times for Members who use paratransit.
    a. Members may arrive late at appointments because of delays or other problems with paratransit scheduling or reliability.
4. Policies to enable compliance with federal law that guarantees access to Provider offices for people with disabilities who use service animals.
    a. Members with service animals expect the animal to accompany them into the waiting and examination rooms. This is protected under the Americans with Disabilities Act. This policy statement simply prepares staff to respond accordingly.

Policies for Conducting the Examination:

1. Training of healthcare Providers in the operation of accessible equipment.
    a. Staff must know how to operate accessible equipment, such as adjustable height exam tables and scales so they can be regularly and easily utilized.

Policies for Follow-up or Referral:

1. Current or potential Members including people with disabilities should only be referred to another Provider for established medical reasons or specialized expertise.
    a. Referral results in a delay of treatment and subjects Members to additional time, expense, and reduces Member choice of Providers.
2. Knowledge and/or attention to the accessibility of laboratories, testing facilities, specialists, or other healthcare delivery venues to which Members are referred.
    a. Members may be unable to comply with medical referrals if the referred location is not accessible and/or not prepared to provide the recommended service.

Provider Accessibility Initiative

Wellcare is committed to providing equal access to quality health care and services that are physically and programmatically accessible for our Members with disabilities. In May of 2017, our parent company, Centene, launched a Provider Accessibility Initiative (PAI) to increase the percentage of Centene's Providers that meet minimum federal and state disability access standards.

One of the goals of the PAI is to improve the accuracy, completeness, and transparency of Provider self-reported disability access data in Provider Directories so that Members with disabilities have the most accurate, accessible, and up-to-date information possible related to a Provider's disability access. To accomplish this, Providers are asked to complete a self-report of disability access that will be verified by Wellcare through an onsite Accessibility Site Review (ASR).

Wellcare's expectation for Providers, as communicated through the Provider contract, is full compliance with all federal and state disability access laws and regulations (including, but not limited to, the Medicaid/CHIP Managed Care final rule provisions noted above, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act. "Minimum accessibility," as defined in the ASR Tool, is not to be confused with, nor is intended to replace, the obligation of full compliance with all federal and state disability access laws and regulations, which remains the legal responsibility of Wellcare Providers.

Cultural Competency Survey

Providers may access the Cultural Competency Survey at go.wellcare.com. Select the appropriate state from the drop-down menu, then select Provider/Medicare/Forms.

Pharmacy and Therapeutics

Wellcare provides access to quality, cost-effective medications for eligible beneficiaries by maintaining a network of conveniently located pharmacies. An electronic adjudication system efficiently processes prescription drug claims at the point of dispensing to confirm eligibility, make drug and benefit coverage determinations, to evaluate for patient safety, and to adjudicate the claim with the appropriate pharmacy Provider payment.

Network contracting and the adjudication of pharmacy claims are managed by Express Scripts, the pharmacy benefit manager (PBM). Wellcare's pharmacy department has oversight of the PBM for these functions and provides a Medicare prescription drug formulary, which is created and modified through the Express Scripts Pharmacy and Therapeutics (P&T) Committee.

The pharmacy department reviews and responds to all drug exception requests or coverage determinations (DERs) and medication appeals (redeterminations) through a formalized process that utilizes the drug formulary, prior authorization protocols, and prescriber supplied documentation. The department also coordinates onsite and telephonic interactions with prescribing Providers to evaluate, review, and guide physician prescribing practices through a Provider Education Program (PEP). Emphasis is placed on the quality of care provided to Members through Medication Therapy Management (MTM) services as well as quality initiatives, which include, but are not limited to, Member and prescriber outreach and coordinated efforts with Quality Improvement Organizations (QIOs).

Pharmacy data, analysis, and interventions are reported to the Pharmacy Quality Oversight Committee (PQOC), Pharmacy and Therapeutics Committee, the National Medicare Quality Improvement Committee and Utilization Management Committee.

It is the policy of Wellcare for its Pharmacy Department to notify Members who have received a medication affected by a Class 1 and/or a Class 2 retail level recall as well as its authorized prescribers.

Wellcare's Pharmacy Department shall also notify affected Members and authorized prescribers of market withdrawals:

1. The remaining provisions of this section shall apply to the extent that the Formulary Services receives an alert from one of the following regarding a drug recall or planned market withdrawal:
    a. The FDA via email (fda@service.govdelivery.com)
    b. Facts and Comparisons news items
    c. Pharmaceutical company communications to healthcare professionals
2. Formulary Services shall review the alert to determine if the recall is relevant to Wellcare's Membership. Wholesale-only drug recalls and withdrawals do not require notification of Providers or Members.
3. Formulary Services shall identify and notify Members who have received the recalled or withdrawn medication in the 90 days prior to the date the notifications were discovered.
4. Formulary Services shall notify authorized prescribers of product recalls and market withdrawals, which include voluntary withdrawals by the manufacturer and those under an FDA requirement.
5. For Class 1 Recalls, Members and authorized prescribers shall be notified within 10 calendar days of the date in which Wellcare discovered the recall.
6. For Class 2 Recalls, Members and authorized prescribers shall be notified within 30 calendar days of the date in which Wellcare discovered the recall when affected Members can be identified from batch and lot numbers.
7. For Market Withdrawals, Members and authorized prescribers shall be notified within 30 calendar days of the FDA alert when affected Members can be identified from batch and lot numbers.

Chronic Care Improvement Program

Medicare Advantage organizations (MAOs) must have an ongoing Chronic Care Improvement Program (CCIP). CCIPs promote effective management of chronic disease, improve care and health outcomes for Members with chronic conditions, and are conducted over a three-year period. CCIPs foster treatment adherence, disease education, and advocacy designed to improve outcomes. The MAO focuses on patient-centered care for Members' complex medical, behavioral health, and socioeconomic needs that often require more frequent monitoring and/or costly treatment. Effective management of chronic disease is important to slow disease progression, prevent complications and development of comorbidities, reduce preventable emergency room (ER) encounters and inpatient stays, improve quality of life, and save costs for the MAO and for the Member.

Members are engaged through several methods, including, but not limited to, initial and subsequent health risks assessments and referrals from Providers, discharges planners, and case and utilization managers. The MAO works to ensure that:

- Quantifiable, measurable data is reviewed, analyzed, and reported to the National Medicare QIUMC annually
- Target goals, barriers, and specific interventions are developed based on data analysis to increase care management and preventive services utilization and improve health outcomes
- Best practices are identified and implemented

The program is applicable to MAOs and interrelates with aspects of Population Health Services, model of care, and care management.

Diamond Designation™ Program

This program is applicable to Medicare Providers in the following markets: Connecticut, Florida, Georgia, Hawaii, Kentucky, Maine, Mississippi, New Jersey, New York, and Tennessee. The Diamond Designation Program provides ratings on the quality and efficiency of care across 14 different specialty areas in total; however, only 10 specialties are evaluated for Medicare Providers and specialties vary per market. The Program emphasizes quality over efficiency. Provider ratings are determined and reported at a medical practice/group level based on Tax Identification Number.

We aim to update the Diamond Designation Program at least every two years with the Program Year 2025 update becoming effective November 24, 2025.

Specialty Types Included in Program Year 2025 for Medicare Providers	
Cardiology	Neurology
Endocrinology	Ophthalmology
Gastroenterology	Orthopedic Surgery
General Surgery	Podiatry
Nephrology	Pulmonology

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

The Diamond Designation Program methodology for evaluation is based on national standards and incorporates feedback from physicians and other clinicians as well as Members. The health plan

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

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

Web Resources

Wellcare periodically updates clinical, coverage and preventive guidelines as well as other resource documents posted on its website. Please check go.wellcare.com frequently for the latest news and updated documents. Select the appropriate state from the drop-down menu and click on *Quality* under *Medicare* in the *Providers* drop-down menu. For a copy of the National Medicare and SNP Quality Improvement and Utilization Management Program Evaluation please email: MedicareQualityProgramOperations@centene.com**.**

Section 5: Medicare Star Ratings

Overview

The Centers for Medicare and Medicaid Services (CMS) uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the healthcare system. This rating system applies to Medicare Advantage plans that cover both health services and prescription drugs (MA-PD).

The ratings are posted on the CMS consumer website, (www.medicare.gov/), to help beneficiaries when choosing an MA and MA-PD plan offered in their area. The Star Rating program is designed to promote improvement in quality and recognize Providers for demonstrating an increase in performance measures over a defined period of time.

CMS's Star ratings program is based on measures in nine different domains:

Part C

1. Staying healthy: screenings, tests and vaccines
2. Managing chronic (long-term) conditions
3. Member experience with the health plan
4. Member complaints, problems getting services and improvement in the health plan's performance
5. Health plan customer service

Part D

1. Drug plan customer service
2. Member complaints and changes in the drug plan's performance
3. Member experience with the drug plan
4. Drug safety and accuracy of drug pricing

How can providers help improve Star ratings?

- Continue to encourage their patients to obtain preventive screenings annually or as recommended, including but not limited to:
    - Breast and/or colon cancer screening
    - Annual flu vaccine
- Continue to monitor and assess the well-being of patients with chronic conditions in various ways, including:
    - Diabetes care
    - Retinal eye exam
    - Routine monitoring to ensure HbA1c control (<9)
    - Ensure members remain adherent to their diabetic medications and receive necessary statin therapy
    - Controlling high blood pressure (<140/90)

- Ensure members remain adherent to their hypertension medications (RAS antagonists)
- Statin therapy for patients with cardiovascular disease
- Ensure members remain adherent to their cholesterol medications (statin therapy)

- Provide timely osteoporosis management for women who have had a fracture through one of the following (within six months of the fracture):
  - Bone mineral density test
  - Medication therapy to treat osteoporosis
- Continue talking to your patients and document interventions regarding topics such as improving or maintaining mental and physical health, issues with bladder control and fall prevention.
- Create office practices to identify noncompliant patients at the time of their appointments.
- Submit complete and correct encounters/claims with appropriate codes and properly document medical chart for all members.
- Review the gap-in-care files listing members with open gaps, which is available on our secure portal.
- Follow up with patients within 14 days post-hospitalization and complete post-hospitalization medication reconciliation.
- Identify opportunities for you or your office to have impact on member gaps in care.

Healthcare Effectiveness Data and Information Set (HEDIS™)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA). CMS uses HEDIS rates to evaluate the effectiveness of a managed care plan's ability to demonstrate improvement in preventive health outreach to its members. As federal and state governments move toward a healthcare industry driven by quality, HEDIS rates are becoming more important, not only to the health plan, but also to the individual provider.

HEDIS rate calculations

HEDIS rates are calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include breast cancer screening (routine mammography), osteoporosis management in women who had a fracture, access to PCP services and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT II, ICD-10 and HCPCS codes can reduce the necessity of medical record reviews. Examples of HEDIS measures typically requiring medical record review include hemoglobin A1c control for patients with diabetes (results including HbA1c, nephropathy, dilated retinal eye exams and blood pressures) and colorectal cancer screening (colonoscopy, sigmoidoscopy, FOBT, CT, colonography or FIT-DNA test). Medication review post-

hospitalization and controlling blood pressure (blood pressure results <140/90 for members with high blood pressure).

Who conducts medical record reviews (MRR) for HEDIS?

Wellcare may contract with an independent national Medical Record Review (MRR) vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS can occur anytime throughout the year but are usually conducted March through May. Prompt cooperation with the MRR process is greatly needed and appreciated.

As a reminder, sharing of protected health information (PHI) used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Wellcare that allows it to collect PHI on our behalf.

How can providers improve their HEDIS scores?

- Understand the specifications established for each HEDIS measure.
- Submit claims and encounter data for each and every service rendered. All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Wellcare. Claims and encounter data is the most efficient way to report HEDIS.
- Submit claims and encounter data correctly, accurately, and on time. If services rendered are not filed or billed accurately, they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided. Keep accurate chart/medical record documentation of each member service and document conversation/services.
- Submit claims and encounter data using CPT codes related to HEDIS measures such as diabetes, eye exam and blood pressure.
- Contact the quality improvement department with questions, comments or concerns related to the annual HEDIS project or the medical record reviews.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey

The CAHPS survey is a member satisfaction survey that is included as a part of the Star ratings system. It is a standardized survey administered annually to members by CMS's certified survey vendor. The survey provides information on the experiences of Members with Medicare Advantage Organization (MAO) and practitioner services and gives a general indication of how well practitioners and the MAO is meeting the members' expectations. Member responses to the CAHPS survey are used in various aspects of the Star rating program including monitoring of practitioner access and availability. CAHPS survey material that may reflect on the service of providers includes:

- Whether the member received an annual flu vaccine

- Whether members perceive they are getting needed care, tests or treatment needed, including specialist appointments and prescriptions
- Whether the member's personal doctor's office followed up to give the member test results
- Whether the member's personal doctor is informed and up to date on care received from specialist

Wellcare uses information regarding member experiences to measure member satisfaction with their healthcare. Sources of data used to evaluate experience include the annual Consumer Assessment of Health Providers and Systems (CAHPS) survey, the annual Experience of Care and Behavioral Health Outcomes (ECHO®), grievances and appeals.

Medicare Health Outcomes Survey (HOS)

The Medicare HOS is a patient-reported outcomes measure used in the Medicare Star ratings program. The goal of the Medicare HOS is to gather data to help target quality improvement. The HOS assesses practitioners' and a Medicare Advantage Organization's (MAO) ability to maintain or improve the physical and mental health of the MAO's Medicare members over time. Wellcare HOS questions that may reflect on the service of providers include:

- Whether the member perceives their physical or mental health is maintained or improving
- Look for opportunities to discuss and address concerns regarding the following:
    - Mobility: Address potential needs for assistive devices.
    - Physical activity: Discuss starting, increasing or maintaining members' level of physical activity.
    - Mental health: Address social interactions and other behavioral health needs that may require further follow-up if provider has discussed fall risks and bladder control with the member by considering the following:
    - Fall risk prevention: Educate members on fall risk prevention by addressing any needs for assistive devices and reviewing any potential high-risk medications that could increase their fall risk.
    - Bladder Control: Assess the need for bladder control education and potential treatment.

The goal of Star ratings is to improve the quality of care and general health status for Medicare beneficiaries and support the efforts of CMS to improve the level of accountability for the care provided by physicians, hospitals and other providers. Wellcare supports these goals, and the organization strives for the highest rating of five stars in all domains. The Quality Improvement Committee receives Star rating results annually.

Value-Based Providers

SUDS

Supplemental data is any data used in HEDIS rate calculations for events and procedures that occur during patient encounters to be captured for gap closure.

Benefits of Supplemental Data:

- Close Care Gaps not closed through claims submissions.
- Fewer charts to request during HEDIS project.
- Improved provider incentive.

Bi-Directional EMR Data Exchange

A bi-directional exchange of data allows payers to share insights embedded directly within the EMR. Payers identify information needed for Risk Adjustment, Chronic Care Management, and Care Gaps and display this data as a **Point of Care Alert** within the provider's EMR to be seen at the time of service, along with being used for pre-visit planning.

Providers can review and disposition the data without interrupting their workflow during the member visit, and therefore use the data in a prospective manner.

- Assess (confirm), disagree, or resolve suspected and chronic conditions-just like an Appointment Agenda, they must disposition every alert that is presented to them.
- Document Care Gap Closure.

The information entered by the providers is transmitted back to the payer once the provider locks their progress note. The payer does not have direct access to a provider's EMR.

Billing Practices

CPT II

To enhance the accuracy of quality reporting and streamline the closure of patient care gaps, all participating providers are strongly encouraged to submit applicable CPT Category II and HCPCS codes during patient encounters. These codes improve data capture, reduce administrative burden, and contribute to more accurate performance measurement and incentive alignment.

Code Submission Standards

CPT Category II and HCPCS codes should be submitted as part of the standard claims process to verify the completion of quality care activities.
Wellcare supports select CPT II and HCPCS codes by assigning a $0.01 Medicare fee schedule amount to prevent claim denials due to non-payable codes.

HOW DOES THIS HELP PROVIDERS?

Reduces dropped codes and denied claims due to non-payable codes.
Lessens the administrative burden for providers by reducing chart collection/ medical record submissions.
Improved reporting of open and closed care needs.

WHICH MEASURES DO THESE CODES APPLY TO?

- Controlling Blood Pressure (Including Diabetics)
- HbA1c levels
- Diabetic Retinal Eye Exams
- Advance Care Planning
- Care of Older Adults
- Functional Status Assessment
- Medication List and Review
- Pain Assessment
- Medication Reconciliation Post Discharge
- Medication List and Review after hospital discharge

Social Determinants of Health

To ensure a whole-person approach to care, providers are encouraged to assess and document Social Determinants of Health (SDoH) and Health-Related Social Needs (HRSN) using appropriate ICD-10 Z-codes and CMS G-codes. Capturing this information helps to identify and address unmet social and economic needs that may negatively impact health outcomes and care quality.

Definitions

- **Social Determinants of Health (SDoH):** Conditions in the environments where people are born, live, learn, work, play, and worship that affect health, functioning, and quality of life.
- **Health-Related Social Needs (HRSN):** Unmet social or economic needs such as access to food, safe housing, transportation, utilities, and personal safety.

Coding Guidelines for Documentation

Providers are encouraged to use ICD-10-CM Z55–Z65 codes to document social, economic, and environmental factors that may influence a member's health status and outcomes. Accurate coding of these factors supports care coordination, population health management, and appropriate resource allocation.

The Z55–Z65 code range includes:

- **Z55**: Problems related to education and literacy
- **Z56**: Problems related to employment and unemployment
- **Z59**: Problems related to housing and economic circumstances

- Z60–Z65: Psychosocial, environmental, and other personal risk factors

Clinical and Operational Benefits

Addressing SDoH through accurate documentation and coordinated interventions can provide measurable value across clinical and operational domains, including:

- Improved clinical outcomes through early identification and proactive management of member needs.
- Reduction in avoidable emergency department visits and hospital admissions, supporting effective chronic care management.
- Enhanced coordination with community-based organizations and social service agencies to connect members with appropriate resources.
- Lower downstream healthcare costs, improved member satisfaction, and more effective long-term care planning.

Provider Responsibilities

Providers play an important role in identifying and addressing Social Determinants of Health (SDoH) for members. Responsibilities include:

- Incorporating SDoH screening questions during patient visits or intake processes to identify potential social or environmental barriers to care.
- Accurately documenting member responses using appropriate ICD-10-CM Z55–Z65 codes in both the medical record and on claims.
- Referring members to internal care coordination teams or external community-based organizations when applicable needs are identified.
- Educating practice staff on the importance of capturing SDoH and the impact this data has on care delivery, quality reporting, and member outcomes.

Annual Primary Visits

Contracts with higher Annual Primary Visit (APV) rates often yield higher Star Ratings. APVs—including Annual Wellness Visits (AWVs) and Routine Physical Exams (RPEs)—are critical components of the clinical model of care for preventive services, chronic condition management, and overall quality improvement. Providers are encouraged to conduct and document these visits to support clinical outcomes and enhance member engagement.

Annual Wellness Visit (AWV)

- Unique to Medicare, this visit allows the provider and member to meet and create a personalized prevention plan.
- Covered once per calendar year
- CPT Codes: G0438, G0439

Routine Physical Exam (RPE)

- Medicare Advantage supplemental benefit providing a comprehensive physical exam to screen for disease and promote preventive care.
- Covered once per calendar year
- CPT Codes:
    - **New patient**: 99381–99387
    - **Established patient**: 99391–99397

Quality Impact

- APV drives compliance in all HEDIS measures (highest impact on COA-PA, BCS, and COL).
- Rx measures average 4% more adherence than members without an APV.

Helpful Practices

- Capture all applicable diagnosis and chronic conditions using accurate ICD-10 codes
- Use CPT Category II codes to reflect clinical outcomes, reducing chart retrieval and supplemental data requests.
- Submit complete and timely claims to capture the APV, associated screenings, and chronic condition management services.

Regularly Accessing Data Reports

Providers should utilize the standard suite of 11 reports delivered to the SFTP site on a daily to monthly cadence to support care coordination, quality improvement, and operational performance.

Reports include:

- 834 (Membership Eligibility)
    - 834 EDI X12 Eligibility File
- AES Membership File
    - Membership File

- MMR (Monthly Membership Report)
    - Basic accounting file of beneficiary level payments
- MOR (Model Output Report)
    - Risk adjustment model output data file
- MAO-004
    - Encounter data diagnosis eligible for risk adjustment
- Quality Raw Files
    - 5 levels of quality results, from member detail to overall quality scores
- Census
    - Report of the authorizations
- NRXData
    - RX claims file
- IPACLM
    - Daily FFS claims extract
- PCLMIPA
    - Monthly paid claims
- Suncap
    - Capitation tied to vendor ID

Joint Operating Committee and Local Performance Team Engagement

Engagement between Providers and local performance teams is essential for value-based care success. These interactions foster accountability, improve performance, and align care delivery strategies with state and local priorities.

Purpose

- Facilitate collaboration and consistency across markets
- Support high-quality, cost-effective, member-centered care

Regular Engagement

- Attend scheduled touchpoints with local market teams (monthly, bi-monthly, or quarterly as determined by the health plan).
- Meetings may be virtual or in-person, as appropriate.

Performance Review and Strategic Alignment

- Review quality performance metrics, cost trends, utilization patterns, and care coordination strategies.
- Respond to performance dashboards, reports, and improvement plans.

Operational Updates and Data Exchange

- Share and validate data related to attribution, risk stratification, and care gap closure efforts.

- Participating in feedback loops will be established to address data integrity issues and workflow optimization.

Member-centric Focus

- Address region-specific member needs, SDoH factors, and patient experience improvements.
- Share local best practices and culturally competent strategies that support underserved communities.

Enforcement and Non-Compliance

Non-participation in required meetings may result in remediation or other contractual actions as outlined in the Provider Agreement.

Timely Roster Submission

Accurate provider records are essential to ensure timely processing of demographic and enrollment updates. Internal teams and external partners must submit provider rosters and related updates to the Provider Data Management (PDM) Team promptly and in the appropriate format.

The PDM Team is responsible for the submission and processing of contracted provider demographic and data updates received from internal teams and external partners. Core responsibilities include:

- Processing roster submissions for contracted providers and practitioners
- Performing demographic updates, including changes to address, phone number, TIN/NPI, and specialties
- Managing provider/practitioner enrollment into health plan systems
- Conducting provider setup reviews and troubleshooting as needed
- Updating billing and mailing addresses

Submission Timeliness

- Submit rosters per established schedules or contractual obligations.
- Provide updates for new enrollments, terminations, or demographic changes as soon as they are known.

Roster Format Requirements

- Complete, accurate, and in the approved format
- All required fields populated to ensure proper processing

Types of Submissions

- Existing Provider & Practitioner Enrollments
- Demographic Updates
- Terminations
- Practice Site Additions or Deletions

Note: Timely, accurate submissions reduce processing delays, maintain network accuracy, and prevent member disruption.

Section 6: Utilization Management, Care Management and Disease Management

Utilization Management

Overview

The Utilization Management (UM) Program defines and describes Wellcare's multidisciplinary, comprehensive approach and process to manage resource allocation. The UM Program describes the use of the review guidelines, Wellcare's adverse determination process, the assessment of new technology and delegation oversight.

The UM program includes components of prior authorization, concurrent and retrospective review activities. Each component is designed to provide for the evaluation of healthcare and services based on Member coverage, the appropriateness of such care and services, and the extent of coverage and payment to Providers of care.

Wellcare does not reward its employees, practitioners, physicians, or other individuals or entities performing utilization management activities for rendering denial of coverage, services, or care determinations. Wellcare does not provide financial incentives to encourage or promote underutilization.

Wellcare's UM programs are intended to support Members and Providers in the delivery of quality, efficient care and to promote the correct administration of benefits. Treating professionals and their patients are responsible for deciding what care is to be provided. These UM programs are not intended to, and do not, supplant or interfere with the roles of professionals and patients in making care-delivery decisions.

Medical Necessity or Medically Necessary

Medically Necessary services are services that include medical or allied care and are:

- Necessary to protect life, prevent significant illness or significant disability or to alleviate severe pain.
- Individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the Member's needs.
- Consistent with generally accepted professional medical standards and not experimental or investigational.
- Reflective of the level of service that can be provided safely and for which not equally effective and more conservative or less costly treatment is available statewide.
- Provided in a manner not primarily intended for the convenience of the Member, the Member's caretaker, or the healthcare Provider.
- Not custodial care as defined by CMS.

For healthcare items and services provided in a hospital on an inpatient basis, "Medically Necessary" also means that such items and services cannot, consistent with the provisions of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient facility of a different type. The fact that a healthcare Provider has prescribed, recommended, or approved healthcare items or services does not, in itself, make such items or services Medically Necessary.

Prior Authorization

Prior authorization allows for efficient use of Covered Services by enabling Members to receive the most appropriate level of care in the most appropriate setting. Prior authorization may be obtained by the Member's PCP or by a treating specialist or facility to which they were referred. Wellcare has a process to determine Medical Necessity and benefits coverage for inpatient and outpatient services prior to services being rendered. Prior authorization requirements apply to pre-service decisions.

Wellcare will issue a decision to the Member or the Member's representative within the following timeframes, as required by CMS guidelines:

- Expedited Request: within 72 hours
- Standard Part B Request: within 7 calendar days
- Standard Pre-Service Request: within 7 calendar days
- Standard Post-Service Request: within 30 calendar days

If a request is denied, Wellcare will include a specific reason for the denial in its response. These timeframes are designed to support timely access to care and ensure transparency in prior authorization determinations.

Providers may access the authorization look-up tool by going to go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Authorization Lookup* under *Tools* in the *Providers* drop-down menu.

Providers may submit requests for authorization by:

- Submitting an authorization request via Availity Essentials, with InterQual integration
- Submitting an authorization request via Wellcare's secure Provider portal at provider.wellcare.com
- Faxing a properly completed Inpatient, Outpatient, Durable Medical Equipment (DME) and Orthotic and Prosthetic, or Home Health and Skilled Therapy Services Authorization Request Form
- Contacting Wellcare via phone for inpatient notifications and urgent outpatient services

It is necessary to include the following information in the request for services:

- Member name and identification number
- The requesting Provider's name, address, Wellcare ID number, NPI number, and phone and fax numbers

- The recommended servicing Provider's name, address, Wellcare ID number, NPI number, and phone and fax numbers
- Diagnosis code(s) and place of service
- Services being requested and Physician's Current Procedural Terminology, 4th Edition (CPT-4) code(s)
- Medical history and any pertinent medical information related to the request, including current plan of treatment and progress notes as to the necessity, effectiveness and goals of said treatment

For the appropriate contact information, refer to the state-specific *Quick Reference Guide* on go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

All forms are on go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Forms* under *Medicare* in the *Providers* drop-down menu.

Evolent Authorizations

Evolent is partnering with Wellcare to provide several specialty programs for prior authorization review in select states.

Evolent's delegation over Advanced Diagnostic Imaging, Physical Medicine, Interventional Pain Management (IPM), and Musculoskeletal Care Management (MSK) requires prior authorization requests. Please route all requests to RadMD.com to obtain online authorizations.

For urgent authorization requests, please call **1-800-424-5388**.

Evolent's delegation over Interventional Cardiology and Oncology (both medical and radiation oncology) requires prior authorization requests. Please route all requests to my.newcenturyhealth.com or by calling **1-800-424-5388, option 1**.

Call our Provider Services department for more information.

Advanced Diagnostic Imaging

As part of a continued commitment to further improve advanced imaging and radiology services, Wellcare is using Evolent to provide prior authorization services and utilization management for advanced imaging and radiology services. Evolent focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.
Prior authorization is required for the following outpatient radiology procedures:

- CT/CTA/CCTA
- MRI/MRA

- PET

Key Provisions:

- Emergency room, observation, and inpatient imaging procedures do not require authorization;
- It is the responsibility of the ordering physician to obtain authorization; and
- Providers rendering the above services should verify that the necessary authorization has been obtained; failure to do so may result in denial of all or a portion of the claim.

To reach and obtain authorization, please call **1-800-424-5388** and follow the prompt for radiology authorizations. Evolent also provides an interactive website which may be used to obtain online authorizations. Please visit RadMD.com for more information or call our Provider Services department.

Cardiac Solutions

Advanced Imaging

Wellcare, in collaboration with Evolent, will launch a cardiac imaging program to promote health care quality for patients with possible cardiac disease. Under this program, prior authorization will be required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a patient's diagnosis or treatment—and to recommend an alternate approach when indicated. By supporting the most efficient diagnosis and management of cardiac disease, Evolent addresses unnecessary procedures and promotes the least invasive, most medically appropriate approach.

In addition to the other procedures that currently require prior authorization for members, prior authorization will be required for the following cardiac procedures:

- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Echocardiography
- Stress Echocardiography

The following services do not require authorization through NIA:

- Inpatient advanced radiology services
- Observation setting advanced radiology services
- Emergency Room radiology services

To reach Evolent and obtain authorization, please call **1-800-424-5388** and follow the prompt for radiology and cardiac authorizations. Evolent also provides an interactive website which may be used to obtain online authorizations. Please visit RadMD.com for more information.

Interventional Cardiology

This is a new cardiology prior authorization program. This program is intended to help providers easily and effectively deliver quality patient care. Effective Jan. 1, 2025, cardiology services rendered in a physician's office, and an outpatient hospital ambulatory setting, or in an inpatient setting (planned professional services only) must be submitted to Evolent for prior authorization. This requirement applies to all members ages 18 and older.

Approvals issued before Jan. 1, 2025 are effective until the authorization end date, but all prior authorization requests needed after Jan. 1, 2025 must be submitted to Evolent.

Prior authorizations can be requested by:

- Visiting Evolent's web portal at my.newcenturyhealth.com or
- Calling **1-800-424-5388**, Option 1, (Monday through Friday, 8 a.m. to 8 p.m. EST).

Physical Medicine Program

To help ensure that physical medicine services (physical, occupational and speech therapy) provided to our members are consistent with nationally recognized clinical guidelines, Medicare has partnered with Evolent to implement a prior authorization program for physical medicine services. Evolent provides utilization management services for outpatient physical, occupational and speech therapy services on behalf of members.

Outpatient physical, occupational and speech therapy requests are reviewed by Evolent's peer consultants to determine whether the services meet policy criteria for medically necessary and appropriate care. The medical necessity determinations are based on a review of objective, contemporaneous, and clearly documented clinical records that may be requested to help support the appropriateness of care. Clinical review helps determine whether such services are both medically necessary and eligible for coverage. Although prior authorization for the therapy evaluation alone is not required, additional services provided at the time of the evaluation and for any ongoing care is required through Evolent. There is no need to send patient records in advance. Evolent will contact the provider via phone and fax if additional clinical information is needed to complete the request. If the clinical documentation fails to establish that care is medically necessary, is not received, or is not received in an appropriate amount of time, it may result in non-certification of the authorization request.

Under terms of the agreement between Wellcare and Evolent, Evolent oversees the Therapy Management program and continues to be responsible for claims adjudication. If Evolent therapy peer reviewers determine that the care provided fails to meet our criteria for covered therapy services, you and the patient will receive notice of the coverage decision.

Should you have questions, please contact Provider Services at **1-800-424-5388**.

Interventional Pain Management (IPM)

Evolent manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures. It is the responsibility of the ordering physician to obtain authorization for all IPM procedures outlined below. Outpatient IPM procedures requiring prior authorization include:

- Spinal Epidural Injections
- Paravertebral Facet Joint Injections or Blocks
- Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)
- Sacroiliac Joint Injections
- Spinal Cord Stimulators

Note: A separate prior authorization number is required for each procedure ordered. Prior authorization is not required through Evolent for services performed in the emergency department, on an inpatient basis or in conjunction with a surgery. Prior authorization and/or notification of admission is still required through Wellcare. To obtain authorization through Evolent, visit RadMD.com or call **1-800-424-5388**.

Musculoskeletal Care Management (MSK)

In keeping with our commitment to promoting continuous quality improvement for services provided to Wellcare members, Wellcare has partnered with Evolent to implement a Musculoskeletal Care Management (MSK) program. This program includes prior authorization for non-emergent MSK procedures for Wellcare members. This decision is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

How The Program Works

MSK Surgeries: Prior authorization will be required for the following non-emergent inpatient and outpatient hip, knee, shoulder, lumbar and cervical surgeries:

Hip

- Revision/Conversion Hip Arthroplasty
- Total Hip Arthroplasty/Resurfacing
- Femoroacetabular Impingement (FAI) Hip Surgery (includes CAM/pincher & labral repair)
- Hip Surgery – Other (includes synovectomy, loose body removal, debridement, diagnostic hip arthroscopy, and extra-articular arthroscopy knee)

Knee

- Revision Knee Arthroplasty
- Total Knee Arthroplasty (TKA)
- Partial-Unicompartmental Knee Arthroplasty (UKA)
- Knee Manipulation under Anesthesia (MUA)
- Knee Ligament Reconstruction/Repair
- Knee Meniscectomy/Meniscal Repair/Meniscal Transplant

- Knee Surgery – Other (includes synovectomy, loose body removal, diagnostic knee arthroscopy, debridement with or without chondroplasty, lateral release/patellar realignment, articular cartilage restoration)

Shoulder

- Revision Shoulder Arthroplasty
- Total/Reverse Shoulder Arthroplasty or Resurfacing
- Partial Shoulder Arthroplasty/Hemiarthroplasty
- Shoulder Rotator Cuff Repair
- Shoulder Labral Repair
- Frozen Shoulder /Adhesive Capsulitis Repair
- Shoulder Surgery – Other (includes debridement, manipulation, decompression, tenotomy, tenodesis, synovectomy, claviculectomy, diagnostic shoulder arthroscopy)

Cervical

- Cervical Anterior Decompression with Fusion –Single & Multiple Levels
- Cervical Posterior Decompression with Fusion –Single & Multiple Levels
- Cervical Posterior Decompression (without fusion)
- Cervical Artificial Disc Replacement – Single & Two Levels
- Cervical Anterior Decompression (without fusion)

Lumbar

- Lumbar Microdiscectomy
- Lumbar Decompression (Laminotomy, Laminectomy, Facetectomy & Foraminotomy)
- Lumbar Spine Fusion (Arthrodesis) With or Without Decompression – Single & Multiple Levels
- Lumbar Artificial Disc – Single & Multiple Levels
- Sacroiliac
- Sacroiliac Joint Fusion

As a part of the Evolent clinical review process, actively practicing, orthopedic surgeon specialists (hip, knee, and shoulder) or neurosurgeons (spine) will conduct the medical necessity reviews and determinations of musculoskeletal surgery cases.

Please refer to the "Solutions" tab on the Evolent home page for additional information on the MSK program. Checklists and tip sheets are available there to help providers ensure surgical procedures are delivered according to national clinical guidelines.

Should you have questions, please contact Evolent at 1-800-424-5388.

Organization Determinations

For all organization determinations, Providers may contact Wellcare by mail, phone, fax, or via Wellcare's website. Wellcare requires prior authorization and/or pre-certification for:

- All non-emergent and non-urgent inpatient admissions except for routine newborn deliveries.
- All non-emergent or non-urgent out-of-network services (except out-of-area renal dialysis).

- Service requests identified in the Medicare authorization guidelines are maintained within the Clinical Services Department. Refer to the state-specific *Quick Reference Guide* on go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

Failure to obtain authorization prior to an elective or non-emergency service is grounds for denial of a post-service authorization request or claim submission.

For initial and continuation of services, Wellcare has appropriate mechanisms to ensure consistent application of review criteria for authorization reviews, which include:

- Medical Necessity – Approved medical review criteria will be referenced and applied
- Inter-rater reliability – A process that evaluates the consistency of decisions made by licensed staff when making authorization decisions and promotes the consistent application of medical review criteria
- Consultation with the requesting Provider when appropriate

Standard Organization Determination – An organization determination will be made as expeditiously as the Member's health condition requires, but no later than 7 calendar days after Wellcare receives the request for service. If the request is denied, the determination will include a specific reason for denial. An extension may be granted for 14 additional calendar days if the Member requests an extension, or if Wellcare justifies the need for additional information and documents, documenting how the delay is in the interest of the Member.

Expedited Organization Determination – A Member or any Provider may request that Wellcare expedite an organization determination when the Member or their Provider believes that waiting for a decision under the standard timeframe could place the Member's life, health or ability to regain maximum function in serious jeopardy. The determination will be made as expeditiously as the Member's health condition requires, but no later than 72 hours after receiving the Member's or Provider's request. If the request is denied, the determination will include a specific reason for the denial. An extension may be granted for 14 additional calendar days if the Member requests an extension, or if Wellcare justifies the need for additional information and documents, documenting how the delay is in the interest of the Member.

For Part B drugs, the determination will be made as expeditiously as the Member's health condition requires, but no later than 24 hours after receiving the Member's or Provider's request.

Wellcare's organization determination system provides authorization numbers and effective dates for the authorization and specifies the services being authorized. The requesting Provider will be notified of the authorization verbally via telephone or by fax.

In the event of an adverse determination, Wellcare will notify the Member and the Member's representative (if appropriate) in writing and provide written notice to the Provider. Written notification to Providers will include the UM Department's contact information to allow Providers the opportunity to discuss the adverse determination decision. The Provider may request a copy of the criteria used

for a specific determination of Medical Necessity by contacting the UM Department. The Member may request a copy of the criteria used for a specific determination of Medical Necessity by contacting Customer Service.

Prior Authorization for Members Enrolled in a Point-of-Service Plan

The POS option allows Members covered by certain Wellcare products to use Providers outside of the Wellcare network, at an additional cost. The Member will pay more to access services outside the network, except for emergency services. Preservice evaluation (preservice authorization) is recommended for non-emergency out-of-network services covered under the Member's POS benefit. The Provider referring for out-of-network treatment must inform the Member that there is a higher cost-sharing when using the Member's POS benefit.

In the following circumstances, the Provider or Member should request a preservice evaluation (preservice authorization) so that the POS benefit Cost Share does not apply:

- Network inadequacy
- Transition of Care (TOC) period for new Members
- Continuation of care
- If the network panel is closed

Contact Wellcare's UM department via Provider Services for any questions pertaining to the POS option by referring to the state-specific *Quick Reference Guide* on go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

Notifications

Notifications are communications to Wellcare with information related to a service rendered to a Member, or a Member's admission to a facility. Providers are required to notify Wellcare when Members receive care in any of the following settings:

- Acute Care Hospitals, including Critical Access Hospitals and Behavioral Health Hospitals
- Inpatient Rehabilitation Facilities
- Long-Term Acute Care Hospitals
- Skilled Nursing Facilities

A notification enables Wellcare to log the admission and follow up with the facility to receive clinical information. Notification can be submitted by fax or phone, or via the secure portal at go.wellcare.com for registered Providers. The notification information should include Member's name, date of birth, and Member ID; the facility name; and the admitting diagnosis.

Wellcare requires Providers to notify Wellcare by the next business day of a Member's observation or inpatient admission to a hospital. Failure to notify Wellcare of admission by the next business day may result in a denial of the inpatient authorization and/or claim.

Concurrent Review

Wellcare facilitates the oversight and evaluation of Members when admitted to hospitals, rehabilitation centers and skilled nursing facilities (SNF). This oversight includes reviewing continued acute care stays to promote appropriate utilization of healthcare resources and to promote quality outcomes for Members.

Wellcare provides oversight when Members receive acute care services in facilities mentioned above to determine the initial/ongoing Medical Necessity, the appropriate level of care and the appropriate length of stay, and the ability to facilitate a timely discharge.

Concurrent review is initiated after 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 will be reviewed in accordance with appropriate Medical Necessity criteria in order to:

- Promote the delivery of services in a timely and efficient manner
- Promote meeting established standards of quality care
- Implement timely and efficient transfer to a lower level of care when clinically indicated and appropriate
- Complete timely and effective discharge planning
- Identify referrals appropriate for DM or quality-of-care review
- Identify cases appropriate for follow up by the CM/service coordinator

Concurrent review decisions are made using objective criteria based on sound medical evidence.

These review criteria are used as a guideline. Decisions will take into account the Member's medical condition and comorbidities. The review process is performed under the direction of the Wellcare Medical Director.

Wellcare will base the frequency of its on-site and telephonic electronic review on the clinical condition of the Member. The frequency of the reviews for extension of initial determinations is based on the severity/complexity of the patient's condition, necessary treatment and discharge planning activity including possible placement in a different level of care. Wellcare requests clinical information to support the appropriateness of the admission, continued length of stay, level of care, treatment, and discharge plans.

The treating Provider and the facility utilization review staff can provide review information telephonically, via fax, or through access to electronic records. When a facility determines that a Member no longer needs inpatient care but is unable to obtain the agreement of the physician, the facility may request a Quality Improvement Organization (QIO) review. Prior to requesting a QIO review, the facility should consult Wellcare.

Discharge Planning

Discharge planning begins upon notification of the Member's inpatient status to facilitate continuity of care, post-hospitalization services, referrals to a SNF or rehabilitation facility, evaluating for a lower level of care and maximizing services in a cost-effective manner. As part of the UM process, Wellcare will help coordinate the transition of Member care from one level of care to another. The discharge plan will include a comprehensive evaluation of the Member's health needs and identification of the services and supplies required to facilitate appropriate care following discharge from an institutional setting. This will be based on the information received from the institution and/or Provider caring for the Member.

Some of the services involved in the discharge plan include, but are not limited to:

- DME
- Transfers to an appropriate level of care, such as an inpatient nursing rehabilitation (INR) facility, long-term acute care facility (LTAC) or SNF
- Home healthcare
- Medications
- Physical, occupational, or speech therapy (PT, OT, ST)

Retrospective Review

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

Retrospective review initiated by Wellcare

Wellcare requires periodic documentation including, but not limited to, the medical record, UB and/or itemized bill to complete an audit of the Provider-submitted coding, treatment, clinical outcome, and diagnosis relative to a submitted claim. On request, and within the timeframes reasonably requested by Wellcare, 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 only if, at the time of treatment, the Member was not eligible but became eligible with Wellcare retroactively or in cases of emergency treatment and the payer is not known at the time of service.

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 timeframe once, for up to 14 calendar days of the post-service request.

Referrals

Referrals are requests by a PCP for a Member to be evaluated and/or treated by a participating specialty Provider. Referrals are not required by the PCP but are recommended. The PCP is encouraged to document the reason for the referral and the name of the specialist in the Member's record. The specialist should document the request for consultation when/if received. Wellcare does not require a written referral as a condition of payment for services. No pre-communication with Wellcare is necessary. If Member is using a POS benefit, the Member's PCP should always coordinate care with out-of-network Providers and, if necessary, contact Wellcare for approval. The PCP may not refuse to refer to non-network Providers when one is not available in network regardless of medical group or independent practice association affiliation.

Criteria for Utilization Management Determinations

Wellcare's UM Department utilizes review criteria that are nationally recognized and based on sound scientific medical evidence. Clinicians with an unrestricted license, professional knowledge and/or clinical expertise in the area actively participate in the discussion, adoption and application of all utilization decision-making criteria on an annual basis.

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

- Federal law (e.g., National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and Medicare Coverage Articles)
- State law/guidelines (e.g., when State requirements trump or exceed federal requirements);
- Wellcare Clinical Policies (clinical coverage guidelines or CCGs)
- Nationally recognized decision support tools such as InterQual Clinical Decision Support Criteria or MCG (formerly Milliman Care Guidelines®)
- Member benefits
- State Provider handbooks, as appropriate
- CA/LOCUS
- American Society of Addiction Medicine (ASAM)

Wellcare's nurse reviewer and/or Medical Director apply Medical Necessity criteria in the context of the Member's individual circumstance and capacity of the local Provider delivery system. The Medical Director may use their clinical judgment in addition to the criteria listed above as circumstances require.

The review criteria and guidelines are available to Providers upon request. Members and Providers may request a copy of the criteria used for a specific determination of Medical Necessity by contacting Provider Services.

The medical review criteria stated below are updated and approved at least annually by the Clinical Policy Committee, Medical Advisory Committee and the National Medicare Quality Improvement and

Utilization Management Committee (QIUMC). Appropriate, actively practicing physicians and other Providers with current knowledge relevant to the criteria or scripts being reviewed have an opportunity to give advice or comment on the development or adoption of UM criteria and on instructions for applying the criteria.

Wellcare will:

- Consistently apply review criteria for authorization decisions
- Consult with the requesting Provider when appropriate

One or more of the following criteria are used when services are requested that require utilization review:

Type of Criteria	Updated
Clinical Policies (Clinical Coverage Guidelines (CCGs)	Annually
MCG Health (formerly Milliman Care Guidelines)	Annually
InterQual®	Annually
Hayes, Inc. Online™ (Medical Technology)	Ongoing
Medicare Carrier and Intermediary Coverage Decisions	Ongoing
Medicare National Coverage Decisions	Ongoing
Federal Statutes, Laws, and Regulations	Ongoing
CA/LOCUS	Annually
American Society of Addiction Medicine (ASAM)	Annually

When applying criteria to Members with more complicated conditions, Wellcare will consider the following factors:

- Age
- Comorbidities
- Complications
- Progress of treatment
- Psychological situation
- Home environment, when applicable

Wellcare will also consider characteristics of the local delivery system available for specific Members, such as:

- Availability of SNFs, subacute care facilities or home care in Wellcare's service area to support the Member after hospital discharge
- Coverage of benefits for SNFs, subacute care facilities or home care when needed
- Local hospitals' ability to provide all recommended services within the estimated length of stay

When Wellcare's standard UM guidelines and criteria do not apply due to individual patient (Member) factors and the available resources of the local delivery system, Wellcare's Clinical Services staff will conduct individual case conferences with healthcare professionals to determine the most appropriate alternative service for that Member. Clinical accuracy of all organizational determinations and reconsiderations involving Medical Necessity are overseen by a Medical Director. All new medical technology or experimental and investigational procedures will require review by the Medical Director prior to approval in order to establish guidelines where applicable.

Peer Review Requests

For prior authorization requests, Wellcare provides an opportunity for the attending physician or ordering Provider to request a physician discussion prior to issuance of an Adverse Determination. The requesting Provider or facility will have the opportunity to discuss the decision with the peer clinical reviewer within the turnaround time of the prior authorization request. Wellcare will provide notification of determination to Providers verbally or via facsimile and notification will include the Utilization Management Department's contact information for requesting a peer-to-peer discussion. Wellcare will respond to the request within two business days.

Emergency Services

Emergency Services are covered inpatient and outpatient services that are:

- Furnished by a Provider qualified to furnish emergency services
- Needed to evaluate or stabilize an Emergency Medical Condition

It is Wellcare's policy that emergency services are covered:

- Regardless of whether services are obtained within or outside the network of available Providers.
- Regardless of whether there is prior authorization for the services. In addition:
    - No materials furnished to Members (including wallet card instructions) may contain instructions to seek prior authorization for emergency services. As noted in the Member Handbook, Members have a right to call 911 at their discretion.
    - No materials furnished to Providers, including contracts, may contain instructions to Providers to seek prior authorization before the Member has been stabilized.
- In accordance with a prudent layperson's definition of "emergency medical condition" regardless of the final medical diagnosis.
- Whenever a Wellcare Provider or other Wellcare representative instructs a Member to seek emergency services within or outside the Member's Wellcare plan coverage.

Wellcare is not responsible for the care provided for an unrelated non-emergency problem during treatment for an emergency situation. For example, Wellcare is not responsible for any costs such as

a biopsy associated with treatment of skin lesions performed by the attending Provider who is treating a fracture.

Transition of Care

Transition of care benefits are available temporarily for newly eligible Members who are in active treatment or who have a previously approved procedure(s) with a Provider not contracted with the plan.

To promote a transition undertaken in an orderly manner that maximizes Member safety and continuity of care, Providers shall cooperate with Wellcare for the transition of Members to other participating Providers and, when applicable, continue providing Covered Services to Members.

If a new Member has an existing relationship with a Provider who is not part of Wellcare's Provider network, Wellcare will permit the Member to continue an ongoing course of treatment by the non-participating Provider during a transitional period of:

- The lesser of the period of active treatment for a chronic or acute medical condition or up to 90 days; or
- The postpartum period for Members in their second or third trimester of pregnancy; or
- When a longer period is required by Laws or Program Requirements.

For Members transitioning to the plan, Wellcare will honor any written documentation of prior authorization of ongoing Covered Services for a period of at least 90 calendar days after the effective date of enrollment.

For all Members, written documentation of prior authorization of ongoing services includes the following, if the services were prearranged prior to enrollment with Wellcare:

- Prior existing orders
- Provider appointments (for example, dental appointments, surgeries, etc.)
- Prescriptions (including prescriptions at non-participating pharmacies)

Wellcare can delay service authorization if written documentation is not available in a timely manner. Providers may contact the Claims Department for claims payment or claims resolution issues and their Provider Relations representative for rate negotiations.

Members who are acute inpatients at the time of disenrollment from Wellcare will be covered by Wellcare throughout the acute inpatient stay. However, Wellcare will not be responsible for any discharge needs the Member may have.

Continuity of Care

When a Member is in active treatment with a Provider who is not part of Wellcare's Provider network, Wellcare will permit the Member to continue the ongoing course of treatment with the non-participating Provider until the treatment concludes, until the Member has stabilized, or until it is clinically appropriate for the Member to transition to an in-network Provider if one is available.

Continued Care with a Terminated Provider

When a Provider terminates participation in Wellcare's network, or is terminated by Wellcare without cause, Wellcare will provide coverage for Members in active treatment to continue either through the completion of their condition (up to 90 calendar days) or until the Member selects a new Provider. Care provided after termination shall continue under the same terms, conditions, and payment arrangements as in the terminated contract.

If an obstetrical Provider terminates network participation without cause and requests an approval for continued coverage for treatment for a pregnant Member who is in treatment, the Member will be permitted to continue receiving benefits for that care until the Member's postpartum visit is completed.

If a Provider's network participation is terminated by Wellcare for cause, Wellcare may direct the Member immediately to another participating Provider for continued services and treatment and may deny coverage for further services received from the terminated Provider.

Provider Network

Wellcare maintains and monitors a panel of PCPs from which the Member may select a personal PCP. All Members may select and/or change their PCP to another PCP participating in Wellcare's Medicare Advantage network, without interference. Wellcare requires Members to obtain a referral before receiving specialist services and has a mechanism for assigning PCPs to Members who do not select one. Wellcare will also:

- Make available a network of Providers to deliver Medically Necessary specialist care.
- Give Members the option of direct access to a women's health specialist within the network for women's routine and preventive healthcare services. Wellcare will arrange for specialty care outside of Wellcare's Provider network when network Providers are unavailable or inadequate to meet a Member's medical needs.
- Have in effect procedures that:
    - Establish and implement a treatment plan that is appropriate.
    - Include an adequate number of direct access visits to specialists.
    - Are time-specific and updated periodically.
    - Facilitate coordination among Providers.
    - Consider the Member's input.

Second Opinion

Members have the right to a second clinical opinion in any instance when the Member disagrees with their Provider's opinion of the reasonableness or necessity of procedures or is subject to a serious injury or illness.

The second opinion, if requested, is to come from a Provider chosen by the Member who may select:

- A Provider who is participating with Wellcare; or

- If a network Provider is not available, a non-participating Provider located in the same geographical service area of Wellcare, who has a Medicare ID

Wellcare will be financially responsible for a second opinion. Members must inform their PCP of their desire for a second opinion. If a participating Wellcare Provider is selected, the PCP will issue a referral to the Member for the visit. If a non-participating Provider is required, the PCP will contact Wellcare for authorization. Any tests that are deemed necessary because the second opinion will be conducted by participating Wellcare Providers. The PCP will review the second opinion and develop a treatment plan for the Member. If the PCP disagrees with the second opinion request for services, the PCP must still submit the request for services to Wellcare for an organization determination on the recommendation.

The Member may file an appeal if Wellcare denies the second opinion Provider's request for services. The Member may file a grievance if the Member wishes to follow the recommendation of the second opinion Provider, and the PCP does not forward the request for services to Wellcare.

Medicare Quality Improvement Organization Review Process

A Provider must ensure that Members receive written notification of termination of service from the Provider no later than two calendar days before the proposed end of service for SNFs, Home Health Agencies (HHAs), and Comprehensive Outpatient Rehabilitation Facilities (CORFs). The standard *Notice of Medicare Non-Coverage* letter required by CMS will be issued. This letter includes the date coverage of service ends and the process to request an expedited appeal with the appropriate QIO. Upon notification by the QIO that a Member has requested an appeal, Wellcare will issue a *Detailed Explanation of Non-Coverage* that indicates why services are either no longer reasonable or necessary or are no longer covered.

The standardized *Notice of Medicare Non-Coverage* of SNF, HHA and CORF services will be given to the Member or, if appropriate, to the Member's representative, by the Provider of service no later than two calendar days before the proposed end of services. If the Member's services are expected to be fewer than two calendar days in duration, the Provider must notify the Member or, if appropriate, the Member's representative, at time of admission. If the services will be rendered in a non-institutional setting and the span of time between the services exceeds two calendar days, the notice should be given no later than two calendar days prior to termination of the service.

Wellcare is financially liable for continued services until two calendar days after the Member receives valid notice. A Member may waive continuation of services if they agree with being discharged sooner than two calendar days after receiving the notice. Members who desire a fast-track appeal must submit a request for appeal to the QIO, in writing or by telephone, by noon of the first calendar day after the day of delivery of the termination notice or, where a Member receives the *Notice of Medicare Non-Coverage* more than two calendar days prior to the date coverage is expected to end, by noon of the day before coverage ends.

Coverage of Covered Services continues until the date and time designated on the termination notice, unless the Member appeals and the QIO reverses Wellcare's decision. A Member who fails to request an immediate fast-track QIO review in accordance with these requirements may still file a request for an expedited reconsideration with Wellcare.

Required Notification to Members for Observation Services

In compliance with the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) that was effective August 6, 2015, contracted hospitals and Critical Access Hospitals must deliver the Medicare Outpatient Observation Notice (MOON) to any Member who receives observation services as an outpatient for more than 24 hours. The MOON is a standardized notice to a Member informing that the Member is an outpatient receiving observation services and not an inpatient of the hospital or Critical Access Hospital and the implications of such status. The MOON must be delivered no later than 36 hours after observation services are initiated or, if the Member is released from observation less than 36 hours after observation was initiated, upon the Member's release from observation.

The OMB-approved Medicare Outpatient Observation Notice and accompanying form instructions is at cms.gov/Medicare/Medicare-General-Information/BNI/index.html.

Notification of Hospital Discharge Appeal Rights

Prior to discharging a Member or lowering the level of care within a hospital setting, Wellcare will secure concurrence from the Provider responsible for the Member's inpatient care.
Wellcare will ensure that Members receive a valid written notification of termination of inpatient services from the facility according to the guidelines set by Medicare. Hospitals must issue the *Important Message* within two calendar days of admission, obtain signature of the patient or the signature of their authorized representative, and provide a signed follow-up copy to the patient as far in advance of discharge as possible, but not more than two calendar days before discharge. This letter will include the process to request an immediate review with the appropriate QIO.

Members who want an immediate review must submit a request to the QIO, in writing or by telephone, by midnight of the day of discharge. The request must be submitted before the Member leaves the hospital. If the Member fails to make a timely request to the QIO, they may request an expedited reconsideration by Wellcare.

Upon notification by the QIO that a Member has requested an immediate review, Wellcare will contact the facility, request all relevant medical records and a copy of the executed IM, and evaluate for validity. If, after review, Wellcare concurs that the discharge is warranted, Wellcare will issue a *Detailed Notice of Discharge* or request that the hospital issue a *Detailed Notice of Discharge* providing a reason why services are either no longer reasonable, necessary or covered. Coverage of inpatient services continues until the date and time designated on the *Detailed Notice of Discharge*, unless the Member requests an immediate QIO review. Liability for further inpatient hospital services depends on the QIO decision.

If the QIO determines that the Member did not receive valid notice, coverage of inpatient services by Wellcare continues until at least two calendar days after valid notice has been received. Continuation of coverage is not required if the QIO determines that the coverage could pose a threat to the Member's health or safety.

The burden of proof lies with Wellcare to demonstrate that discharge is the correct decision, either based on Medical Necessity, or based on other Medicare coverage policies. To meet this burden, Wellcare must supply any and all information that the QIO requires to sustain Wellcare's decision.

If the QIO reverses Wellcare's termination decision, Wellcare must provide the Member with a new notice when the hospital or Wellcare once again determines that the Member no longer requires acute inpatient hospital care.

Availability of Utilization Management Staff

Wellcare's Utilization Management Department provides medical and support staff resources, including a Medical Director, to process requests and provide information for the routine or urgent authorization/pre-certification of services, utilization management functions, Provider questions, comments or inquiries. We are available 24 hours a day, seven days a week, including holidays. Wellcare is staffed by Intake Coordinators/Care Management Coordinators who help physicians and Members obtain authorization for urgent services 24 hours per day, seven days per week.

For more information on contacting the Utilization Management Department via Provider Services, refer to the state-specific *Quick Reference Guide* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

Care Management Program

Overview

Wellcare offers comprehensive Care Management services to facilitate patient assessment, planning, education and advocacy, to improve health outcomes for patients with physical, behavioral and/or social determinant of health issues, which may include inadequate access to care, and resources needed to optimize their health. Providers must help coordinate the placement and cost-effective treatment of patients who are eligible for Wellcare's Care Management Programs. For specific information on Care Management Programs for Special Needs Plan Members, or Model of Care, see *Section 13: Special Needs Plan Members* in this manual.

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

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

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

Wellcare's Care Management team is an integrated multidisciplinary team of clinical and nonclinical specialists including, but not limited to, care managers, care navigators, care coordinators and other care management support staff. The Care Management team assesses the Member's risk factors, develops an individualized care plan, establishes health goals, monitors outcomes, and evaluates the outcome for possible revisions of the care plan. The care management team works collaboratively with PCPs and other specialists to coordinate care for the Member and expedite access to care and needed services.

Wellcare's Care Management teams also serve in a support capacity to the PCP and assist in actively linking the Member to Providers, medical services, residential, social and other support services, as needed. Providers may request care management services for any Member.

The care management process begins with Member identification and follows the Member until discharge from the program. Members may be identified for care management in various ways, including:

- A referral from a Member's PCP
- Member self-referral
- Referral from a family Member
- Referral from Wellcare's internal departments
- After completing a health risk assessment
- Data mining for Members with high utilization

Wellcare's philosophy is that the Care Management Program is an integral management tool in providing a continuum of care for Members. Key elements of the care management process include:

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

- Care Planning – Collaboration with the Member and/or caregiver as well as the PCP/Specialist to identify the best ways to fill any identified gaps or barriers to improve access and adherence to the Provider's plan of care. Individual Care Plans (ICPs) are shared with the Member and PCP, and other Members of the care team in accordance with the Model of Care. As a general rule of thumb, Providers can also find their Member's ICP on the Provider portal.
- 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.
- Member Advocacy – Advocating on behalf of the Member within the complex labyrinth of the healthcare system. Care managers assist Members with seeking the services to optimize their health. Care management emphasizes continuity of care for Members through the coordination of care among physicians and other Providers.

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

Members commonly identified for Wellcare's Care Management Program may include:

- Catastrophic Injuries – Such as head injury, near drowning, burns
- Multiple Chronic Conditions – Multiple comorbidities such as diabetes, chronic obstructive pulmonary disease (COPD), and hypertension, or multiple barriers to quality healthcare (for example, Acquired Immune Deficiency Syndrome [AIDS])
- Transplantation – Organ failure, donor matching, post-transplant follow-up
- Complex Discharge Needs – Members discharged home from acute inpatient or SNFs with multiple service and coordination needs (for example, DME, PT/OT, home health) complicated, non-healing wounds, advanced illness, etc.

Care managers may work closely with the Provider regarding when to discharge the Member from the Care Management Program, based on the Member's needs. A Member may be discharged from the Care Management Program if they:

- Are meeting primary care plan goals
- Declined additional care management services
- Disenrolled from Wellcare
- Are unable to be contacted by Wellcare

Provider Access to Care Management

Refer to *Access to Care Management Programs* in the *Disease Management* section below.

Complex Care Management Programs

As a part of Wellcare's services, Complex Care Management Programs (CCMP) are also offered to Members. Complex Care Management is the concept of reducing healthcare costs and improving quality of life for individuals with multiple or complex conditions through integrative care.

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

Not all participants identified with specific targeted diagnoses will be enrolled in the CCMP. Participants with selected disease states will be stratified into risk groups that will determine the need and level of intervention. High-risk participants with co-morbid or complex conditions will be referred for care management program evaluation. Complex case management is considered an opt-out program such that all eligible Members have the right to participate or to decline to participate.

To refer a Member for complex care management contact Member Services at the number listed on the backside of the member's ID card, contact Provider Services by the appropriate phone listed in this manual, or submit a referral online through the secure portal at go.wellcare.com.

Wellcare encourages referrals from Providers, Members, hospital discharge planners, and others in the healthcare community, for Members with identified needs and a desire to work with case management to optimize their potential well-being.

Interventions for Members identified vary depending on their level of need. Interventions are based on industry-recognized *Clinical Practice Guidelines*. Members identified at the highest stratification levels receive a comprehensive assessment by a nurse, chronic condition or health goal specific educational materials, a Member centered, prioritized plan of care based on their identified goals, and follow-up assessments to monitor adherence to the plan of care that documents progress towards goal attainment.

*Clinical Practice Guideline*s adopted by Wellcare are at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Clinical Guidelines* under *Tools* in the *Providers* drop-down menu, then Clinical Practice Guidelines, or call contact Provider Services by the appropriate phone listed in this manual for assistance.

Access to Care Management Programs

Wellcare's Transition Needs Assessment (TNA) Program assists new Members in their transition from Medicare or another managed care organization to Wellcare. The program involves outreach to these Members prior to their effective date and within the first 30 days of their enrollment. During this outreach, Members are gauged for their healthcare needs including, but not limited to, their primary and specialist Providers, current prescriptions, DME, and home health. Members are also screened

for eligibility for Wellcare's Care Management and Disease Management programs, and any additional behavioral healthcare needs.

If a Provider would like to refer an established Member as a potential candidate to Wellcare's Care Management programs or would like more information, they may call the care management referral line. For more information on the care management referral line, refer to the state-specific *Quick Reference Guides* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

Section 7: Claims and Encounters

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 the Customer Service Department. For more information on claims submission, refer to the state-specific *Quick Reference Guides* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

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 a Provider has 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 systems, 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.
EOPs can be viewed and/or downloaded and printed from PaySpan's website, once registration is completed.

Providers can register using PaySpan's enhanced Provider registration process at payspanhealth.com. Providers can access additional resources by clicking *Need More Help* on the PaySpan homepage. PaySpan Health Support can be reached via email at Providersupport@payspanhealth.com, or by phone at 1-877-331-7154 or on the web.

Timely Claims Submission

Unless otherwise stated in the Provider Agreement, participating Providers must submit Clean Claims (initial, corrected, and voided) to Wellcare within 180 calendar days* from the date of discharge (for inpatient services) or the date of service (for all other services)[5]. The start date for determining the timely filing period is the "from" date reported on a CMS-1500 or 837-P for professional claims or the "through" date used on the UB-04 or 837-I for institutional claims.

Unless prohibited by federal law or CMS, Wellcare may deny payment of any claim that fails to meet Wellcare's submission requirements for Clean Claims or failure to timely submit a Clean Claim to

*95 days for Texas health plans

Wellcare. A Provider whose claim is denied as described in this paragraph must not bill or accept payment from the Member for the services in question.

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

- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by Wellcare
- A Provider's electronic submission sheet that contains all the following identifiers:
    - Patient name
    - Provider name
    - Date of service to match Explanation of Benefits (EOB)/claim(s) in question
    - Prior submission bill dates
    - Wellcare's product name or line of business

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

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

Tax ID and National Provider Identifier Requirements

Wellcare requires the payer-issued Tax Identification Number (Tax ID/TIN) and National Provider Identifier (NPI) on all claim submissions, with the exception of atypical Providers (Providers that do not provide healthcare services, and instead provide services such as home and vehicle modifications, taxi services and respite care). Atypical Providers must pre-register with Wellcare before submitting claims to avoid NPI rejections.

Wellcare will reject claims without the Tax ID and NPI, and such claims will not qualify as Clean Claims. More information on NPI requirements, including the Health Insurance Portability and Accountability Act of 1996's (HIPAA) NPI Final Rule Administrative Simplification, is available at www.cms.gov/regulations-guidance/HIPAA.

Taxonomy

To increase appropriate adjudication, Providers are encouraged to submit claims with the correct taxonomy code consistent with Provider's specialty and services being rendered. Wellcare may reject the claim or pay it at the lower reimbursement rate if the taxonomy code is incorrect or omitted. In such cases, Provider must not bill or accept payment from the Member for the amount denied or reduced by Wellcare.

Preauthorization number

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

National Drug Codes

Wellcare follows CMS guidelines regarding National Drug Codes (NDC). Providers must submit National Drug Codes 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 guidelines.
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 based on the date of service (those limits are described above under "Timely Claims Submission"). For more information on encounters, see the *Encounters Data* section below.

Claims Submission Requirements

Providers using electronic submission shall submit Clean Claims to Wellcare or its designee, as applicable, using the HIPAA-compliant 837 electronic format or a CMS 1500/UB-04 (or their successors), as applicable. 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 or compensation is due for a Covered Service, and 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 or Non-Covered Services, including cases in which payment is denied or reduced because of Provider's failure to follow the requirements set forth in this manual.

For more information on paper submission of claims for Covered Services, see the "Paper Claims Submissions" subsection below, and refer to the state-specific *Quick Reference Guides* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

For Texas Providers: Skilled Nursing Facility Providers must electronically submit a resident transaction notice (form 3618/3619) to the Texas Health and Human Services Commission (HHSC) Medicaid claims administrator within seventy-two (72) hours after a Dual Eligible Member's admission or discharge from the nursing facility per TX Code § 554.2615.

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 Wellcare's *Companion Guides* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Claims* under *Medicare* in the *Providers* drop-down menu.

Since most clearinghouses can exchange data with one another, Providers should work with their existing clearinghouse, or the clearinghouses Wellcare uses, to establish EDI with Wellcare. For a list

of clearinghouses Wellcare uses, for information on the Wellcare's unique payer identification numbers used to identify Wellcare on electronic claims submissions, or to contact Wellcare's EDI team, refer to the *Quick Reference Guide* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

275 Claim Attachment Transactions via EDI

275 EDI transactions are excluded for Arizona Medicare (Wellcare Liberty Plan) and States, such as CA and WA, where IPA delegations process a portion or all of a Medicare Member's claim submission.

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

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

For more information on EDI implementation with Wellcare, refer to the *Wellcare Companion Guides* at wellcare.com/Providers/Medicare.

HIPAA Electronic Transactions and Code Sets

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

To promote consistency and efficiency for all claims and encounter submissions to Wellcare, it is Wellcare's policy that these requirements apply to all paper and DDE transactions.

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 cms.gov, and the ICD-10 Lookup Tool at cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx for specific codes.

Paper Claims Submissions

Providers are encouraged to submit claims to Wellcare 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 state-specific *Quick Reference Guides* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

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:

- All paper claims must be submitted on 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 form
    - Typed. Do not print, handwrite, or stamp any extraneous data on the form
    - In black ink
    - In large, dark font such as, PICA or ARIAL, and 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

For additional information published by CMS see:

- CMS UB-04 Fact Sheet: cms.gov
- CMS-1500 Fact Sheet: cms.gov

Claims Processing

Readmission

Wellcare may choose to review claims, as it deems appropriate, based on data analysis. Wellcare may review hospital admissions on a specific Member if it appears that two or more admissions are related based on the data analysis. Based upon the claim review (including a review of medical records if requested from the Provider), Wellcare will apply its readmission policy and make all appropriate adjustments to the claim, including recovery of payments which are not supported by the medical record.

Pre-Admission Services Payment Policy

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

Disclosure of Coding Edits

Wellcare uses claims editing software programs to assist in determining proper coding for Provider claims payment, directly and indirectly utilizing third party vendors. 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 state-specific regulations. These software programs may result in claim edits for specific procedure code combinations, including, but not limited to, potentially improper billing practices, waste and error, inappropriate, excessive, mishandled, misused, improper, incorrect, erroneous, or inaccurate claim practices, and related policies and other issues that may result in improper payments. These claim edits may also result in adjustments to the Provider's claims payment and/or a request for medical records or other documentation to verify that all procedures and/or services billed are properly supported in accordance with correct coding guidelines, prior to or subsequent to payment. A reduction in payment as a result of claim policies and/or processing procedures is not an indication that the service provided is a Non-Covered Service, and thus Providers must not bill or collect payment from Members for such reductions in payment. Providers may request reconsideration of any adjustments produced by these claims editing software programs by submitting a timely request for reconsideration to Wellcare.

Prompt Payment

Wellcare will process claims in accordance with the terms of your Provider agreement. We make it a top priority to process claims within 20 calendar days.

Rate Updates

Wellcare implements and prospectively applies changes to its fee schedules and CMS changes to Medicare fee schedules as of the later of:

- The effective date of the change; or
- 45 days from the date CMS publishes the change on its website.

Wellcare will not retrospectively apply increases or decreases in rates to claims that have already been processed.

Coordination of Benefits (COB)

Wellcare shall coordinate payment for Covered Services in accordance with the terms of a Member's Benefit Plan, applicable state and federal laws, and applicable CMS guidance. If Wellcare is the secondary insurer, 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 payer. COB information can be submitted to Wellcare by an EDI transaction with the COB data completed in the appropriate COB elements. Only paper submitters need to send a copy of the primary insurer's explanation of benefits.

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.

Members under the Medicare Advantage line of business may be covered under more than one insurance policy at a time. For example:

- If a claim is submitted for payment consideration secondary to primary insurance carrier, other primary insurance information, such as the primary carrier's EOB, must be provided with the claim. Wellcare has the capability of receiving EOB information electronically. To submit other insurance information electronically, refer to the *Wellcare Companion Guides* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Claims* under *Medicare* in the *Providers* drop-down menu.
- If Wellcare has information on file to suggest the Member has other insurance primary to Wellcare's, Wellcare may deny the claim.
- If the primary insurance has terminated, the Provider is responsible for submitting the initial claim with proof that coverage was terminated. If primary insurance has retroactively terminated, the Provider is responsible for submitting the initial claim with proof payment has been returned back to the primary insurance carrier.
- If benefits are coordinated with another insurance carrier as primary and the payment amount is equal to or exceeds Wellcare's liability, no additional payment will be made.

Unless the applicable benefit plans (the Benefit Plan issued by Wellcare and the benefit document issued by the other payer) or applicable law provide otherwise, the grid below for MA Members outlines when Wellcare would be the primary or secondary payer:

- Medicaid is always the payer of last resort.

Order of Benefit Determination

Member	Condition	Pays First (Primary)	Pays Second (Secondary)
Age 65 or older and covered by a group health plan because of work or covered under a working spouse of any age	Employer has 20 or more employees	Other coverage	Wellcare
Age 65 or older and covered by a group health plan because of work or covered under a working spouse of any age	Employer has fewer than 20 employees	Wellcare	Other coverage
Age 65 or older and covered by a group health plan after retirement	Has Medicare coverage	Wellcare	Other coverage
Disabled and covered by a large group health plan from work or from a family Member working	Employer has 100 or more employees	Other coverage	Wellcare
Has end-stage renal disease (ESRD) and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Other coverage	Wellcare
Has end-stage renal disease (ESRD) and group health plan coverage (including a retirement plan)	After 30 months	Wellcare	Other coverage
Has end-stage renal disease (ESRD) and group health plan coverage, and COBRA coverage	First 30 months of eligibility or entitlement to Medicare	Other coverage	Wellcare

Member	Condition	Pays First (Primary)	Pays Second (Secondary)
In an accident where no-fault or liability insurance is involved	Entitled to Medicare	Other coverage	Wellcare
Workers' compensation/Job-related illness or injury	Entitled to Medicare	Other coverage	Non-covered Medicare service
Veteran with Veteran benefits	Entitled to Medicare and Veterans' benefits	Other coverage	Non-covered Medicare service
Covered under TRICARE	Service from a military hospital or other federal Provider	Other coverage	Non-covered Medicare service
Covered under TRICARE	Covered Medicare services not provided by a military hospital or other federal Provider	Wellcare	Other coverage
Black lung disease and covered under the Federal Black Lung Program	Entitled to Medicare and Federal Black Lung Program	Other coverage	Wellcare
Age 65 or over or disabled and covered by Medicare and COBRA	Entitled to Medicare	Wellcare	Other coverage

Encounters Data

Overview

Wellcare requires all delegated vendors, delegated Providers, and capitated Providers to submit encounter data to Wellcare, even if they are reimbursed through a capitated arrangement.
This section is intended to give Providers necessary information to allow them to submit encounter data to Wellcare. If the encounter data does not meet the requirements set forth in Wellcare's government contracts for timeliness of submission, completeness or accuracy, federal and state agencies (for example, CMS) have the ability to impose significant financial sanctions on Wellcare.

Timely and Complete Encounters Submission

Unless otherwise stated in the Agreement, vendors and Providers must *submit* complete and accurate encounter files to Wellcare as follows:

- On a weekly basis
- Capitated entities will submit within 10 calendar days of service date
- Non-capitated entities will submit within 10 calendar days of the paid date

The above applies to both corrected claims (error correction encounters) and capitation-priced encounters.

Accurate Encounters Submission

All encounter transactions submitted via DDE or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines per the federal requirements. SNIP levels 1-5 shall be maintained. Once Wellcare receives a Provider's encounters, the encounters are loaded into Wellcare's encounters system and processed. The encounters are subjected to a series of SNIP Edits to ensure that the encounter has all the required information, and that the information is accurate.

For more information on Workgroup for Electronic Data Interchange (WEDI™) SNIP edits, refer to the *Transaction Compliance and Certification* white paper at wedi.org. For more information on submitting encounters electronically, refer to the *Companion Guides* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Claims* under *Medicare* in the *Providers* drop-down menu.

Vendors are required to comply with any additional encounters validations as defined by CMS.

Encounters Submission Methods

Delegated Providers may submit encounters using several methods: electronically, through Wellcare's contracted clearinghouse(s), via DDE or using Wellcare's Secure File Transfer Protocol (SFTP) process.

Submitting Encounters Using 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 and process. Refer to Wellcare's ANSI ASC X12 837I, 837P, and 837D Healthcare 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, go to go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Claims* under *Medicare* in the *Providers* drop-down menu.

Submitting Encounters Using DDE

Delegated vendors and Providers may submit their encounter information directly to Wellcare using the DDE portal. The DDE tool can be found on the secure Provider portal at provider.wellcare.com. For more information on free DDE options, refer to the state-specific *Provider Resource Guide* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare i*n the *Providers* drop-down menu.

Encounters Data Types

There are four encounter types for which delegated vendors and Providers are required to submit encounter records to Wellcare. Encounter records must 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 manual is intended to be used in conjunction with Wellcare's ANSI ASC X12 837I, 837P and 837D healthcare claim/encounter institutional, professional, and dental guides.
Encounters submitted to Wellcare from a delegated Provider can be a new, voided or 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 applicable regulatory agency
- Replaced or overlaid encounter – An encounter that is updated or corrected within the 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 from Wellcare for Covered Services constitutes payment in full, with the exception of applicable 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.

Providers may not bill Members for:

- The difference between actual charges and the contracted reimbursement amount
- Services denied due to timely filing requirements
- Covered Services for which a claim has been returned and denied for lack of information
- Remaining or denied charges for those services where the Provider fails to notify Wellcare of a service that required Prior Authorization
- Covered Services for which payment was reduced as a result of claim editing as described in this manual
- Covered Services that were not Medically Necessary, in the judgment of Wellcare, unless prior to rendering the service the Provider obtains the Member's informed written consent, and the Member receives information that they will be financially responsible for the specific services
- Any other instance in which payment for a Covered Service is denied or reduced, in accordance with the Agreement or this manual, as a result of a Provider not complying with the requirements of the Agreement or this manual
- Cost share for full-dual DSNP Members with Medicaid secondary coverage

Member Expenses and Maximum Out-of-Pocket

The Provider is responsible for collecting Member Expenses. Providers are not to bill Members for missed appointments, administrative fees, or other similar type fees. If a Provider collects Member Expenses determined by Wellcare to exceed the correct amount of Member Expenses, the Provider must promptly reimburse the Member the excess amount. The Provider may determine an excess amount by referring to the Explanation of Payment (EOP).

For MA Benefit Plans, Member Expenses are limited by a maximum out-of-pocket amount. For more information on maximum out-of-pocket amounts, and the responsibilities of a Provider to a Member, refer to Section 2 of this manual: *Provider Administrative Guidelines*.

Provider-Preventable Conditions

Wellcare follows CMS guidelines regarding Hospital-Acquired Conditions, Never Events, and other Provider-Preventable Conditions (collectively, PPCs). Under Section 42 CFR 447.26 (implemented July 1, 2012), these PPCs are non-payable for Medicaid and Medicare. Additional PPCs may be added by individual Medicaid states.

Hospital-Acquired Conditions are additional non-payable conditions listed on the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html and include such events as an air embolism, falls and catheter-associated urinary tract infection. Never

Events are defined as a surgical or other invasive procedure to treat a medical condition when the practitioner erroneously performs. Examples include:

- A different procedure altogether
- The correct procedure but on the wrong body part
- The correct procedure on the wrong patient

CMS updates the Never Events list of procedures annually and Wellcare adjusts accordingly. Providers may not bill, attempt to collect from, or accept any payment from Wellcare or the Member for PPCs.

Reopening and Revising Determinations

A reopening is a remedial action to change a binding determination or decision that resulted in either overpayment or underpayment, even though the determination or decision was correct based on the evidence of record. A reopening request must be made in writing, clearly stating the specific reason for requesting the reopening.

All decisions to grant reopening are at the discretion of Wellcare. See the *Medicare Claims Processing manual*, Chapter 34, for Reopening and Revision of Claim Determinations and Decisions guidelines. Reopenings are distinct from the Provider appeal and dispute processes.

Claims Payment Disputes

The claims payment dispute process addresses claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Participating Providers may submit claim payment disputes to Wellcare in writing. Disputes should be filed within the applicable timeframe outlined in the Provider's contract and any state-specific requirements. When submitting a dispute, Providers should include sufficient information and supporting documentation to allow for review (e.g., claim details, denial reason, and any relevant records).

Wellcare will review the dispute in accordance with internal guidelines, the Provider's contract, and applicable regulatory requirements. A determination will be communicated to the Provider following completion of the review process.

Note: State-specific requirements, including timeframes and documentation standards, may vary and will supersede the general process described above. Providers should reference their contract and the applicable Quick Reference Guide (QRG) for complete details.

When submitting a dispute, the Provider must provide the following information:

- Date(s) of service
- Place of service code
- Denial reason code
- Member name

- Member ID number and/or date of birth
- Claim number
- Provider name
- Provider address / city / state / Zip / telephone / fax / contact person
- Provider Tax ID/TIN
- Total billed charges
- Authorization number (if applicable)
- The Provider's statement explaining the reason for the dispute
- Supporting documentation when necessary (e.g., proof of timely filing, medical records, good cause)

Claim payment disputes received without the necessary documentation will be upheld by Wellcare due to lack of information. It is the responsibility of the participating Provider to include the requested documentation. Medical records and patient information shall be supplied at the request of Wellcare or appropriate regulatory agencies when required for claim payment disputes. The participating Provider is not permitted to charge Wellcare or the Member for copies of medical records and patient information provided for this purpose.

If the request for claim payment disputes results in an adjusted claim, the participating Provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the participating Provider will receive a revised EOP or letter detailing the decision.

Claim Payment Disputes Form & Submission Process

Form

The claim payment dispute form must be completed in its entirety. The participating Provider claim payment dispute form for Wellcare plans can be located here.

Provider Portal

Preferred method of submitting the participating Provider claim payment dispute form for Wellcare plans is via the Wellcare Provider Portal.

Mail

Send this form with all pertinent medical and supporting documentation for the request to the address listed on the back of the member's ID card.

Quick Reference Guides (QRGs)

Please refer to the State-specific Quick Reference Guides (QRGs) at go.wellcare.com. Select the appropriate State from the drop-down menu and click on Overview under Medicare in the Providers drop-down menu or contact the Provider relations department.

Claim Payment Disputes Timely Filing

Participating Providers may submit claim payment disputes to Wellcare in writing. Disputes should be filed within the applicable timeframe outlined in the Provider's contract and any state-specific requirements. When submitting a dispute, Providers should include sufficient information and supporting documentation to allow for review (e.g., claim details, denial reason, and any relevant records).

Wellcare will review the dispute in accordance with internal guidelines, the Provider's contract, and applicable regulatory requirements. A determination will be communicated to the Provider following completion of the review process.

Note: State-specific requirements, including timeframes and documentation standards, may vary and will supersede the general process described above. Providers should reference their contract and the applicable Quick Reference Guide (QRG) for complete details.

Corrected or Voided Claims

Corrected and/or voided claims are subject to timely claims submission, that is, timely filing guidelines. How to submit a corrected or voided claim electronically:

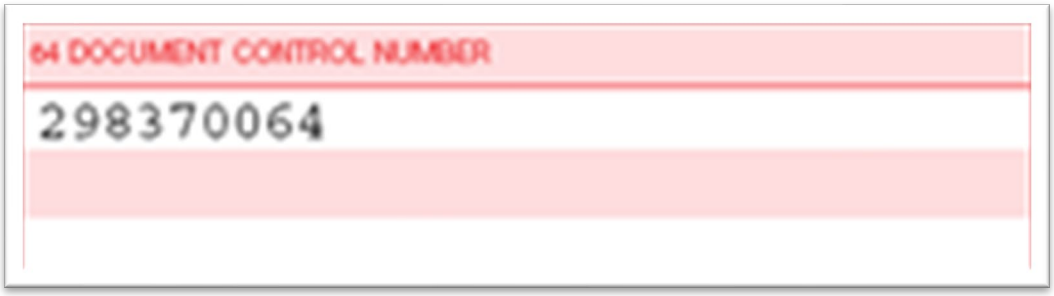
- Loop 2300 Segment CLM composite element CLM05-3 should be '7' or '8' – indicating to replace '7' or void '8'
- Loop 2300 Segment REF element REF01 should be 'F8' indicating the following number is the control number assigned to the original bill (original claim reference number)
- Loop 2300 Segment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

These codes are not intended for use for original claim submission or rejected claims.
To submit a corrected or voided claim via paper:

- For Institutional claims, the Provider must include Wellcare's original claim number or claim number the Provider is requesting be voided and bill the frequency code per industry standards.

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

Box 64 – Place the claim number in Box 64



- For Professional claims, the Provider must include Wellcare's original claim number or the claim number the Provider is requesting be voided and bill the 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 "corrected claim" or "voided claim" is handwritten, stamped or typed on the claim form without the appropriate Frequency Code "7" or "8" on either Institutional or Professional claims along with the reference number as indicated above, the claim will be considered an original first-time claim submission.
The correction or void process involves two transactions:

- The original or claim number the Provider is requesting be voided will be negated – paid or zero payment (zero net amount due to a copayment, coinsurance or deductible) – and noted

"*Payment lost/voided/missed*." This process will deduct the payment for this claim, or zero net amount if applicable.

- The corrected or voided claim will be processed with the newly submitted information and noted "*Adjusted per corrected bill*." This process will pay out the newly calculated amount on this corrected or voided claim with a new claim number.

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

Reimbursement

Wellcare applies the CMS site-of-service payment differentials in its fee schedules for CPT-4 codes based on the place of treatment (physician office services versus other places of treatment).

Non-Participating Provider Reimbursement

All services rendered by non-participating Providers and facilities require authorization with the exception of family-planning education and counseling, in-office visits for family planning, childhood immunization administration, and emergency transportation and services. Non-participating Providers are reimbursed at 100% of the Medicare rate in effect on the date of service.

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 Wellcare's Medical Director regarding 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 Providers should not submit a claim for such visits and Providers are not compensated separately. Follow-up days included in the global surgical period vary by procedure and are based on CMS policy.
- Multiple Procedures – Payment for multiple procedures is based on current CMS percentages methodologies. 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 – Payment for an assistant surgeon and/or a non-physician practitioner for assistant surgery is based on current CMS percentages methodologies. 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 – Payment for a co-surgeon is based on current CMS percentages methodologies. In these cases, each surgeon should report their distinct, operative work by adding the appropriate modifier to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the appropriate modifier following Coding Guidelines.

Modifiers

Wellcare follows CMS guidelines regarding modifiers and only reimburses modifiers reimbursed by CMS. Pricing modifier(s) should be placed in the first position(s) of the claim form.

Allied Health Providers

Wellcare follows CMS reimbursement guidelines regarding Allied Health Professionals.

Telemedicine

To the extent provided in the applicable Benefit Plan, telemedicine is a covered plan benefit, subject to limitations and administrative guidelines. Telemedicine is defined as the practice of healthcare delivery by a practitioner who is located at a site other than the site where a recipient is located, for the purpose of evaluation, diagnosis, or treatment. Telemedicine services provide the Member with enhanced healthcare services, the opportunity to improve health outcomes, and information when meeting face-to-face is unavailable.

Wellcare follows current CMS guidelines for telemedicine. For telemedicine claims to be processed correctly Provider shall follow all applicable Coding Guidelines, Rules and Regulations set forth by CMS, AMA, and/or other Respectable Medical Billing and Coding Organizations.

When telemedicine is a covered plan benefit, Wellcare reimburses for:

- Practitioners providing telemedicine services licensed within their scope of practice to perform the service.
- Telemedicine services using interactive telecommunications equipment to communicate between a recipient and a practitioner.

Wellcare does not reimburse for:

- Standard phone calls, chart review(s), faxes, or email; in combination or individually, these are not considered telemedicine services unless certain special circumstances and/or exemptions are indicated by DMS.
- Equipment required to provide telemedicine services.

Overpayment Recovery

Wellcare strives for 100% payment quality but recognizes that a small percentage of financial overpayments will occur. An overpayment can occur due to reasons such as retroactive Member termination, inappropriate coding, duplication of payments, non-authorized services, erroneous contract or fee schedule reimbursement, non-covered benefit(s), audits (including Risk Adjustment Data Validation (RADV)), and other reasons.

To the extent possible, Wellcare will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, Wellcare will follow the same methodology used by the CMS Recovery Audit Contractor (RAC) program by limiting its recovery to three years from the last payment date, unless a different approach is required by the Agreement. 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 state or federal government program (including, but not limited to, RADV or other audits) or coverage that is provided by a 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 overpayment reason and amount, contact information and instructions on how to send the refund. If the overpayment results from coordination of benefits, the written notice will specify the name of the carrier and coverage period for the Member. The notice will also provide the carrier address Wellcare has on file but recognizes that the Provider may use the carrier address it has on file. The standard request notification provides 45 calendar days for the Provider to send in the refund, request further information or dispute the overpayment. For more information on the CMS RAC, refer to the CMS website at www.cms.gov/Research-Statistics-Data-and-Systems/Medicare-FFS/Recovery-Audit-Program.

Failure of the Provider to respond within the above timeframes 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, the Provider may be contacted by Wellcare, or its designee, to arrange payment.

If the Provider independently identifies an overpayment, it can send a corrected claim (refer to the corrected claim section of the manual); contact Provider Services to arrange an offset against future payments; or send a refund and explanation of the overpayment to:

Wellcare Comprehensive Health Management

Cost Containment Department
P.O. Box 947945
Atlanta, GA 30394-7945

For more information on contacting Provider Services, refer to the state-specific *Quick Reference Guides* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

Benefits During Disaster and Catastrophic Events

Providers should follow Medicaid and CMS for mandates based on the state of emergency.

Disaster and Catastrophic Events Claims Modifiers

Type of Claim	Modifier
An Institutional claim	*Condition Code* will be DR or Modifier CR
A Professional claim	*Modifier* will be CR Code

Conducts Investigative Audits

Quality healthcare is based on accurate and complete medical record documentation. Wellcare's Special Investigations Unit (SIU) conducts medical record audits as part of our investigation process. Medical records are requested from the Provider. Wellcare's clinical investigators, all of whom are certified professional coders, nurses, and/or have behavioral licensure, research and pull the federal regulations/guidelines for each Provider specialty. The clinical investigators perform a comprehensive review that includes how the claim was billed and whether the documentation meets basic billing and coding requirements, as well as documentation requirements as established by the Centers for Medicaid and Medicare Services (CMS) and the applicable state guidelines. Wellcare's reviews incorporate Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs), CMS guidelines, federal guidelines and regulations determined by each state.

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 uses 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 cms.gov and the ICD-10 Lookup Tool at 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 go.wellcare.com. Select the appropriate state from the drop-down menu and click on *ICD-10 Compliance* under *News and Education* in the *Providers* drop-down menu.

Section 8: Credentialing

Overview

For purposes of *Section 8: Credentialing* in this manual, all references to "Providers" shall include all who provide health or health-related services, including the following: physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/healthcare delivery organizations. Credentialing is the process by which the appropriate Wellcare peer review bodies evaluate the credentials and qualifications of practitioners.

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 healthcare
- Accreditation status, as applicable to non-individuals

Practitioners are required to be credentialed prior to being listed as a Wellcare-participating network Provider.

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 asks for information regarding professional liability claims history and suspension or restriction of hospital privileges, criminal history, licensure, Drug Enforcement Administration (DEA) certification, or Medicare/Medicaid sanctions. Please take note of the following credentialing process highlights:

- Primary source verifications are obtained in accordance with state and federal regulatory agencies, accreditation, and Wellcare policy and procedure requirements, and include a query to the National Practitioner Data Bank.
- Physicians, allied health professionals, and ancillary facilities/healthcare delivery organizations are required to be credentialed in order to be network Providers of services to Wellcare Members.
- Satisfactory site inspection evaluations are required to be performed in accordance with state and federal accreditation requirements.

- After the credentialing process has been completed and the Credentialing Committee renders a participation decision, a timely notification of the credentialing decision is forwarded to the Provider. If a denial was issued, the Provider is advised of their Appeal Rights in writing.

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

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

Practitioner Rights

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

Practitioner's Right to Be Informed of Credentialing/Recredentialing Application Status

Written requests for information may be emailed to Provider Services. Please refer to the applicable *Quick Reference Guide* for the corresponding state's recredentialing email address. Upon receipt of a written request, Wellcare will provide written information to the practitioner on the status of the credentialing/recredentialing application, generally within 15 business days. The information provided will advise of any items pending verification, needing to be verified, any non-response in obtaining verifications, and any discrepancies in verification information received compared with the information provided by the practitioner.

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

All practitioners participating within the Wellcare network have the right to review certain information obtained by Wellcare that is used to evaluate their credentialing and/or re-credentialing applications. This includes information obtained from any outside primary source, such as the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank, malpractice insurance carriers, and state licensing agencies. This does not allow a practitioner to review peer review-protected information such as references, personal recommendations, or other information. The practitioner may review documentation submitted by them in support of the application/recredentialing 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 recredentialing. 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

If 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 their 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 will include:

- The nature of the discrepant information
- The process for correcting the erroneous information submitted by another source
- The format for submitting corrections
- The timeframe for submitting the corrections (within 30 days from the date of the notification)
- The addressee in the Credentialing Department 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 Controlled Dangerous Substance (CDS) or Controlled Substance Registration (CSR) certificate (applicable for M.D., D.O., D.P.M., D.D.S., D.M.D.).
- Work History – Practitioners must provide a minimum of five years' relevant work history as a health professional.
- Board Certification – Providers 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). Primary care Providers 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 plan. Existing Providers who get restricted from participation in any government program are subject to immediate termination in accordance with Wellcare policy and procedure and the Agreement.

- 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.
- Liability Insurance – Wellcare Providers (all disciplines) are required to carry and continue to maintain professional liability insurance, unless otherwise agreed by Wellcare in writing.

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

Site Inspection Evaluation

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

- Office site criteria
- Physical accessibility
- Physical appearance
- 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 recredentialing 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. AHPs include, but are not limited to the following:

- Nurse practitioners
- Certified nurse midwives
- Physician assistants
- Osteopathic assistants

- Social workers
- Physical therapists
- Occupational therapists
- Audiologists
- Behavioral health Providers

Ancillary Healthcare 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 participating Provider.

Recredentialing

In accordance with regulatory, accreditation, and Wellcare policy and procedure, recredentialing is required at least once every 36 months.

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) List of Excluded Individuals and Entities (LEIE) report of exclusions and reinstatements, for the most current available information. This information is cross-checked against Wellcare's network of Providers. If participating Providers are identified as being currently excluded, such Providers are subject to immediate termination, in accordance with Wellcare policies and procedures and the Agreement.

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.

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

Credentialing and Peer Review

The Purpose of the Credentialing Program is to set criteria and establish regulatorily compliant policies and procedures to verify the professional qualifications of participating Providers in order to provide an integrated network of qualified practitioners and facilities for the provision of safe and effective care and services to enrolled Membership across all of Wellcare. Credentialing uses primary and secondary source verifications obtained in accordance with regulatory and accreditation requirements, and Wellcare's policies and procedures. Information and documentation relating to individual practitioners or facilities is collected, verified, reviewed, and evaluated in order to approve or deny Provider network participation. Approved Providers are assigned a specialty and scope of practice that is consistent with their boards of certification, accredited training, or licensure (as applicable). Specialty designations and delineation of scope of services of approved facilities is consistent with recognized industry service standards and/or standards of participation developed by Wellcare that may include certification, licensure, and/or accreditation, as applicable to Provider type. Re-credentialing of a Provider shall be undertaken at least every 36 months. Monitoring and evaluation of the quality and appropriateness of patient care, clinical performance, and utilization of resources of Providers is incorporated in the re-credentialing process.

The Medical Director is responsible for peer review activities. Peer review is conducted during the investigation of quality of care or service concerns including potential compromises of Member safety. There are multiple reasons such investigations may be initiated, including adverse/sentinel events, Member complaints, over-or under-utilization comparisons, and coordination/continuity of care statistics. The scope of the review encompasses medical, behavioral, and pharmaceutical services as applicable and determines if there is evidence of poor quality.

As a general matter, for each Wellcare Health Plan, the Wellcare Credentialing and Peer Review Committee is the principal physician committee that reviews and makes recommendations on credentialing, re-credentialing, and peer review activity for quality of care or conduct issues. The committee is chaired by a Medical Director. Committee Membership includes a credentialing department designee and at least one participating physician. Credentialing activities are monitored and reported to Credentialing Committee and the National Medicare Quality Improvement Utilization Management Committee (QIUMC) on a quarterly basis. Work Plan data is reported to the QIUMC.

Participating Provider Appeal through the Dispute Resolution Peer Review Process

Wellcare may immediately suspend, pending investigation, the participation status of a Provider who, in the sole opinion of Wellcare's Medical Director, is engaged in behavior or practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of Members. Wellcare has a participating Provider dispute resolution peer review panel process if Wellcare chooses to alter the conditions of participation of a Provider based on issues of quality of care, conduct or service. If such a process is implemented, regulatory agencies may need to be notified.

The Provider dispute resolution peer review process has two levels. All disputes in connection with the actions listed below are referred to 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 which 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 to the Provider dispute resolution peer review panel process:

- Suspension of participating Provider status for reasons associated with clinical care, conduct, or service.
- Revocation of participating Provider status for reasons associated with clinical care, conduct, or service.
- Non-renewal of participating Provider status at time of recredentialing 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, the practitioner's rights, and the process for obtaining the first- or second-level dispute resolution peer review panel, are provided to the practitioner.

The practitioner has 30 days from the date of Wellcare's notice to submit a written request to Wellcare. This request must be sent by a nationally recognized overnight carrier or U.S. certified mail, with return receipt, to invoke the dispute resolution peer review panel process. Upon Wellcare's timely receipt of the request, Wellcare's Medical Director or their 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 review panel hearing. The practitioner has the burden of proof by clear and convincing evidence that the reason for the termination recommendation lacks any factual basis, or that such basis or the conclusion(s) drawn therefrom, are arbitrary, unreasonable or capricious.

The dispute resolution peer review panel shall consider and decide the case objectively and in good faith. Wellcare's Medical Director, within five business days after final adjournment of the dispute resolution peer review panel hearing, shall notify the practitioner of the results of the first-level panel hearing. If the findings are positive for the practitioner, the process concludes and the action against the practitioner's network participation status does not go forward.

If the findings of the first-level panel hearing are adverse to the practitioner, the practitioner may access the second-level peer review panel by following the notice information contained in the letter

notifying the practitioner of the adverse determination of the first-level peer review panel. Within 10 calendar days of the request for a second-level peer review panel hearing, the Medical Director or their designee shall notify the practitioner of the date, time, and access number for the second-level peer review panel hearing.

The second-level dispute resolution peer review panel shall consider and decide the case objectively and in good faith. The Medical Director, within five business days after final adjournment of the second-level dispute resolution peer review panel hearing, shall notify the practitioner of the results of the second-level panel hearing via certified or overnight recorded delivery mail. The findings of the second-level peer review panel shall be final. The findings of the second-level peer review panel shall be final, except that the Provider may pursue applicable dispute resolution rights, if any, in the Agreement.

A practitioner who fails to request the Provider dispute resolution peer review process within the time and in the manner specified waives all rights to such review to which they might otherwise have been entitled. Wellcare may terminate the practitioner and may 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 12: Delegated Entities* of this manual for further details. Washington Providers may use the Standardized Delegated Roster Template for submission of quarterly Provider data.

Section 9: Participating Provider Reconsiderations (Appeals)

Provider Retrospective Appeals Overview

A Provider may appeal a claim or utilization review denial on their own behalf by providing Wellcare with a letter of appeal or an appeal form with supporting documentation such as medical records. Appeal forms are at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Forms* under *Medicare* in the *Providers* drop-down menu.

Providers have 90 calendar days from Wellcare's original utilization management review decision or claim denial to file a Provider appeal. Appeals after that time will be denied for untimely filing. If the Provider feels that the appeal was filed within the appropriate timeframe, the Provider may submit documentation showing proof of timely filing. Examples of acceptable proof include but are not limited to a registered postal receipt signed by a representative of Wellcare, a similar receipt from other commercial delivery services, or a fax submission confirmation.

Upon receipt of all required documentation, Wellcare has up to 60 calendar days to review the appeal for Medical Necessity and/or conformity to Wellcare guidelines and to render a decision to reverse or affirm. Required documentation includes the Member's name and/or identification number, date of services, and reason why the Provider believes the decision should be reversed. Additional required information varies based on the type of appeal being requested. For example, if the Provider is requesting a Medical Necessity review, medical records should be submitted. If the Provider is appealing a denial based on untimely filing, proof of timely filing should be submitted. If the Provider is appealing the denial based on not having a prior authorization, then documentation regarding why the service was rendered without prior authorization must be submitted.

Appeals received without the necessary documentation to support medical necessity review will not be reviewed by Wellcare due to lack of information. If the Provider believes that they have adequate medical documentation to support the request for appeal, it is the responsibility of the Provider to provide the requested documentation within 60 calendar days of the lack of medical information denial to review the appeal. Records and documents received after that time will not be reviewed and the appeal will remain closed.

Please refer to Claim Payment Dispute subsection in Section 7 for denial of payment, where a denial has been issued for reasons such as: no prior authorization, benefits exhausted, service exceeds authorization, days billed exceed authorization, nursery days exceed mother's stay, payment error/not authorized, authorization denied, authorization expired, requires authorization, or lack of medical information.

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.

A participating Provider may request reconsideration of a claim or utilization review denial. The reconsideration process addresses the following:

- DN004 - Authorization denied
- LTUDT - Medical records required to support UDT claim billed
- DMNNE - Denied medical necessity not established with information provided
- LT313 - Medical records required to support drug test over limit
- DN019 - Denied after medical review
- LT115 - Radiology service not service by diagnosis. Submit medical records
- Other codes as applicable

Reconsideration Request Information to Submit

- Member name
- Member ID number
- Member date of birth
- Date(s) of service
- Place of service code
- Claim number
- Authorization number
- Denial reason code
- Provider name
- Provider Tax ID / TIN / NPI
- Provider address / city / state / Zip / telephone / fax / contact person
- Total billed changes
- The Provider's statement explaining the reason for the reconsideration request
- Supporting documentation when necessary (e.g., proof of timely filing, medical records, proof of why services were rendered without prior authorization)

Medical records and patient information shall be supplied at the request of Wellcare or appropriate regulatory agencies when required for reconsiderations. The participating Provider is not permitted to charge Wellcare or the Member for copies of medical records and patient information provided for this purpose.

If the request for reconsideration results in an adjusted claim, the participating Provider will receive a revised EOP. If the original decision is upheld, the participating Provider will receive a revised EOP or letter detailing the decision.

Reconsideration Request Form & Submission Process

Form:
The reconsideration form must be completed in its entirety. The participating Provider reconsideration request form can be located here.

Provider Portal:
The provider portal is the preferred method of submitting the participating Provider reconsideration request form.

Mail:
Send this form with all pertinent medical and supporting documentation for the request to:

State	Health Plan	Address
AR, MO, TX	Wellcare By Allwell	Wellcare By Allwell Appeals & Grievances Medicare Operations P.O. Box 3060 Farmington, MO 63640-3822
AZ, DE, IA, IN, KS, NE, NV, OH, OK, PA, WI	Wellcare	Wellcare Attn: Appeals Department P.O. Box 3060 Farmington, MO 63640-3060
AR, CT, FL, GA, HI, IL, KY, LA, ME, MI, MO, MS, NC, NJ, NY, SC, TN, TX, WA	Wellcare	Wellcare Attn: Appeals Department P.O. Box 31368 Tampa, FL 33631-3368

Fax:
Send this form with all pertinent medical and supporting documentation for the request to fax number **1-866- 201-0657** for Wellcare and **1-844-273-2671** for Wellcare By Allwell.

Participating Provider Reconsideration Appeals Decisions

Reconsideration Decision Overturned (Approval)

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

After the decision to reverse the denial has been made, any claims previously denied as a result of the now-reversed denial will be adjusted for payment.

Reconsideration Decision Upheld (Adverse Determination)

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

For denials based on Medical Necessity, the criteria used to make the decision will be provided in the letter. The Participating Provider may also request a copy of the clinical rationale used in making the reconsideration decision by sending a written request to the appeals address listed in the decision letter.

Member Reconsideration Process

Overview

A Member reconsideration, also known as an appeal, is a formal request from a Member for a review of an action taken by Wellcare. With the Member's written consent, a reconsideration may also be filed on the Member's behalf by an authorized representative, or by a Physician who has or is currently treating the Member. All appeal rights described in *Section 9* of this manual that apply to Members will also apply to the Member's authorized representative or a Physician acting on behalf of the Member with the Member's consent when appropriate.

To request an appeal of a decision made by Wellcare, a Member may file a reconsideration request orally or in writing within 65 days from the date of the Notice of Action.

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

- 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 CMS

Wellcare gives Members reasonable assistance in completing forms and other procedural steps for a reconsideration, including, but not limited to, providing interpreter services and toll-free telephone numbers with TTY and interpreter capability. The timeframe to submit additional information is limited for expedited appeals.

Wellcare will assign decision-makers who were not involved in reconsiderations of previous levels of review. When deciding a reconsideration based on lack of Medical Necessity, the reviewers will be healthcare professionals with clinical expertise in treating the Member's condition/disease or will seek advice from professionals with expertise in the field of medicine related to the request.

Wellcare will not retaliate against any Provider acting on behalf of or in support of a Member requesting a reconsideration or an expedited reconsideration.

Appointment of Representative

If the Member wishes to use a representative, they must complete a *Medicare Appointment of Representative* (AOR) form or equivalent notice. The Member and the person who will be representing the Member must sign the AOR form. The form is at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Forms* under *Medicare* in the *Providers* drop-down menu. Prior to the service(s) being rendered, physicians may appeal on behalf of the Member.

Types of Appeals Requests

A Member may request an expedited, standard pre-service or retrospective appeal.
Standard pre-service appeals are requests for coverage of services that Wellcare has determined are not Covered Services, are not Medically Necessary or are otherwise outside of the Member's Benefit Plan. A pre-service appeal must be filed before the Member has received the service.

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

Appeal Decision Time Frames

Wellcare will issue a decision to the Member or the Member's representative within the following timeframes:

- Expedited Request 72 hours
- Standard Pre-Service Request: 30 calendar days (seven calendar days for Pharmacy Appeals)
- Retrospective Request: 60 calendar days (seven calendar days for Pharmacy Appeals)

Expedited Reconsiderations

To request an expedited reconsideration, a Member or a Provider (regardless of whether the Provider participates in Wellcare's network) must submit a verbal or written request directly to Wellcare. A request to expedite a reconsideration 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.

A request for payment of a service already provided to a Member is not eligible to be reviewed as an expedited reconsideration. If a reconsideration is expedited, Wellcare will complete the expedited reconsideration and give the Member (and the Provider involved, as appropriate) notice of the decision as expeditiously as the Member's health condition requires, but no later than 72 hours after receiving a valid and complete request for reconsideration.

If Wellcare denies the request to expedite a reconsideration, Wellcare will provide the Member with verbal notification within 24 hours. Within three calendar days of the verbal notification, Wellcare will mail a letter to the Member explaining:

- That Wellcare will automatically process the request using the 30-calendar-day timeframe for standard reconsiderations;
- The Member's right to file an expedited grievance if they disagree with Wellcare's decision not to expedite the reconsideration, and providing instructions about the expedited grievance process and its timeframes; and
- The Member's right to resubmit a request for an expedited reconsideration, and that if the Member gets any Provider's support indicating that applying the standard timeframe for making a determination could seriously jeopardize the Member's life, health or ability to regain maximum function, the request will be expedited automatically.
- Provides instruction about the grievance process and its timeframes.

Pre-Service and Retrospective Reconsiderations

A Member may file a reconsideration request either verbally or in writing within 65 calendar days of the date of the adverse determination by contacting the Customer Service Department.

A Member may also present their appeal in person (as used here, "in person" also includes appeals conducted via telephone). To do so, the Member must call Wellcare Customer Service to advise that the Member would like to present the reconsideration in person. If the Member would like to present their appeal in person, Wellcare will arrange a time and date that works best for the Member and Wellcare. A Member of the management team and a Wellcare Medical Director will participate in the in-person appeal.

After the Member presents the information, Wellcare will mail the decision to the Member within the timeframe specified above, based on the type of appeal. If the Member's request for reconsideration is submitted after 65 calendar days, then good cause must be shown for Wellcare to accept the late request.

Examples of good cause include, but are not limited to:

- The Member did not personally receive the adverse organization determination notice or received it 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 reconsideration process.
- The Member lacked capacity to understand the timeframe for filing a request for reconsideration.

- The delay is a result of the additional time required to produce Member documents in an accessible format (for example, large print or Braille). The delay is the result of an individual having sought and received help from an auxiliary resource (such as a State Health Insurance Assistance Program (SHIP) or senior center), on account of their disability, in order to be able to file the appeal.
-

Member Reconsideration Decisions

Standard Pre-Service or Retrospective Reconsideration Decisions

If Wellcare reverses its initial decision, Wellcare will either issue an authorization for the pre-service request or send payment if the service has already been provided. If Wellcare affirms its initial action and/or denial of medical appeals (does not apply to pharmacy appeals), in whole or in part, it will:

- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. For standard pre-service appeals, the IRE has 30 days from receipt of the appeal to issue a final determination. For retrospective reconsideration appeals, the IRE has 60 days from receipt of the appeal to issue a final determination.

Once a final determination has been made, the IRE will notify the Member and Wellcare. If the IRE agrees with Wellcare, the IRE will provide the Member further appeal rights. If the IRE reverses the initial denial, the IRE will notify the Member or representative in writing of the decision. Wellcare will load an approved authorization for preservice appeal. For retrospective appeals, effectuate the claim.

Expedited Reconsideration Decisions

If Wellcare reverses its initial action and/or the denial, it will notify the Member verbally within 72 hours of receipt of the expedited appeal request followed with written notification of the appeal decision.

If Wellcare affirms its initial action and/or denial of medical appeals (does not apply to pharmacy appeals) (in whole or in part), it will:

- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. The IRE has 72 hours from receipt of the case to issue a final determination.
- Notify the Member of the decision to affirm the initial denial and that the case has been forwarded to the IRE.

Once a final determination has been made, the IRE will notify the Member and Wellcare. If the IRE agrees with Wellcare, the IRE will provide the Member further appeal rights. If the IRE reverses the initial denial, the IRE notifies the Member or representative in writing of the decision. Wellcare will load an approved authorization for preservice appeal.

Members and Providers are encouraged to contact the Plan to report issues. Wellcare has a dedicated Grievance team to review all reported grievances. Concerns may be reported via telephone, the company website, or in writing. A thorough review is conducted on all expressions of dissatisfaction received from our Members or authorized representatives on behalf of the Members. Concerns are carefully analyzed and completely resolved; the best interests of the Member are always considered in accordance with Wellcare's coverage and service requirements.

Reconsideration Levels

There are five levels of reconsideration available to Medicare beneficiaries enrolled in Medicare Advantage plans after an adverse organization determination has been made. These levels will be followed sequentially only if the original denial continues to be upheld at each level by the reviewing entity:

1. Reconsideration of adverse organization determination by Wellcare.
2. Reconsideration of adverse organization determination by the independent review entity (IRE).
3. Hearing by an administrative law judge (ALJ), if the appropriate threshold requirements set forth in §100.2 have been met.
4. Medicare appeals council (MAC) review.
5. Judicial review, if the appropriate threshold requirements have been met.

Section 10: Grievances

Member Grievances

Provider

Per CMS guidance, Providers acting on their own behalf are not entitled to file a grievance.

Member Grievance Overview

The Member may file a grievance. With the Member's written consent, a grievance may also be filed on the Member's behalf by an authorized representative (which may include a Provider). All grievance rights described in *Section 10* of this manual that apply to Members will also apply to the Member's authorized representative (including a Provider acting on behalf of the Member with the Member's consent). If the Member wishes to use a representative, then they must complete a *Medicare Appointment of Representative* (AOR) statement or equivalent notice. The Member and the person who will be representing the Member must sign the AOR statement. The form is at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Forms* under *Medicare* in the *Providers* drop-down menu.

Examples of issues that may result in a grievance include, but are not limited to:

- Rudeness by Provider or office staff
- Refusal to see Member (other than in the case of patient discharge from office)
- Office conditions
- Adverse health impacts resulting from treatment

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 or a Member's representative may file a standard grievance request either orally (via Customer Service or in person) or in writing within 60 calendar days of the date of the incident or when the Member was made aware of the incident. Contact information for the Grievance Department is on the state-specific *Quick Reference Guides* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

Members and Providers are encouraged to contact the Plan to report issues. Concerns may be reported via telephone, the company website, or in writing. A thorough review is conducted on all

expressions of dissatisfaction received from our Members or authorized representatives on behalf of the Members. Concerns are carefully analyzed and completely resolved; the best interests of the Member are always considered in accordance with Wellcare's coverage and service requirements.

Grievance Resolution

Standard

A Member or Member's representative shall be notified of the decision as expeditiously as the case requires, based on the Member's health status, but no later than 30 calendar days after the date Wellcare receives the verbal or written grievance, consistent with applicable federal law. Wellcare will respond to the grievance either in writing or verbally upon review of the Member's grievance.

An extension of up to 14 calendar days may be requested by the Member or the Member's representative. Wellcare may also initiate an extension if the need for additional information can be justified, and the extension is in the Member's best interest. In all cases, extensions must be well-documented. Wellcare will provide the Member or the Member's representative prompt written notification regarding Wellcare's intention to extend the grievance decision.

The Grievance Department will inform the Member of the determination of the grievance as follows:

- Grievances submitted in writing will be responded to in writing
- Grievances submitted verbally may be responded to in writing or verbally
- All grievances related to quality of care will include a description of the Member's right to file a written complaint with the QIO. For any complaint submitted to a QIO, Wellcare will cooperate with the QIO in resolving the complaint

Wellcare provides all Members with written information about the grievance procedures/process available to them, as well as the complaint processes. Wellcare also provides written information to Members and/or their appointed representative(s) about the grievance procedure at initial enrollment, upon involuntary disenrollment initiated by Wellcare, upon the denial of a Member's request for an expedited review of a determination or appeal, upon the Member's request, and annually thereafter. Wellcare will provide written information to Members and/or their appointed representatives about the QIO process at initial enrollment and annually thereafter.

The facts surrounding a complaint will determine whether the complaint includes a coverage determination, organization determination or an appeal, and, if so, the complaint will be routed appropriately for review and resolution.

Expedited

A Member may request an expedited grievance if Wellcare makes the decision not to expedite an organizational determination or pre-service appeal, or if Wellcare invokes an extension to a review. Wellcare will respond to an expedited grievance within 24 hours of receipt. The grievance will be

investigated to ensure that the plan's decision regarding expediting or extending the review time frame does not jeopardize the Member's health.

Wellcare will contact the Member or the Member's representative via telephone with the expedited resolution and will mail the resolution letter to the Member or the Member's authorized representative within three business days after the grievance is resolved. The resolution will also be documented in the Member's record.

Section 11: Compliance and Regulatory Requirements

Overview

Wellcare's Corporate Ethics and Compliance Program, as may be amended from time to time, 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 Providers' employees and Providers' subcontractors and their employees, are required to comply with Wellcare's Compliance Program requirements. Wellcare's compliance-related training requirements include, but are not limited to, the following initiatives:

- HIPAA Privacy and Security Training
    - Summarizes privacy and security requirements in accordance with the federal standards established pursuant to HIPAA and subsequent amendments to HIPAA.
    - Training includes, but is not limited to, discussion on:
- Proper uses and disclosures of PHI
- Member rights
- Physical and technical safeguards
- Fraud, Waste and Abuse (FWA) Training
    - Must include, but is not limited to:
- Special Needs Plan Model of Care
- Laws and regulations related to fraud, waste and abuse (e.g., 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

Providers, including Provider's employees and/or Provider's subcontractors, must report to Wellcare any suspected fraud, waste or abuse, misconduct or criminal acts by Wellcare or any Provider, including Provider's employees and/or Provider's subcontractors, or by Wellcare Members. Reports may be made anonymously through the Fraud, Waste and Abuse Hotline at **1-866-685-8664**. Details of the Corporate Ethics and Compliance Program can be found at www.centene.com/who-we-are-/ethics-and-integrity.

Special Needs Plans (SNP) Model of Care Training

Applicable to participating and non-participating Providers that treat SNP Members, Wellcare reviews and updates, as needed, the Model of Care training annually at the beginning of each year. Wellcare offers a printable self-study training guide which can be found at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the Providers drop-down menu. If Providers would like to request a copy mailed, they can contact Provider Services or their Provider Relations representative.

For more information regarding Special Needs Plans see *Section 13: Special Needs Plan (SNP) Members* below.

Marketing Medicare Advantage Plans

Medicare Advantage plan marketing is regulated by CMS. Providers should familiarize themselves with CMS regulations at 42 CFR Part 422, Subpart V (replacing regulations formerly at 42 CFR 422.80), and the CMS *Managed Care manual*, Chapter 3, *Medicare Communications and Marketing Guidelines* (MCMGs), including, without limitation, materials governing "Provider-Initiated Activities" in Section 60.1. Providers must adhere to all applicable laws, regulations and CMS guidelines regarding MA plan marketing, including, without limitation, 42 CFR Part 422, Subpart V and the MCMGs.

CMS holds plan sponsors such as Wellcare responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting Providers. Providers are not authorized to engage in any marketing activity on behalf of Wellcare without the prior express written consent of an authorized Wellcare representative, and then only in strict accordance with such consent.

Code of Conduct and Business Ethics

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 go.wellcare.com. Select the appropriate state from the drop-down menu and click on *About Us* under *Corporate Information* in the *Corporate* drop-down menu. From this page, select *Wellcare Compliance* from the right navigation bar.

Wellcare's Corporate Ethics and Compliance Program

The Code of Conduct and Business Ethics is the foundation of iCare, Wellcare's Corporate Ethics and Compliance Program. It describes Wellcare's firm commitment to operating in accordance with the laws and regulations governing its business and accepted standards of business integrity. All employees, participating Providers and other contractors should familiarize themselves with Wellcare's Code of Conduct and Business Ethics. Wellcare employees, Members, participating Providers and other contractors of Wellcare are encouraged to report compliance concerns and any suspected or actual misconduct by Wellcare using the Ethics and Compliance Hotline at 1-800-345-

1642. Details of the Corporate Ethics and Compliance Program and how to contact the Fraud Hotline can be found at www.centene.com.

Fraud, Waste and Abuse

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

Federal and state regulatory agencies, law enforcement, and Wellcare vigorously investigate incidents of suspected fraud, waste, and abuse. Providers are cautioned that unbundling, fragmenting, up-coding, and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD), Physicians' Current Procedural Terminology (CPT), the 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, waste, 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 educational training requirements with respect to FWA. To meet federal regulation standards specific to Fraud, Waste, and Abuse (§ 423.504), Providers and their employees must complete a FWA training program within 90 days of contracting with the Wellcare Health Plan and annually thereafter.

As a Provider in our Medicare network, Providers are required to check the OIG/GSA Exclusion and CMS Preclusion List prior to hiring or contracting and monthly thereafter as outlined below for all staff, volunteers, temporary employees, consultants, Directors, and any contractors that would meet the requirements as outlined in The Act §1862(e)(1)(B), 42 C.F.R. §§ 422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6), 1001.1901. Medicare payment may not be made for items or services furnished or prescribed by a precluded or excluded Provider or entity.

To report suspicions of fraud, waste and abuse, call the Fraud, Waste and Abuse Hotline at 1-866-685-8664.

Confidentiality of Member Information and Release of Records

Medical records must 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 their case must be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the privacy and security rules and regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended.

All Provider practice personnel must be trained on HIPAA Privacy and Security regulations. The practice must ensure that there is a procedure or process in place for maintaining the confidentiality of Members' medical records and other PHI as defined under HIPAA; and that 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 must 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). Provider employees who have access to Member records and other confidential information are required to sign a confidentiality statement.

Examples of confidential information include, but are not limited to, the following:

- Medical records
- Communication between a Member and a physician regarding the Member's medical care and treatment
- All personal and/or 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 AIDS or HIV testing, which is protected under federal or state law

The NPP informs the patient or Member of their rights under HIPAA and how the Provider and/or Wellcare may use or disclose the Member's PHI. HIPAA regulations require each covered entity to provide a NPP to each new patient or Member.

Disclosure of Information

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 Customer Service using the toll-free telephone number found on the Member's ID card. Providers may contact Provider Services by referring to the state-specific *Quick Reference Guides* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

Medicare Regulatory Requirements

As a Medicare contracted Provider, you are required to follow a number of Medicare regulations and CMS requirements. Some of these requirements are found in your Provider Agreement. Others have been described throughout the body of this manual. A general list of the requirements can be reviewed below:

- Providers may not discriminate against Medicare Members in any way based on the health status of the Member.
- Providers may not discriminate against Medicare Members in any way on the basis of race, color, national origin, sex, age, or disability in accordance with subsection 92.8 of Section 1557 of the Patient Protection and Affordable Care Act.
- Providers must ensure that Members have adequate access to covered health services.
- Providers may not impose cost sharing on Members for influenza vaccinations or pneumococcal vaccinations.
- Providers must allow Members to directly access screening mammography and influenza vaccinations.
- Providers must provide Members with direct access to health specialists for routine and preventive healthcare.
- Providers must comply with Plan processes to identify, access, and establish treatment for complex and serious medical conditions.
- Wellcare will give Providers at least 180 days written notice of termination if electing to terminate our agreement without cause. Providers agree to notify Wellcare according to the terms outlined in the Participation Agreement.
- Providers will ensure that their hours of operations are convenient to the Member and do not discriminate against the Member for any reason. Providers will ensure necessary services are available to Members 24 hours a day, seven days a week. Providers must provide backup in case of absence.
- Marketing materials must adhere to CMS guidelines and regulations and cannot be distributed to Wellcare Members without CMS and/or Wellcare approvals of the materials and forms.

- Services must be provided to Members in a culturally competent manner, including Members with limited reading skills, limited English proficiency, Members who are deaf or hard of hearing, or are blind, or have low vision and diverse cultural and ethnic backgrounds.
- Providers will work with Wellcare procedures to inform our Members of healthcare needs that require follow-up and provide necessary training in self-care.
- Providers will document in a prominent part of the Member's medical record whether the Member has executed an advance directive.
- Providers must provide services in a manner consistent with professionally recognized standards of care.
- Providers must cooperate with Wellcare to disclose to CMS all information necessary to evaluate and administer the program, and all information CMS may need to permit Members to make an informed choice about their Medicare coverage.
- Providers must cooperate with Wellcare in notifying Members of Provider contract terminations.
- Providers must cooperate with the activities of any CMS-approved independent quality review or improvement organization.
- Providers must comply with any Wellcare medical policies, QI programs and medical management procedures.
- Providers will cooperate with Wellcare in disclosing quality and performance indicators to CMS.
- Providers must cooperate with Wellcare procedures for handling grievances, appeals, and expedited appeals.
- Providers must request prior authorization from the plan if the Provider believes an item or service may not be covered for a Member or could only be covered under specific conditions. If the Provider does not request prior authorization, the claim may be denied, and the Provider will be liable for the cost of the service. Note: if the item or service is never covered by the plan as clearly denoted in the Member's Evidence of Coverage, no prior notice of denial is required, and the Member may be held responsible for the full cost of the item or service.
- Providers must allow CMS or its designee access to records related to Wellcare services for a period of at least 10 years following the final date of service or termination of this agreement, unless a longer period is required by applicable state or federal law.
- Provider must comply with all CMS requirements regarding the accuracy and confidentiality of medical records.
- Provider shall provide services in accordance with Wellcare policy: (a) for all Members, for the duration of the Wellcare contract period with CMS, and (b) for Members who are hospitalized on the date the CMS contract with Wellcare terminates, or, in the event of an insolvency, through discharge.
- Provider shall disclose to Wellcare all offshore contractor information with an attestation for each such offshore contractor, in a format required or permitted by CMS.

Section 12: Delegated Entities

Overview

Wellcare may, by written contract, delegate certain functions under Wellcare's contracts with CMS and/or applicable state governmental agencies. These functions include, but are not limited to, contracts for administration and management services, sales and marketing, utilization management, quality management, care management, disease management, claims processing, credentialing, network management, Provider appeals, and Customer Service. Wellcare may delegate all or a portion of these activities to another entity (a Delegated Entity).

Wellcare oversees the provision of services provided by the Delegated Entity and/or subdelegate and is accountable to the federal and state agencies for the performance of all delegated functions. It is the sole responsibility of Wellcare to monitor and evaluate the performance of the delegated functions to ensure compliance with regulatory requirements, contractual obligations, accreditation standards, and Wellcare policies and procedures.

Delegation Oversight Process

Wellcare's Delegation Oversight Committee (DOC) was formed to provide oversight for all subcontracted vendors where specific services are delegated to an entity. Wellcare defines a "delegated entity" as a subcontractor that performs a core function under one of Wellcare's government contracts. The Delegation Oversight Committee is chaired by the Director, Corporate Compliance – Delegation Oversight. The committee Members include appointed representatives from the following areas: Corporate Compliance, Shared Services Operations, Clinical Services Organization and a market representative from each Regional Area. The Chief Compliance Officer has ultimate authority as to the composition of the Delegation Oversight Committee Membership. The Delegation Oversight Committee holds monthly meetings, or more frequently as circumstances dictate. Refer to *Section 11: Compliance and Regulatory Requirements* of this manual for additional information regarding compliance requirements.

Wellcare ensures compliance through the delegation oversight process and the Delegation Oversight Committee by:

- Conducting pre-delegation audits and reviewing the results to evaluate the prospective entity's ability to perform the delegated function.
- Providing guidance on written agreement standards with delegated entities to clearly define and describe the delegated activities, responsibilities and required regulatory reports to be provided by the entity.
- Conducting ongoing monitoring activities to evaluate an entity's performance and compliance with regulatory and accreditation requirements.

- Conducting annual audits to verify the entity's performance and processes support sustained compliance with regulatory requirements and accreditation standards.
- Developing and implementing Corrective Action Plans (CAPs) if the Delegated Entity's performance is substandard or terms of the agreement are violated.
- Reviewing and initiating recommendations to Senior Management and the Chief Compliance Officer for the revocation and/or termination of those entities not performing to the expectations of the current contractual agreement and regulatory requirements of Wellcare's Medicare and Medicaid programs.
- Tracking and trending internal compliance with oversight standards, entity performance, and outcomes.

Section 13: Dual-Eligible Members

Chronic Condition Members Overview

Chronic Special Needs Plans (C-SNP) are a type of Medicare Advantage Benefit Plan that limits enrollment to Medicare-eligible Members that are also diagnosed with a designated chronic condition. Wellcare enrolls Members in its C-SNPs that have diabetes mellitus, chronic heart failure, and/or cardiovascular disease. These benefit plans provide benefit packages that provide more targeted coordination or integrated care and may offer specialized services than a regular Medicare Advantage plan and that meet the need associated with the condition.

Verifying Chronic Condition Eligibility

Upon receipt of the Member's application, Wellcare will verify the Member's applicable chronic condition(s) through one of the following methods:

- A copy of the Member's medical record showing confirmation of condition is included with the application, or a prequalification form is included with the enrollment application
- When a CMS approved prequalification assessment tool is received with an application, Wellcare will confirm the Member's qualifying chronic condition(s) from their treating Provider
- Phone verification directly from the Provider or other documentation from the Provider validating the Member's condition(s)

If by the end of the first month of enrollment, no confirmation has been received, Wellcare will send the Member a notice of their disenrollment for not having a qualifying condition. The disenrollment is effective at the end of the second month of enrollment.

Dual-Eligible Members Overview

Individuals who have Medicare and Medicaid coverage are called "dual eligible." For dual eligible Members, Medicaid may cover Medicare premiums, Medicare Parts A and B cost share and certain benefits not covered by Medicare.

Dual Eligible Special Needs Plans (D-SNP) are a type of Medicare Advantage Benefit Plan that only enroll dual-eligible Members. These Benefit Plans provide a coordinated Medicare-Medicaid benefit package that may offer more targeted coordination or integrated care than a regular Medicare Advantage plan.

Types of Dual-Eligible Members

Medicare Savings Programs (MSP) are Medicaid-administered programs for individuals on Medicare who have limited income and resources. There are multiple MSP eligibility categories, and the

categories are based upon the beneficiary's income and asset levels, as well as "medically needy" status. Members learn of their MSP eligibility from an award letter they receive from the state Medicaid agency.

Providers may verify Member's MSP status through the automated Medicaid eligibility-verification systems in the state in which the person is a resident or by calling Provider Services at the appropriate phone listed in this manual.

Please note, the state Medicaid agency defines all state optional MSP levels, and levels and eligibility criteria may vary among states. Please contact the state Medicaid agency for full MSP information.

Payments and Billing

For Members with MSP eligibility status of SLMB+, FBDE, QMB and QMB+ Members, typically, Medicaid will pay for any Medicare Parts A and B cost-share amounts. Any supplemental benefit cost share amounts (e.g., hearing, vision, dental) are usually the responsibility of the Member. In addition, federal law prohibits Medicare Providers from billing individuals who have an MSP QMB/QMB+ status. All Medicare Providers and suppliers, not only those that accept Medicaid, must not charge individuals enrolled in the QMB/QMB+ program for Medicare cost-sharing. While individuals enrolled in QMB do not pay Medicare deductibles, coinsurance, or copays, they may have a small Medicaid copay for certain Medicaid-covered services. QMB/QMB+ Members keep cost-share protection even when crossing state lines to receive care. Further, QMB/QMB+ Members cannot elect to pay Medicare cost share. Providers who bill QMB/QMB+ Members for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions.

QI, QDWI and SLMB Members will be responsible for any Medicare cost-share amounts.

For all Members enrolled in Wellcare's New Jersey Fully Integrated Dual-Eligible Special Needs Plan (FIDE SNP) (Wellcare Liberty), Providers may never charge a cost share for any service or prescription. However, if a Member loses Medicaid status and enters the six-month Deeming Period, the Member will still have Medicare benefits and will be responsible for Medicare copay/coinsurance. *Please see the Addendum for further information*.

The Provider will receive an Explanation of Payment (EOP) that lists instructions on how to bill for any Medicare Parts A and B cost share amounts due. Generally, Medicare cost share amounts that are due as a result of the provision of services to a dual-eligible Member are billed to the state Medicaid agency or billed to Wellcare or Wellcare's delegated vendor.

Some SNPs will have a Part B deductible amount applied prior to payment. This deductible is considered a cost-sharing amount and may be covered by the state Medicaid agency or its designee, dependent on the Member's MSP level, if the state has managed Medicaid, or by Wellcare via an agreement with the state. Providers should bill Wellcare as they do today and submit the EOP

provided by Wellcare to the state for payment. If Wellcare is responsible for this amount via an agreement with the state, Wellcare will pay this amount on behalf of the state.

Members who enroll after January of each year might have had their deductible amount paid for previously by the state or another health plan. In this instance, Providers should follow the billing process identified above and then send Best Available Evidence (BAE) illustrating that the Member has met their deductible. An example of BAE could be a remittance from the state/health plan illustrating that they have met the Member's deductible previously. If the BAE is submitted and approved, Wellcare will readjudicate the claim and send appropriate payment to the Provider.

Services that apply to the SNP Part B deductible include:

- Cardiac rehabilitation services
- Intensive cardiac rehabilitation services
- Pulmonary rehabilitation services
- SET for PAD services
- Partial hospitalization
- Chiropractic services
- Occupational therapy services
- Physician specialist services
- Mental health specialty services
- Podiatry services
- Other healthcare professional
- Psychiatric services
- Physical therapy and speech-language pathology services (except in Georgia)
- Opioid treatment services
- Outpatient diagnostic procedures/tests, and lab services
- Diagnostic radiological services
- Therapeutic radiological services
- Outpatient X-ray services
- Outpatient hospital services
- Ambulatory surgical center (ASC) services
- Outpatient substance abuse
- Observation services
- Outpatient blood services
- Ground ambulance services
- Air ambulance services
- Durable medical equipment (DME)
- Prosthetics/medical supplies
- Dialysis services
- Kidney disease education services

Referral of Dual-Eligible Members

When a Provider refers a dual-eligible Member to another Provider for services, the referring Provider should refer the dual-eligible Member to a Provider who participates with both Wellcare and the state Medicaid agency. A directory of Providers who participate with the state Medicaid plan can be located at the state's Medicaid website.

Dual-Eligible Members Who Lose Medicaid Eligibility/Status

CMS requires D-SNP plans to provide a Member a period of at least 30 days and up to six months to allow those dual-eligible Members who have lost Medicaid eligibility or had a change in status an opportunity to regain their eligibility. This period is called the "Deeming Period." A change in status occurs when a dual-eligible Member either loses Medicaid eligibility or when a change in Medicaid eligibility occurs that affects the Member responsibility and therefore eligibility for the specific D-SNP Benefit Plan enrolled. Wellcare implements a six-month Deeming Period for D-SNP plans.

If a Member has been deemed into a cost-share protected status during the Deeming Period, Wellcare applies the appropriate payment methodology to process claims and pays 100% of the Medicare allowable for all plans. Providers must accept Wellcare's payment as payment in full and may not balance bill the Member. If a Member is cost share protected, the Evidence of Payment that is sent to the Provider will note the Member's cost share protected status.

Dual-Eligible State-Specific Contract Obligations

State	Note
Arizona	Providers may access a list of benefit offerings at go.wellcare.com/AZ
Arkansas	Providers may access a list of benefit offerings at go.wellcare.com/AllwellAR
California	Providers may access a list of benefit offerings at go.wellcare.com/HealthNetCA or go.wellcare.com/WCandCVH
Delaware	Providers may access a list of benefit offerings at go.wellcare.com/DE or go.wellcare.com/DEFirst
Florida	Providers may access a list of benefit offerings at go.wellcare.com/SunshineFL
Hawaii	Providers may access a list of benefit offerings at go.wellcare.com/OhanaHI
Indiana	Providers may access a list of benefit offerings at go.wellcare.com/IN
Iowa	Provider may access a list of benefit offerings at go.wellcare.com/IA

State	Note
Kansas	Providers may access a list of benefit offerings at go.wellcare.com/KS
Michigan	Providers may access a list of benefit offerings at go.wellcare.com/MeridianMI
Missouri	Providers may access a list of benefit offerings at go.wellcare.com/AllwellMO or www.wellcare.com/missouri
Nebraska	Providers may access a list of benefit offerings at go.wellcare.com/NE
Nevada	Provider may access a list of benefit offering at go.wellcare.com/NV
New Jersey	Providers must accept payment received from Wellcare as payment in full for Covered Services included in the combined Medicare Advantage, NJ FamilyCare Plan A, and MLTSS benefit package. If Wellcare does not reimburse for a Covered Service, Providers may not seek payment from Members, Member representatives, the New Jersey Division of Medical Assistance and Health Services, or any Local Department of Social Services office. Please visit go.wellcare.com/FidelisNJ for more information.
New York	Providers must accept payment received from Wellcare for Covered Services included in the Combined Medicare Advantage and Medicaid Advantage benefit package as payment in full. If Wellcare does not reimburse for a Covered Service, Providers may not seek payment from the State Department of Health, Local Departments of Social Services, Members, or Member representatives. Some Medicaid benefits are provided by the state Medicaid plan on a fee-for-service basis. The state Medicaid Program has responsibility for the payment of these benefits. Please visit go.wellcare.com/FidelisNY for more information.
Ohio	Providers may access a list of benefit offerings at go.wellcare.com/OH or go.wellcare.com/BuckeyeOH
Oklahoma	Providers may access a list of benefit offerings at go.wellcare.com/OK
Oregon	Providers may access a list of benefit offerings at go.wellcare.com/OR
South Carolina	Providers may access a list of benefit offerings at go.wellcare.com/ATC
Texas	Providers may access a list of benefit offerings at go.wellcare.com/AllwellTX or go.wellcare.com/SuperiorTX
Washington	Providers may access a list of benefit offerings at wellcare.com/Washington

State	Note
Wisconsin	Provider may access a list of benefit offerings at go.wellcare.com/WI

SNP Care Management Program Overview

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) mandates a health risk assessment, care plan, qualifying face-to-face encounter, and an interdisciplinary care team for SNP Members as well as an evaluation of care effectiveness by the health plan. Wellcare's Model of Care (MOC) is tailored specifically to SNP Members in an effort to meet the populations' functional, psychosocial and medical needs in a Member-centric fashion.

Health Risk Assessment: Conducted by Wellcare – Wellcare's SNP Care Management process begins with the Health Risk Assessment (HRA) for all SNP Members. The HRA assesses Member risk in the following areas: SDOH, functional, psychosocial, behavioral, cognitive, and medical. Once completed, the HRA is stratified into a risk of low, moderate, or high. The risk level indicates the Member's needs and appropriate level of care management services. Members identified for enrollment into a Care Management program are outreached for engagement and to complete a comprehensive needs assessment. Initial assessments are conducted within 90 days of enrollment and annual reassessments are conducted within one year of the initial assessment.

Comprehensive Assessment: Conducted by Wellcare – Members referred for enrollment into a Care Management program are telephonically outreached by the care management team who conduct a comprehensive needs assessment with the SNP Member and/or caregiver in order to collect additional social, medical and behavioral information to support the Member-centric individualized care plan (ICP). The comprehensive needs assessment is based on *Clinical Practice Guidelines* and allows the care plan to be generated using these guidelines.

Individualized Care Plans: Generated by Wellcare – Each SNP Member will receive an Individualized Care Plan (ICP) based on the Member's HRA responses. Once the Member, and/or caregiver completes the health risk assessment, an ICP is generated that reflects the Member's specific problems, prioritized goals, and interventions. The ICP generated tracks dates and goal progress. The frequency of contact will vary depending on the risk level of the Member and specific goal timeframes. The ICP is shared with the Member and their caregiver, the PCP, and as appropriate, other Members of the care team for input and updates. If a Member is Unable to Reach (UTR) or declines to participate in the HRAT, the ICP is developed based on a standard care plan consisting of age and gender appropriate goals and interventions for preventative care and may be further tailored using available Member data.

Interdisciplinary Care Team: Wellcare and Providers – The ICP is shared with the Members of the ICT in an effort to provide feedback and promote collaboration regarding the Member's goals and current health status. The ICT includes the Member, the Member's caregiver (if appropriate), and the

Member's PCP at minimum and includes other appropriate supports as appropriate such as a Wellcare care manager and/or specialists according to the Member's needs. Other Members of the ICT can include social service supports, behavioral health specialists, state coordinators, and others preferred by the Member. ICT communication is facilitated by the primary coordinator which may include the PCP, Wellcare care manager or another appropriate ICT Member. For Members enrolled in a Care Management program, the care manager communicates and coordinates with the Members of the ICT to educate the Member, provide advocacy, and assist them as they navigate the healthcare system.

Face-to-face Encounters: Wellcare and Providers – Wellcare ensures that Members are provided a face-to-face encounter either in person or virtually within the first 12 months of their enrollment and annually thereafter. The face-to-face encounter is completed for the purpose of delivering healthcare, care management, or care coordination services and can be completed with an in-network treating Provider on the Member's interdisciplinary care team or with Wellcare care management/care coordination staff. Members who cannot be seen by their Providers within a 12-month period, either in-person or virtually, should contact Wellcare to schedule a virtual appointment with contact Provider Services at the appropriate phone listed in this manual.

Care Transitions: Wellcare and Providers – When Members move from one setting to another, Wellcare facilitates transitions through communication and coordination with the Member, caregiver, treating Providers, and their primary care practitioner. During this communication with the Member, any changes to the Member's health status and any resulting changes to the care plan are discussed. The Member's primary care Provider will be notified of the transition and informed of any needs to assist with a smoother transition process. All SNP Members who undergo a transition of care receive:

- Contact by a Wellcare utilization management and/or care management staff
- Discharge planning with a concurrent review nurse or discharge planner
- Post-discharge follow-up from care management
- Education on transition and transition prevention
- If applicable, review of medications with a registered nurse

Provider Required Participation

To meet the intent of the MIPPA legislation, Providers are expected to participate in the MOC for all SNP plan Members. The requirements for participation are as follows:

- Complete the required annual MOC training. Both participating and non-participating Providers that routinely treat SNP Members are required to complete MOC training annually. Wellcare offers a printable self-study training guide which can be found at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu. Providers who would like a copy mailed can contact Provider Services or their Provider Relations representative.

- Become familiar with Wellcare's *Clinical Practice Guidelines*, which are adopted nationally recognized, evidence-based guidelines.
- Review and update the Member care plan provided by the Care Management Department.
- Participate in the ICT for all SNP Members in a Provider's patient panel and give feedback as appropriate. Care managers will communicate with the Members of the ICT for any updates to the ICP.

Section 14: Behavioral Health

Overview

Wellcare offers behavioral health benefits through its Medicare Advantage Benefit Plans. For information regarding how to contact the behavioral health services administrator for each market, please refer to the state-specific *Quick Reference Guides* on go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

Behavioral Health Program

Some behavioral health services may require Prior Authorization, including all services provided by non-participating Providers. Wellcare uses InterQual® and American Society of Addiction Medicine (ASAM), as well as behavioral health guidelines developed by organizations such as the American Psychiatric Association and the CMS National Coverage Policies to make UM decisions regarding behavioral health. These criteria are well-known and nationally accepted guidelines for assessing level of care criteria for behavioral health.

Wellcare's UM reviewer and/or Medical Director apply Medical Necessity criteria in the context of the Member's individual circumstance and capacity of the local Provider Delivery system. The Medical Director may use their clinical judgment in addition to the criteria listed above, as circumstances require.

Coordination of Care Between Medical and Behavioral Health Providers

PCPs and behavioral health providers may offer services within their licensed scope of practice. Behavioral health providers must use the latest DSM for assessments and document diagnoses and outcomes in the member's medical record.

Behavioral Health Providers are encouraged to submit, with the Member's or the 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 Member's identified PCP noting any changes in the treatment plan on the day of discharge.

Wellcare encourages peer-to-peer communication between PCPs and behavioral health Providers. 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.

To maintain continuity of care, patient safety, and Member well-being, communication between behavioral healthcare Providers and medical care 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 impact Member outcomes.

Responsibilities of Behavioral Health Providers

Wellcare monitors Providers against these standards so 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 *Sections 2 and 3: Provider Administrative Guidelines and Member Administrative Guidelines* for other Providers. Behavioral health Providers not in compliance with these standards will be required to implement corrective actions set forth by Wellcare.

Type of Appointment	Access Standard
Non-prescriber BH: Urgent Care	≤ 48 hours
Non-prescriber BH: Non-life-threatening Emergency Care	≤ 6 hours
Non-prescriber BH: Sick Visit	≤ 7 business days
Non-prescriber BH: Routine Well Care	≤ 30 business days
Prescriber BH: Urgent Care	≤ 48 hours
Prescriber BH: Non-life-threatening Emergency Care	≤ 6 hours
Prescriber BH: Sick Visit	≤ 7 business days
Prescriber BH: Routine Well Care	≤ 30 business days

All Members receiving inpatient psychiatric services must be scheduled, *prior to discharge,* for psychiatric outpatient follow-up and/or continuing treatment, 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.

If a Member misses an appointment, the behavioral health Provider must contact the Member within 24 hours to reschedule. Behavioral health Providers are expected to assist Members in accessing emergent, urgent and routine behavioral 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 per day. The behavioral crisis phone number is printed on the Member's card and is available on Wellcare's website.

For information about Wellcare's Care Management and Disease Management Programs, including how to refer a Member for these services, please see *Section 6: Utilization Management, Care Management and Disease Management*.

Section 15: Pharmacy

Overview

Wellcare's pharmaceutical management procedures are an integral part of the Pharmacy Program that promote the use of the most clinically appropriate agent(s) to improve the health and well-being of Members. The utilization management tools that are used to optimize the Pharmacy Program include:

- Formulary
- Prior authorization
- Step therapy
- Quantity limit
- Mail service

These processes are described in detail below. In addition, prescriber and Member involvement is critical to the success of the Pharmacy Program. To help patients get the most out of their pharmacy benefit, please consider the following guidelines when prescribing:

- Follow national standards of care guidelines for treating conditions, such as, the National Institutes of Health (NIH) Asthma Guideline, Joint National Committee (JNC) VIII Hypertension Guidelines.
- Prescribe drugs listed on the formulary.
- 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 state-specific *Quick Reference Guides* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

Formulary

The Wellcare formulary contains information for pharmaceutical management procedures including:

- A list of covered pharmaceuticals, including restrictions and preferences, and copayment information, if applicable.
- How to use the pharmaceutical management procedures, including the prior authorization process and an explanation of limits or quotas on refills, doses, and prescriptions.
- How to submit an exception request.
- The process for generic substitution, therapeutic interchange, and step-therapy protocols.

The formulary is a published prescribing reference and clinical guide of covered prescription drug products selected by Wellcare in consultation with a team of healthcare Providers on the Pharmacy and Therapeutics (P&T) Committee, which represents the prescription therapies believed to be a necessary part of a quality treatment program. The formulary denotes any of the pharmacy utilization management tools that apply to a particular pharmaceutical. The P&T Committee's selection of drugs

is based on the drug's efficacy, safety, side effects, pharmacokinetics, clinical literature, and cost-effectiveness profile. The medications on the formulary are organized by therapeutic class, product name, strength, form and coverage details (quantity limit, prior authorization, and step therapy).

The formulary is at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Pharmacy* under *Medicare* in the *Providers* drop-down menu. Practitioners may call Provider Services at the appropriate phone listed in this manual to receive a copy of the pharmaceutical management procedures and updates by mail, fax, or email.

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

- Website updates
- Pharmacy and Provider communication that detail any major changes to a particular therapy or therapeutic class

Additions and Exceptions to the Formulary

To request consideration for inclusion of a drug to Wellcare's formulary, Providers may write Wellcare, to explain the medical justification for the inclusion. For contact information, refer to the state-specific *Quick Reference Guides* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

For more information on requesting exceptions, refer to the *Coverage Determination Request Process* subsection below.

Coverage Limitations

The following is a list of non-covered (i.e., excluded) drugs and/or categories:

- Agents when used for anorexia, weight loss, or weight gain (even if used for a non-cosmetic purpose (i.e., morbid obesity).
- Agents when used to promote fertility.
- Agents when used for cosmetic purposes or hair growth.
- Agents when used for the symptomatic relief of cough and colds.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Nonprescription over the counter (OTC) drugs.
- Covered outpatient drugs that the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
- Agents when used for the treatment of sexual or erectile dysfunction. However, erectile dysfunction drugs may be covered when prescribed for medically accepted indications

approved by the Food and Drug Administration (FDA) other than sexual or erectile dysfunction, such as pulmonary hypertension.

The bullet points above are a simplified summary of principles that are generally reflected in the formulary. However, they may not perfectly reflect the inclusion or exclusion of every pharmaceutical on the formulary for every Benefit Plan. Consequently, Providers should always review the formulary to confirm the coverage status of a particular pharmaceutical. In the event of any conflict between the formulary and the summary above, the formulary controls.

Generic Medications

Wellcare covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. In most cases, generic drugs cost less than brand-name drugs. To determine whether a particular generic drug is covered, consult the formulary.

Step Therapy

Step Therapy programs are developed by Wellcare's P&T Committee. These programs encourage the use of therapeutically equivalent, lower-cost medication alternatives (first-line therapy) before "stepping up" to alternatives that are usually less cost-effective. Step Therapy programs are intended to be 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 Wellcare's formulary have been evaluated through the use of clinical literature and are approved by Wellcare's P&T Committee.

Drugs requiring step therapy are designated by the letters "ST" on Wellcare's formulary.

Prior Authorization

Prior authorization protocols are developed and reviewed annually by the P&T Committee. Prior authorization protocols indicate the criteria that must be met in order for the drug to be authorized (for example, specific diagnoses, lab values, trial and failure of alternative drug[s]).

Drugs requiring prior authorization are designated by the letters "PA" on Wellcare's formulary. Refer to *Section 6* of this manual for additional information on the process for requesting prior authorization.

Quantity Limits

Quantity limits are used so pharmaceuticals are supplied in quantities consistent with FDA-approved dosing guidelines. Quantity limits are also used to help prevent billing errors.

Drugs that have quantity limits are designated by the letters "QL," and the quantity permitted, on Wellcare's formulary.

Mail Service

Wellcare's preferred mail-service pharmacy is Express Scripts Pharmacy. An Express Scripts Mail Service Order Form is at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Pharmacy* under *Medicare* in the *Providers* drop-down menu.

NM means the drug is not available via the monthly mail service benefit. This is noted in the Requirements/Limits column of the formulary. More than one month's supply of most drugs on the formulary may be received via mail service at a reduced cost share. Please see Chapter 3 *Member Administrative Guidelines* in the Evidence of Coverage subsection for more information.

Injectable and Infusion Services

Certain self-injectable medications, specialty medications and home infusion medications are included within the formulary and covered as part of the outpatient pharmacy benefit. Non-formulary injectable medications, and those listed on the formulary with a prior authorization requirement, require submission of a request form for review to be considered for coverage.
For more information, refer to the *Obtaining a Coverage Determination Request* subsection below.

Over-the-Counter Medications

Medications available to the Member without a prescription are not eligible for coverage under the Member's Medicare Part D benefit. For additional information about an additional pharmacy wrap benefit for over-the-counter medications that may apply to certain Benefit Plans, please refer to the Member's state-specific Summary of Benefits at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Find My Plan* under *Medicare* in the *Members* drop-down menu.

Member Expense

The copayment and/or coinsurance are determined by the Member's Benefit Plan, based on the drug's formulary status. Refer to the Member's state-specific Summary of Benefits for the exact copay/coinsurance at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Find My Plan* under *Medicare* in the *Members* drop-down menu.

Coverage Determination Request Process

The goal of Wellcare's Coverage Determination Request program is to promote the appropriate use, in accordance with FDA-approved indications, of medication regimens that are high-risk, have a high

potential for misuse, or have narrow therapeutic indices. The Coverage Determination Request process is required for:

- Drugs not listed on the formulary
- Drugs listed on the formulary as requiring a prior authorization
- Duplication of therapy
- Prescriptions that exceed the FDA daily or monthly quantity limits, or prescriptions exceeding the permitted QL noted on the formulary
- Most self-injectable and infusion drugs (including chemotherapy) administered in a physician's office
- Drugs that have a step edit and the first-line therapy is inappropriate.

Obtaining a Coverage Determination Request

Complete a *Coverage Determination Request Form online, or call, fax or mail the form* to the Pharmacy Department. The form is located at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Pharmacy* under *Medicare* in the *Providers* drop-down menu. For the appropriate fax number, refer to the state-specific *Quick Reference Guides* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

The Provider must provide medical history and/or other pertinent information when submitting a *Coverage Determination Request Form* for medical exception. If the Coverage Determination Request is approved, the Provider and/or pharmacy will be contacted with the Coverage Determination Request approval. An approval letter is also sent to the Member, and a telephonic attempt is made to inform the Member of the approval. If the Coverage Determination Request is not a candidate for approval based on P&T Committee protocols and guidelines, it is reviewed by a clinical pharmacist and/or a medical director.

For those Coverage Determination Requests that are not approved, a follow-up *Drug Utilization Review (DUR)* Form is faxed to the Provider stating why the Coverage Determination Request was not approved, including a list of the preferred drugs that are available as alternatives, if applicable. A denial letter is also sent to the Member, and a telephonic attempt may be made to inform them of the denial. The treating practitioner has the opportunity to discuss the denial decision with a physician or pharmacist reviewer. Providers may contact Wellcare at the numbers below to request a peer-to-peer discussion to address the denial decision letter.

Applicable plans	Phone Number
PDP plans	1-855-538-0453
Wellcare MAPD plans	1-855-538-0454
Wellcare By Allwell MAPD plans	1-800-867-6564

Providers can request a Coverage Determination on or after Jan. 1, 2026. Any request submitted prior to this date will only be evaluated for the current benefit year.

Medication Appeals

To request an appeal of a Coverage Determination Request decision, contact Wellcare's Pharmacy Appeals Department via phone, fax, mail, or in person. Refer to the state-specific *Quick Reference Guides* at go.wellcare.com. Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu for more information.

Once the appeal of the Coverage Determination Request decision has been properly submitted, the request will follow the appeals process described in *Section 9: Reconsiderations (Appeals) and Section 10: Grievances*.

AcariaHealth™ Specialty Pharmacy

AcariaHealth is a national comprehensive specialty pharmacy focused on improving care and outcomes for patients living with complex and chronic conditions. AcariaHealth is comprised of dedicated healthcare professionals who work closely with physicians' offices, including support with referral and prior authorization processes. This collaboration allows our patients to receive the medicine they need as fast as possible. Representatives are available from Monday through Thursday, from 8 a.m. to 7 p.m., and Friday, from 8 a.m. to 6 p.m., Eastern time.

AcariaHealth Specialty Pharmacy #26, Inc.
8715 Henderson Rd., Tampa, FL 33634
Phone: 1-866-458-9246 (TTY 1-855-516-5636)
Fax: 1-866-458-9245
Website: acariahealth.com

Section 16: Definitions and Abbreviations

Definitions

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

Agreement means the contract under which Provider participates in Wellcare's network for Medicare Advantage Benefit Plans.

Appeal means a request for a review of some action taken by or on behalf of Wellcare.

Benefit Plan means a health benefit policy or other health benefit contract or coverage document (a) issued by Wellcare or (b) administered by Wellcare, pursuant to a government contract. Benefit Plans and their designs are subject to change periodically. This manual applies only to Benefit Plans issued under the Medicare Advantage program.

Centers for Medicare and Medicaid Services (CMS) means the United States federal agency that administers Medicare, Medicaid and the Children's Health Insurance Program (CHIP).

Clean Claim means a claim for Covered Services provided to a Member that (a) is received timely by Wellcare, (b) has no defect, impropriety, or lack of substantiating documentation from the Member's medical record regarding the Covered Services, (c) is not subject to coordination of benefits or subrogation issues, (d) is on a completed, legible CMS 1500 form or UB-04 form or electronic equivalent that follows current HIPAA Administrative Simplification ASC X12 837 standards and additional Wellcare-specific requirements in the *Wellcare Companion Guide*, including all current guidelines regarding coding and inclusive code sets, and (e) includes all relevant information necessary for Wellcare to (1) meet requirements of laws and program requirements for reporting of Covered Services provided to Members, and (2) determine payer liability, and ensure timely processing and payment by Wellcare. A Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim that is under review for Medical Necessity.

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 healthcare items and services covered under a Benefit Plan.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant individual, the health of the individual or their unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Encounter Data means encounter information, data and reports for Covered Services provided to a Member that meets the requirements for Clean Claims.

FBDE means full benefit dual-eligible Members who are eligible to have full Medicaid and full Medicare benefits.

Grievance means any complaint or dispute, other than one that involves a Wellcare determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of Wellcare, regardless of whether remedial action can be taken. Grievances may include, but are not limited to, complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item and may only be brought on behalf of a Member.

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 Office of the Inspector General of the U.S. Department of Health and Human Services (OIG), or (ii) federal procurement or nonprocurement programs, as may be identified in the excluded parties list system maintained by the U.S. 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 nonprocurement programs as determined by a state governmental authority.

Medically Necessary or Medical Necessity means those healthcare items or services that are (i) necessary to protect life, prevent significant illness or significant disability or to alleviate severe pain, (ii) individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the Member's needs, (iii) consistent with generally accepted professional medical standards and not experimental or investigational, (iv) reflective of the level of service that can be provided safely and for which no equally effective and more conservative or less costly treatment is available statewide, (v) provided in a manner not primarily intended for the convenience of the Member, the Member's caretaker or the healthcare Provider, and (vi) not custodial care as defined by CMS. For healthcare items and services provided in a hospital on an inpatient basis, "Medically Necessary" also means that such items and services cannot, consistent with the provisions of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient facility of a different type. The fact that a healthcare Provider has prescribed,

recommended or approved healthcare items or services does not, in itself, make such items or services Medically Necessary.

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

Organization Determination means any determination made by a Medicare health plan with respect to the following:

- Payment for temporarily out-of-the-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.
- Payment for any other health services furnished by a Provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for or reimbursed by the Medicare health plan.
- The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan.
- Reduction or premature discontinuation of a previously authorized ongoing course of treatment.
- Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for healthcare services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

Primary Care Provider (PCP) means a licensed medical doctor (MD) or doctor of osteopathy (DO) or certain other licensed medical practitioners who, within the scope of practice and in accordance with state certification licensure requirements, standards, and practices, are responsible for providing all required primary care services to Members. A PCP shall include general/family practitioners, pediatricians, internists, physician assistants, CNMs or NP-Cs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with licensure requirements.

Provider means an individual or entity that has contracted, directly or indirectly, with Wellcare to provide or arrange for the provision of Covered Services to Members under a Benefit Plan as a participant in Wellcare's network.

QDWI means Qualified Disabled Working Individual whose income is up to 200% of the Federal Poverty Level. These individuals are considered partial dual-eligible Members since Medicaid only pays the Medicare Part A premium and does not pay any Medicare cost share. These Members are not eligible to have full Medicaid benefits.

QMB+ means Qualified Medicare Beneficiary whose income is up to 100% of the Federal Poverty Level. These individuals are considered a zero-cost share dual-eligible Member since Medicaid pays both the Medicare Parts A and B premiums and Medicare Parts A and B cost share. These Members have full Medicaid benefits.

SLMB means Specified Low-Income Medicare Beneficiary whose income is up to 120% of the Federal Poverty Level. These individuals are considered partial dual-eligible Members since Medicaid only pays the Medicare Part B premium and does not pay any Medicare cost share. These Members do not have full Medicaid benefits.

SLMB+ means Specified Low-Income Medicare Beneficiary whose income is up to 120% of the Federal Poverty Level. These individuals are considered a zero cost-share dual-eligible Member since Medicaid pays the Medicare Part B premiums and Medicare Parts A and B cost share. These Members have full Medicaid benefits.

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.

Zero Cost-Share Dual-Eligible Member means a dual-eligible Member who is not responsible for paying any Medicare Part A or Part B cost share amounts.

Abbreviations

- **ACS** – American College of Surgeons
- **AEP** – Annual enrollment period
- **AHP** – Allied health professional
- **AIDS** – Acquired Immune Deficiency Syndrome
- **AIP** – Applicable Integrated Plan
- **ALJ** – Administrative law judge
- **AMA** – American Medical Association
- **ARNP** – Advanced Registered Nurse Practitioner
- **CAD** – Coronary artery disease
- **CAHPS** – Consumer Assessment of Healthcare Providers and Systems
- **CDS** – Controlled Dangerous Substance
- **CHF** – Congestive heart failure
- **CIA** – Corporate Integrity Agreement
- **CLAS** – Culturally and linguistically appropriate services
- **CMS** – Centers for Medicare & Medicaid Services
- **CNM** – Certified Nurse Midwife
- **COB** – Coordination of benefits

- **COPD** – Chronic obstructive pulmonary disease
- **CORF** – Comprehensive outpatient rehabilitation facility
- **CPT-4** – Physician's Current Procedural Terminology, 4th Edition
- **C-SNP** – Chronic Special Needs Plan
- **CSR** – Controlled Substance Registration
- **DDE** – Direct data entry
- **DEA** – Drug Enforcement Agency
- **DM** – Disease Management
- **DME** – Durable medical equipment
- **DOC** – Delegation Oversight Committee
- **DSM-IV** – Diagnostic and Statistical manual of Mental Disorders, 4th Edition
- **D-SNP** – Dual-Eligible Special Needs Plan
- **EDI** – Electronic data interchange
- **EOB** – Explanation of Benefits
- **EOP** – Explanation of Payment
- **ESRD** – End-stage renal disease
- **FBDE** – Full Benefit Dual-Eligible Members
- **FDA** – Food and Drug Administration
- **FFS** – Fee-for-service
- **FIDE** – Fully Integrated Dual Eligible Special Needs Plan
- **FWA** – Fraud, waste and abuse
- **HEDIS** – Healthcare Effectiveness Data and Information Set
- **HHA** – Home health agency
- **HHS** – U.S. Department of Health and Human Services
- **HIDE** – Highly Integrated Dual Eligible Special Needs Plan
- **HIPAA** – Health Insurance Portability and Accountability Act of 1996
- **HIV** – Human Immunodeficiency Virus
- **HMO** – Health maintenance organization
- **HMO-POS** – Health maintenance organization with point-of-service option
- **HOS** – Medicare Health Outcomes Survey
- **HRA** – Health Risk Assessment
- **HTN** – Hypertension
- **ICD-10-CM** – International Classification of Diseases, 10th Revision, Clinical Modification
- **ICP** – Individualized Care Plan
- **ICT** – Interdisciplinary Care Team
- **INR** – Inpatient nursing rehabilitation facility
- **IPA** – Independent physician association
- **IRE** – Independent Review Entity
- **IVR** – Interactive voice response
- **JNC** – Joint National Committee

- **LCSW** – Licensed Clinical Social Worker
- **LTAC** – Long-term acute care facility
- **MA** – Medicare Advantage
- **MAC** – Medicare Appeals Council
- **MIPPA** – Medicare Improvements for Patients and Providers Act of 2008
- **MOC** – Model of Care
- **MOOP** – Maximum out-of-pocket
- **MSP** – Medicare Savings Program
- **NCCI** – National Correct Coding Initiative
- **NCQA** – National Committee for Quality Assurance
- **NDC** – National Drug Codes
- **NIH** – National Institutes of Health
- **NPI** – National Provider Identifier
- **NPP** – Notice of Privacy Practices
- **OA** – Osteopathic Assistant
- **OB** – Obstetric/obstetrical/obstetrician
- **OIG** – Office of Inspector General
- **OT** – Occupational therapy
- **OTC** – Over the counter
- **P&T** – Pharmacy and Therapeutics Committee
- **PA** – Physician Assistant
- **PCP** – Primary Care Provider
- **PHI** – Protected health information
- **POS** – Point-of-service
- **PPC** – Provider-preventable condition
- **PPO** – Preferred Provider Organization
- **Provider ID** – Provider identification number
- **PT**– Physical therapy
- **QDWI** – Qualified Disabled Working Individual
- **QI** – Qualifying Individual
- **QI Program** – Quality Improvement Program (*also referred to as* QIP)
- **QIO** – Quality Improvement Organization
- **QIUMC** -- Quality Improvement and Utilization Management Committee
- **QMB** – Qualified Medicare Beneficiary
- **QMB+** – Qualified Medicare Beneficiary Plus
- **RN** – Registered Nurse
- **SFTP** – Secure file transfer protocol
- **SIE** – Site inspection evaluation
- **SLMB** – Specified Low-Income Medicare Beneficiary
- **SLMB+** – Specified Low-Income Medicare Beneficiary Plus

- SNF – Skilled nursing facility
- SNIP – Strategic National Implementation Process
- SSBCI – Special Supplemental Benefits for the Chronically Ill
- SSN – Social Security Number
- ST – Speech therapy
- Tax ID/TIN – tax identification number
- TNA – Transition Needs Assessment
- TOC – Transition of care
- UM – Utilization management
- WEDI™ – Workgroup for Electronic Data Interchange

Section 17: Wellcare Resources

Wellcare Homepage
go.wellcare.com

Wellcare Provider Homepage
wellcare.com/Providers

Quick Reference Guides, Provider manuals, Forms and Documents, Training and Education
wellcare.com
Select the appropriate state from the drop-down menu and click on *Overview* under *Medicare* in the *Providers* drop-down menu.

Pharmacy
AcariaHealth™ Specialty Pharmacy
acariahealth.com

Clinical Practice Guidelines
Clinical Policies (Clinical Coverage Guidelines (CCGs))
wellcare.com
Select the appropriate state from the drop-down menu and click on *Clinical Guidelines* under *Tools* in the *Providers* drop-down menu.

Claims
wellcare.com
Select the appropriate state from the drop-down menu and click on *Claims* under *Medicare* in the *Providers* drop-down menu.

Quality
wellcare.com
Select the appropriate state from the drop-down menu and click on *Quality* under *Medicare* in the *Providers* drop-down menu.

Addendum

NJ FIDE SNP Provider and Member Appeal Process

Wellcare Liberty HMO ("Plan") is a Dual-Eligible Special Needs Plan (SNP), which means only beneficiaries who live within the plan service area and are eligible for both Medicare and Medicaid may enroll in the plan. In addition, Wellcare Liberty HMO SNP further qualifies as a Fully Integrated Dual-Eligible (FIDE) SNP, which means that Members receive their Medicare benefits from the plan and their full Medicaid benefits – including, when eligible, Long-Term Services and Supports.

As a FIDE SNP, Wellcare Liberty HMO SNP is a zero-cost share plan. This means Members owe nothing for Covered Services as long as they are active with the plan. Members may not be balance billed for Covered Services. Claims for these Members will be adjudicated first through their Medicare benefits and then through their Medicaid benefits. Services not covered by Medicare may be covered by the Members' Medicaid benefits. This includes cost shares (i.e., deductibles, copayments, and coinsurance) for Medicare Covered Services.

Provider Retrospective Appeals Overview

A Provider may appeal a claim denial on their own behalf by submitting an appeal form with supporting documentation such as medical records. Appeal forms are at go.wellcare.com. Select the appropriate state from the drop-down menu and click on "Forms" under Medicare in the "Providers" drop-down menu.

Providers have 90 calendar days from the claim denial to file an appeal. Appeals received after that time will be denied for untimely filing. If the Provider believes that the appeal was filed within the appropriate timeframe, the Provider may submit documentation showing proof of timely filing. The only acceptable proof of timely filing is a registered postal receipt signed by a representative of the Plan, a similar receipt from another commercial delivery service, or proof of electronic submission

Upon receipt of all required documentation, the Plan has up to 30 calendar days to review the appeal. The appeal will be reviewed in accordance with Plan guidelines, and may be reviewed for Medical Necessity, to arrive at a conclusion to reverse or affirm the original denial. Required documentation includes: the Member's name and/or identification number, date(s) of service, and reason why the Provider believes the decision should be reversed. Additional required information varies based on the type of appeal requested. For example, if we determine a medical necessity review is required, the Provider must submit complete medical records. If the Provider appeals a denial based on untimely filing, proof of timely filing should be submitted. If the Provider is appealing the denial based on not having a prior authorization, then documentation regarding why the service was rendered without prior authorization must be submitted.

Wellcare will not review appeals received without the necessary documentation and they may be administratively denied due to lack of information. It is the responsibility of the Provider to provide any documentation that is needed to support the appeal as requested by Plan or by appropriate regulatory agencies. Records and documents received after the submission deadline will not be reviewed and the appeal will remain closed. The Provider is not allowed to charge the Plan or the Member for copies of medical records provided for this purpose.

Provider Retrospective Appeals Decisions

Reversal of Initial Denial

If it is determined during the review that the Provider has complied with Plan protocols and that the appealed services were Medically Necessary, the initial denial will be reversed. The Provider will be notified of this decision in writing. After the decision to reverse the denial has been made, the claims at issue will be adjusted for payment, as applicable, and pursuant to federal and/or state requirements.

Affirmation of Initial Denial

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

For denials based on Medical Necessity, the criteria used to make the decision will be provided in the decision letter. The Provider may also request a copy of the clinical criteria used in making the appeal decision by sending a written request to the appeals address listed in the decision letter.

Member Integrated Appeals Process

Actions

Action, at a minimum, means any of the following:

- An adverse determination under a utilization review program
- Denial of access to specialty and other care
- Denial of continuation of care
- Denial of a choice of Provider
- Denial of coverage of routine patient costs in connection with an approved clinical trial
- Denial of access to needed drugs
- Imposition of arbitrary limitation on Medically Necessary services
- Denial, in whole or in part, of payment for a benefit
- Denial or limited authorization of a requested service, including the type or level of services
- Reduction, suspension, or termination of a previously authorized service

- Failure to provide services in a timely manner
- Denial of a service based on lack of Medical Necessity

Member Appeals Overview

For services that the Plan determines are Medicare-only benefits, the Plan appeal process will comply with all procedures and requirements of 42 CFR Subpart M of Part 422, Chapter 13 of CMS's Medicare Managed Care manual, and Chapter 18 of CMS's Prescription Drug Benefit manual.

The Plan will follow Medicare procedures to notify the Member and Providers, as applicable, regarding the Plan's determination and offer the Member Medicare appeal rights. For services that the Plan determines are Medicaid-only benefits, the Plan shall act in accordance with all procedures and requirements of the Action and Grievance System requirements in compliance with 42 CFR Section 431.200(b), 431.201, 431.206, 431.211, 431.214, 438.52, 438.56, 438.210, 438.213, 438.228, 438.400-438.424, N.J.A.C. 11:24 and the Utilization Management (UM) process per Article 4.6.4. For services the Plan determines to be a benefit covered under both Medicare and Medicaid, the Plan shall act in accordance with all applicable procedures and requirements of 42 CFR Subpart M of Part 422, Chapter 13 of CMS' Medicare Managed Care manual, and Chapter 18 of CMS' Prescription Drug Benefit manual, except as directed otherwise in Article 10.10.3A, and in the integrated appeal process detailed in Article 10.10.3.A.6 et seq.

For Member appeals, the Member, Member's representative, or a Provider acting on behalf of the Member with the Member's written consent may file an appeal. Providers do not have appeal rights through the Member appeals process. However, Providers have the ability to file appeals on their own behalf if a claim is submitted and denied.

The Member, Member's representative, or a Provider acting on the Member's behalf may file for an expedited, standard pre-service or retrospective appeal determination. If the Member wishes to use a representative, then they must complete an Appointment of Representative (AOR) statement. The Member, and the person who will be representing the Member, must sign the AOR statement and return the signed form to the Plan at the address in the Quick Reference Guide available on Wellcare's Provider website at www.wellcare.com/New-Jersey/Providers. The AOR form is at www.wellcare.com/en/new-jersey/Providers/medicare/forms. Prior to the service(s) being rendered, Providers may appeal on behalf of the Member if they have the Member's written consent in their records.

The Plan will not take or threaten to take any punitive action against any Provider acting on behalf of or in support of a Member in requesting a standard appeal or an expedited appeal.
Examples of actions that can be appealed include, but are not limited to:

- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.

- Failure to provide services in a timely manner, as defined by the state.

The Plan ensures that the initial decision-maker(s) are not involved in reconsiderations of previous levels of review. When deciding an appeal of a denial based on lack of Medical Necessity, a grievance regarding the denial of expedited resolution of an appeal, or a grievance or appeal involving clinical issues, the appeal reviewers will be healthcare professionals with clinical expertise in treating the Member's condition/disease or will have sought advice from Providers with expertise in the field of medicine related to the request. A written description or summary of the policy and procedure is available upon request to any Member, Provider, or facility rendering a Covered Service.

The Plan gives Members 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 and interpreter capabilities.

Members are also provided reasonable opportunities to present evidence and allegations of fact or law in person, as well as in writing, at any time during the appeal process. The timeframe to submit additional information is limited for expedited appeals. A Member may also ask for a copy of their appeal file free of charge during the appeal process, or once the appeals process is complete.

Internal Integrated Appeals Process

A Member, or Provider acting on behalf of a Member with the Member's written consent, may appeal any utilization management (UM) determination resulting in a denial, termination, or other limitation of Covered Services.

This form of appeal can be initiated by writing or calling the Plan at the phone number listed on the Member's ID card within 60 days of the date the Member received the notification letter denying, terminating, or limiting a Covered Service.

Types of Appeals

A Member may request a standard pre-service, retrospective, or expedited appeal.

Standard Pre-Service Appeals are requests for services that the Plan has determined are not Covered Services, are not Medically Necessary, or are otherwise outside of the Member's benefit plan.

Retrospective, or Post-Service, Appeals are typically requests for payment for care or services that the Member has already received. Accordingly, a retrospective appeal would never result in the need for an expedited review. These are the only appeals that may be made by the Provider on their own behalf. Only pre-service appeals are eligible to be processed as expedited appeals.

Appeal Decision Timeframes

The Plan will issue a decision to the Member or the Member's representative within the following timeframes:

- Expedited Request: 72 hours
- Standard Part B: 7 calendar days
- Standard Pre-Service/Post Service Request: 30 calendar days

Expedited Appeal Process

To request an expedited appeal, a Member or a Provider (regardless of whether the Provider is contracted with the Plan) must submit an oral or written request directly to the Plan. 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 the Plan makes a decision less than fully favorable to the Member.

Members who orally request an expedited appeal are not required to submit a written appeal request. Members may submit additional information, present evidence, and allegations of fact or law in person as well as in writing. However, the timeframe to submit the information is limited for expedited appeals.

The Plan's UM appeals process requires pertinent medical information that supports the reason for the appeal. If an appeal is submitted without valid and/or pertinent medical information, the Plan will assist the Member, or Provider acting on behalf of the Member, by requesting the pertinent medical records or documentation.

All appeals can be submitted in writing to the Plan to the mailing address listed on the decision letter, as this may vary based on the type of coverage.

Resolution of an Expedited Appeal

Upon receiving an expedited appeal, the Plan 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 the expedited appeal. The Plan will make reasonable efforts to provide verbal notice to the Member with the expedited appeal determination.

If the request for expedited resolution of the appeal is denied, the Plan will provide the Member, the Member's authorized representative, or Provider acting on behalf of the Member with oral notification of the denial. Written notification will subsequently be mailed to the Member within two calendar days of the oral notification. This notice will explain that the Plan will transfer the appeal to the standard timeframe of no more than 30 calendar days for an appeal beginning on the date the Plan received the original request.

Reversal of Denial of an Integrated Appeal

If, upon appeal, the Plan overturns its adverse determination, the Plan will issue its reconsidered determination and send payment or issue authorization for the service, as applicable.

In this event, the Plan will also pay for appealed Covered Services, in accordance with state policy and regulations, 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 an Administrative Appeal

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

- Issue an Integrated Appeal Outcome Notification letter to Member and/or appellant
- Include in the notice the specific reason for the appeal decision in easily understandable language with reference to the benefit provision, guideline, protocol, or other similar criteria on which the appeal decision was based
- Outline the additional levels of appeals available

Medicare Appeal Rights

An Unfavorable Appeal case file will automatically be forwarded to an independent reviewer under the Medicare Appeals process. This reviewer will review the Member's case under Medicare coverage standards. If the independent reviewer denies the Member's request, the Member will receive a written decision. The written decision will explain if the Member has additional appeal rights under Medicare.

State Level Appeal Rights

The Member, the Member's Provider (with the Member's written consent), or another authorized representative can also choose to file an external appeal through the NJ Department of Banking and Insurance. The case will be sent to an Independent Utilization Review Organization (IURO) and will be reviewed by an independent physician. The Member also has the right to request a Medicaid State Fair Hearing. More information on both options is below.

External (IURO) Appeal

If a Member, or a Provider acting on the Member's behalf, is not satisfied with the Plan's Appeal Determination, the appeal may be submitted to an External Independent Utilization Review Organizational (IURO) Process. To request an IURO appeal, Providers must complete the external review form provided with their appeal notice of action and return it within 60 days from receipt of the adverse internal appeal determination to the following address:

NJ Department of Banking and Insurance

Consumer Protection Services
Office of Managed Care
P.O. Box 329
Trenton, New Jersey 08625-0329

Providers and Members may also call the toll-free number at **1-888-393-1062** for assistance. The IURO will render a decision within 45 calendar days.

If the Provider or the treating Provider believes this 45-calendar day timeframe for resolving the appeal could harm the Member's health, or if the Member is inpatient in a hospital, the IURO will render a decision within no more than 48 hours following the receipt of the appeal. The Provider or treating Provider may call the Department of Banking and Insurance at **1-888-393-1062** to make this request.

Medicaid State Fair Hearing

In addition to the right to file an appeal with the Plan, a Member also has a right to file for a Medicaid State Fair Hearing. Members must request the Medicaid State Fair Hearing with the NJ Division of Medical and Health Services (DMAHS) within 120 days of the adverse action whether or not the Member appeals to the IURO. Members can appeal to the IURO before requesting a Medicaid State Fair Hearing and wait for the IURO's decision, or Members can appeal to the IURO at the same time that they request a Medicaid State Fair Hearing. (Please keep in mind that Members make these two requests to different government agencies.) The External (IURO) Appeal is optional and is not required to access the Fair Hearing process.

NOTE: Although Members have 120 calendar days to request a Medicaid State Fair Hearing, they only have 10 calendar days from the date of the Appeals Resolution letter or until the end of the previously approved authorization, whichever is later, to request in writing that services continue during the Medicaid State Fair Hearing process. If the Member does not request that services continue during this timeframe, the services will not continue.

If the Member requests that their services continue while the Member's appeal takes place and the Member's Medicaid State Fair Hearing outcome is not in their favor, the Member may be required to pay for the services. The Member must include their name, address, telephone number, and a copy of the denial letter with their request for a Medicaid State Fair Hearing.

Appeals should be sent to:

State of New Jersey
Division of Medical Assistance and Health Services
Fair Hearing Section
P.O. Box 712
Trenton, NJ 08625-0712

The Medicaid State Fair Hearing will be concluded within 90 days.

Continuation of Benefits

During any stage of the appeal process, the Plan shall continue the Member's benefits if all of the following are met:

- The Member or the Provider files the appeal timely.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized Provider.
- The appeal request is made on or before the final day of the previously approved authorization, or within 10 calendar days of the Plan sending the notification of adverse benefit determination, whichever is later.

For those eligible Members who request the Fair Hearing process, continuation of benefits must be requested in writing within 10 days of the date of the notice of action letter, following an internal or external appeal, or on or before the final day of the previously approved authorization, whichever is later.

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