Medicare Advantage Provider Manual

2023

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Partners in Quality Care

Dear Provider Partner:

At Wellcare By ʻOhana Health Plan 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 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 By ʻOhana Health Plan

Quality Highlights

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1/9/2023	Section 2: Provider Administration Guidelines	Special Supplemental Benefits for the Chronically Ill (SSBCI)	23	Added description

Section 1: Welcome to Wellcare By ‘Ohana

Wellcare By ‘Ohana Health Plan (Wellcare) provides managed care services for Medicare and is a wholly-owned subsidiary of Centene Corporation, a leading multi-line healthcare enterprise. Wellcare serves 1.4 million Medicare members across 36 states. Wellcare’s experience and exclusive commitment to these programs enables Wellcare to serve its Members and Providers as well as manage its operations effectively and efficiently.

Wellcare physical locations:

Wellcare By ‘Ohana Health Plan – Kapolei Office
949 Kamokila Boulevard
3rd Floor, Suite 350
Kapolei, HI 96707

Wellcare By ‘Ohana Health Plan – Maui Office
285 West Ka‘ahumanu Avenue
Suite 101B
Kahului, HI 96732

Wellcare By ‘Ohana Health Plan – Big Island Office
194 Kilauea Avenue
Suites 102 and 103
Hilo, HI 96720

For specific correspondence information, refer to the Wellcare *Quick Reference Guide* at **wellcare.com/Hawaii/Providers/Medicare**.

Mission and Vision

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

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

Our 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 they serve.
- *Accountability* – All associates must be responsible for the commitments Wellcare makes and the results they deliver.
- *One Team* – Wellcare and its associates are expected to demonstrate a collaborative approach in the way they work.

Purpose of this Manual

This Manual is intended for Providers who have contracted to participate in Wellcare's network to deliver quality healthcare services to Members enrolled in a Medicare Advantage (MA) Benefit Plan.

This Manual serves as a guide to Providers and their staff to comply with the policies and procedures governing the administration of our Medicare Advantage Government Program 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 Provider Manual replaces and supersedes any previous versions dated prior to January 9, 2023, and is available at wellcare.com/Hawaii/Providers/Medicare.** A paper copy is available at no charge to Providers upon request.

In accordance with the Agreement, Participating Medicare Providers must abide by all applicable provisions of this Manual. Revisions to this Manual reflect changes made to Wellcare's policies and procedures. As policies and procedures change, updates will be issued by Wellcare in the form of Provider Bulletins and will be incorporated into subsequent versions of this Manual. 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. For material changes, Wellcare will send a formal notice in accordance with the terms of the Agreement. Wellcare may release Provider Bulletins that may override the policies and procedures in this Manual.

Wellcare By ‘Ohana Medicare Advantage

As a Medicare Advantage (MA) managed care organization, coverage includes all of the benefits traditionally covered by Medicare plus added benefits identified in the Benefit Plans 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 benefits
- Preventive care from participating Providers with no copayment

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

Wellcare By ‘Ohana Product

Wellcare’s product is designed to offer enhanced benefits to its Members as well as cost-sharing alternatives. Wellcare’s product is offered in selected markets to allow flexibility and offer a distinct set of benefits to fit Member needs in each area. Please refer to the website at **www.wellcare.com/Hawaii** for more information. Below is a list of the MA products that may change from time to time as Wellcare obtains a license to issue benefits plans under a government contract.

Dual-Eligible Special Needs Plans (DSNP) – A special type of plan that provides more focused healthcare for people who have Medicare and are also entitled to assistance from Medicaid. Like all Medicare Advantage plans, this plan is approved by CMS. It also has a contract with the state Medicaid program to coordinate Medicaid benefits. All services must be provided within the network unless an emergency or urgent need for care arises, or such service is not available in-network. Some services require prior authorization by Wellcare or its designee.

Customer Service Online Tools for Providers

Wellcare offers technology options to save Providers time using the secure web portal, Chat and IVR (Interactive Voice Response System) self-service tools. These self-service tools help Providers do business with Wellcare. We want your interactions with us to be easy, convenient and efficient. Giving Providers and their staff self-service tools and access is a way for us to accomplish this goal. Providers can access this information below or at **wellcare.com/Hawaii**.

Interactive Voice Response (IVR) System

IVR system

- Technology to expedite Provider verification and authentication within the IVR
- Provider/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, allowing Providers to speak their information or 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 is now available through self-service

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 posted at **wellcare.com/Hawaii/Providers/Medicare**.
Providers may contact the appropriate departments at Wellcare by referring to the *Quick Reference Guide* at **wellcare.com/Hawaii/Providers/Medicare**.

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

Website Resources

On Wellcare's website **wellcare.com/Hawaii.** Providers have access to a variety of easy-to-use tools created to streamline day-to-day administrative tasks with Wellcare. Public resources found on the website include:

- Provider Manuals;
- Quick Reference Guides;
- Clinical Practice Guidelines (CPGs);
- Clinical Policies [Clinical Coverage Guidelines (CCGs)]
- Forms and Documents;
- Pharmacy and Provider Lookup (Directories);
- Newsletters and Provider Bulletins;
- Training Materials and Job Aids;
- Member Rights and Responsibilities; and
- Privacy Statement and Notice of Privacy Practices.

Registration is required to use certain key features outlined below.

Using Chat: Get to Know the Benefits of Chat

Faster than email and easier than phone calls, Chat is a convenient way to ask simple questions and receive real-time support. Providers now have the ability to use our Chat application instead of calling and speaking with agents. Here are some ways our Chat support can help you and your staff: multi-session functionality; web support assistance; and real-time claim adjustments.

- **Convenience**
  Live Chat offers the convenience of getting help and answers without having to have a phone call.
- **No Waiting on Hold**
- **Documentation of Interaction**
  Chat logs provide transparency and proof of contact. When Providers engage with Customer Support via phone, they don't typically receive a recording of the verbal

conversation. Live Chat software gives you the option of receiving a transcription of the conversation afterward.

You can access Chat through the 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.

Secure Provider Portal: Key Features and Benefits of Creating an Account

Wellcare's secure, online provider portal provides immediate access to what Providers need most. Providers who create an account can use the following features:

- **Claims Submission Status and Inquiry –** Providers can submit a claim, check status, appeal or dispute claims, and download reports;
- **Member Eligibility, Copay Information and More –** Verify Member eligibility, copays, benefit information, demographic information, care gaps, visit history and more;
- **Authorization Requests –** Providers may submit authorization requests online, attach clinical documentation, check authorization status and submit appeals. Providers may also print and/or save copies of the authorization form;
- **Pharmacy Services and Utilization –** View and download a copy of Wellcare's preferred drug list (PDL), see drug recalls, access pharmacy utilization reports, and obtain information about Wellcare pharmacy services;
- **Secure Inbox –** An inbox to receive general messages from the health plan; and
- **Provider Training –** View the latest available training for Providers, and submit attestations.

Provider Registration Advantage

The secure, online Wellcare provider portal allows Providers to have one username and password and be affiliated with multiple Providers/offices. Administrators can easily manage

users and permissions. Once registered for Wellcare's portal, Providers should retain username and password information for future reference.

How to Register

To create an account, please refer to the *Provider Resource Guide* at **wellcare.com/Hawaii/Providers/Medicare**. For more information about Wellcare's web capabilities, please call Customer Service or contact a Provider Relations Representative to schedule a website in-service training.

Additional Resources

The *Wellcare Provider Resource Guide* contains information about Wellcare's secure online provider portal, Member eligibility, authorizations, filing paper and electronic claims, appeals and more. For more specific instructions on how to complete day-to-day administrative tasks, please see the *Wellcare Provider Resource Guide* at **wellcare.com/Hawaii/Providers/Medicare.**

Another valuable resource is the *Quick Reference Guide,* which contains important addresses, phone/fax numbers and authorization requirements. Providers can find the *Quick Reference Guide* at **wellcare.com/Hawaii/Providers/Medicare.**

Provider Services Phone Numbers and Other Key Contacts

Provider Services toll-free number	**1-888-505-1201**
Secure Provider Portal	**provider.wellcare.com**
PaySpan Health Support	Email: **providersupport@payspanhealth.com** **1-877-331-7154** **payspanhealth.com**
Overpayment Recovery	Wellcare Health Plans Recovery Department P.O. Box 31584 Tampa, FL 33631-3584

Ethics and Compliance Hotline	**1-800-345-1642**
Specialty Pharmacy AcariaHealth Pharmacy #26, Inc.	8715 Henderson Rd. Tampa, FL 33634 Phone: **1-866-458-9246** (TTY **1-855-516-5636**) Fax: **1-866-458-9245** **acariahealth.com**
For more information on contacting Provider Services, refer to the *Quick Reference Guide* at **wellcare.com/Hawaii/Providers/Medicare.**	

Authorizations At-A-Glance

Authorization Look-Up Tool	**wellcare.com/Hawaii/Providers/Authorization-Lookup**
Authorization Requests	• Submit to the secure provider portal at **provider.wellcare.com/** (fastest option) • 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 Quick Reference Guide at **wellcare.com/Hawaii/Providers/Medicare**
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 **wellcare.com/Hawaii/Providers/Medicare/Pharmacy**.

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, they will still need to know how to file claims and understand any policies and procedures that may affect them 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 **wellcare.com/Hawaii/Providers/Non-Ohana-Providers**.

Section 2: Provider Administrative Guidelines

Provider Administrative Overview

In accordance with generally accepted professional standards, participating Medicare 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 [42 C.F.R. § 422.504(a)(3)(iii)]
- Use physician extenders appropriately. Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNPs) shall provide direct Member care within the scope or 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 shall 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 in order 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* and *Section 11: Compliance and Regulatory Requirements*
- Allow Wellcare to use Provider performance data for Quality Improvement activities
- Cooperate with Quality Improvement activities
- Ensure that:
    - All employed physicians and other healthcare practitioners and Providers comply with the terms and conditions of the Agreement

    - To the extent the physician maintains written agreements with employed physicians and other healthcare practitioners and Providers, such agreements contain similar provisions to the Agreement
    - To the extent the physician maintains written agreements with contracted physicians or other healthcare practitioners and Providers, such agreements contain similar provisions to the Agreement
- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene
- Communicate timely clinical information between Providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to Wellcare, the Member, or the requesting party at no charge, unless otherwise agreed upon
- 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 non-Wellcare MA Members
- Ensure that the hours of operation offered to Wellcare Members is no less than those offered to commercial Members
- 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

- Must document the referral to Wellcare-sponsored or community-based programs in the Member's medical record and provide the appropriate follow-up to ensure the Member accessed the services

Responsibilities of All Providers

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

Marketing Medicare Advantage Plans

MA 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 certain MA Member Benefit Plans, Member expenses are limited by a maximum out-of-pocket (MOOP) amount. If a Member has reached the MOOP amount for that particular Member's Benefit Plan, a Provider should not collect any additional out-of- pocket amounts from the Member 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 provider portal or by contacting Wellcare's Customer Service Department. If a Provider collects an out-of-pocket amount that causes a Member to exceed their MOOP, Wellcare will notify that Provider of the amount that was collected in excess of the MOOP. Upon notice, the Provider shall promptly reimburse the Member such amount.

If Wellcare determines that the Provider did not reimburse the amount in excess of MOOP to the Member, Wellcare may pay the excess amount due to the Member directly, and recoup the amount from the Provider. If Wellcare has deducted any Member expenses from the Provider's reimbursement in excess of the Member's MOOP amount, Wellcare will reimburse the Provider for the excess amount deducted to the extent that Wellcare will not have to repay the Member such amount.

Wellcare may audit the Provider's compliance with this section and may require the Provider to submit documentation to Wellcare supporting that the Provider reimbursed Members for amounts in excess of the MOOP amounts.

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

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 (30-day advance notice is recommended) for any of the following changes. Please contact Wellcare at **1-888-505-1201** to report changes to:

- 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

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

Provider Termination

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

- Any contracted Provider must give at least 90 days prior written notice (180 days for 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. Please refer to the Agreement for the details regarding the specific required days for

providing termination notice, as Providers may be required by contract to give more notice than listed above.
- Unless otherwise provided in the termination notice or in the Agreement, the effective date of a termination will be on the last day of the month.

Wellcare follows all applicable laws, regulations and regulatory guidance if it decides to terminate its contract with a Provider.

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 assist Wellcare in arranging and accepting the transfer of Members receiving care out of the service area if the transfer is considered medically acceptable by a Wellcare Provider and the out-of-network attending physician/Provider.

Members with Special Healthcare Needs

Members with special healthcare needs have one or more of the following conditions:
- Physical or developmental disabilities
- Multiple chronic conditions
- Severe mental illness
- Intellectual disabilities 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
- Children and adults with certain 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 a plan of care that adheres 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 ensure Members can obtain needed clinical services within acceptable appointment, in-office waiting times, and after-hours standards. Providers not in compliance with these standards will be required to implement corrective actions.

Type of Appointment	Access Standard
PCP – Urgent	≤ 24 hours
PCP – Non-urgent	≤ 1 week
PCP – Regular and Routine	≤ 30 calendar days
PCP – After-hours Care	24 hours per day, 7 days per week
All Specialists (including High Volume and High Impact) – Urgent	≤ 24 hours
All Specialists (including High Volume and High Impact) – Regular and Routine	≤ 30 calendar days
Behavioral health Provider – Urgent Care	≤ 48 hours
Behavioral health Provider – Initial Routine Care	≤ 10 business days
Behavioral health Provider – Non-Life Threatening Emergency	≤ 6 hours
Behavioral health Provider – Routine Care follow up	≤10 business days

In-office wait times for all standards shall not exceed 15 minutes.

Telephone Arrangements

PCPs must provide or arrange for coverage of services, consultation, or approval for referrals 24 hours per day, 7 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

Please see *Section 14: Behavioral Health* for behavioral health and substance use access standards.

Responsibilities of Primary Care Providers

All MA Members will choose a PCP or one will be assigned to the Member. The following is a summary of responsibilities specific to PCPs who render services to Wellcare Members:

- Coordinate, monitor and supervise the delivery of primary care services to each Member
- See Members for an initial office visit and assessment within the first 90 days of enrollment in Wellcare
- Ensure Members are aware of the availability of public transportation, where applicable
- Provide Wellcare or its designee with access to examine thoroughly the primary care offices, books, records and operations of any "related organization or entity". A related organization or entity is defined as an organization or entity having influence, ownership or control of the Provider and either a financial relationship or a relationship for rendering services to the primary care office
- Submit an encounter to Wellcare for each visit where the Provider sees the Member or the Member receives a Healthcare Effectiveness Data and Information Set (HEDIS®) service[1]. For more information on encounters, refer to *Section 7: Claims and Encounters* in this Manual
- Ensure Members use network Providers. If unable to find an Wellcare-participating Medicare Advantage Provider for services required, call the Clinical Services Department phone number listed on the *Quick Reference Guide* for assistance
- Comply with and participate in corrective action and performance improvement plan(s)

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

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 Wellcare resources:

- Support of Wellcare's Provider Relations, Customer Service, Clinical Services, Marketing and Sales Departments
- The tools and resources available at **wellcare.com/Hawaii/Providers**
- 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 and/or transferring Wellcare Members, PCPs must:

- Submit the request in writing at least 60 days (or such other period of time provided in the Agreement) prior to the effective date of closing the panel
- Maintain the panel to all Wellcare Members who were provided services before the closing of the panel
- Contact Wellcare at **1-888-505-1201** or your Provider Relations Representative

Covering Physicians/Providers

In the event that participating Providers are temporarily unavailable to provide care or referral services to Members, Providers should make arrangements with another Medicare Advantage Wellcare-contracted and credentialed Provider to provide services on their behalf, unless there is an emergency.

Covering Providers should be credentialed by Wellcare and are required to sign an agreement accepting the negotiated rate and agreeing to not balance bill Members. For additional information, please refer to *Section 8: Credentialing*.

In non-emergency cases, should a Provider have a covering physician/Provider who is not contracted and credentialed with Wellcare, contact Wellcare for approval. For more information, refer to the *Quick Reference Guide* at **wellcare.com/Hawaii/Providers/Medicare**.

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

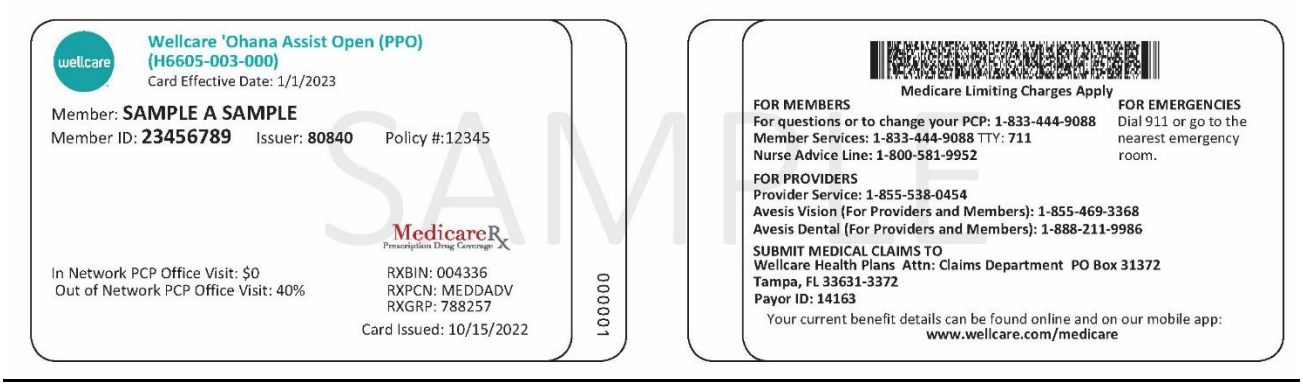
such as a photo ID (if applicable) at each encounter. If there are any discrepancies between the Member's ID card and/or the Provider's eligibility report, Providers should contact Provider Services at: **1-888-505-1201 (TTY: 711).**

Providers may do one of the following to verify eligibility:

- Access the provider portal at **provider.wellcare.com**
- Access Wellcare's Interactive Voice Response (IVR) system
- Contact Wellcare's Customer Service Department

Providers will need their Provider ID number to access Member eligibility through the channels listed above. Verification is always based on the data available at the time of the request, and since subsequent changes in eligibility may not yet be available, verification of eligibility is not a guarantee of coverage or payment. See the Agreement for additional details.

Sample Member ID Card



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

Wellcare provides Special Supplemental Benefits for Chronically Ill (SSBCI) to our highest-risk Members who meet specific criteria for eligibility based on CMS guidelines.

To determine eligibility, Members are required to schedule an office visit with their Provider for evaluation. As part of that visit, we ask that you:

1. Evaluate your patient against the required criteria below. All criteria must be met and the completed attestation form must be received before the patient will receive access to benefits.
    a. Criteria include:
        i. A need for intensive Care Management

1. Patient has had two or more inpatient admissions in the last 60 days, OR patient has had three or more emergency room visits in the last 60 days.

ii. <u>A high risk for hospitalization</u>

1. Patient must be at high risk for unplanned hospitalization (inpatient and/or emergency room visits) in the next 60 days.

iii. <u>Currently diagnosed with one or more qualifying chronic conditions</u>

1. Patient must have an active diagnosis for one or more of the qualifying co-morbid and medically complex conditions. The condition must be life threatening or significantly limit the overall health or function of your patient.

2. Submit an attestation form (via the website linked on the Provider forms page: **wellcare.com/Hawaii/Providers/Medicare/Forms**) indicating if your patient currently meets the criteria.
3. Submit a claim containing the appropriate ICD-10 codes from this office visit indicating a Member has been diagnosed with one or more qualifying chronic conditions.

After we receive and validate all criteria are met, an approval *or* denial letter will be sent to the Member to let them know if they meet the criteria and how to activate the Member benefits.

Termination of a Member

A Wellcare Provider may not seek or request to terminate their relationship with a Member or transfer a Member to another Provider of care, based upon 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. In the event that a participating Provider desires to terminate their relationship with a Member, the Provider should submit a *PCP Request for Transfer of Member* form available at **wellcare.com/Hawaii/Providers/Medicare/Forms** along with adequate documentation establishing that, although they have has attempted to maintain a satisfactory Provider and Member relationship, the Member's non-compliance with treatment or uncooperative behavior is impairing the ability to care for and treat the Member effectively. The Provider should adequately document in the Member's medical record evidence to support their efforts to develop and maintain a satisfactory Provider and Member relationship. Until such time that written notification is received from Wellcare stating, *"The Member has been transferred from*

the Provider's practice, and such transfer has occurred. The Provider shall continue to provide medical care for the Medical in accordance with all applicable standards."

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 regards 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 **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.

Adult Health Screening

An adult health screening should be performed by a Provider 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 **wellcare.com/Hawaii/Providers/Medicare/Quality**.

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 as well as their rights and responsibilities. Wellcare will convey this information through various methods including an *Evidence of Coverage* booklet.

Evidence of Coverage Booklet

All Wellcare Members receive 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

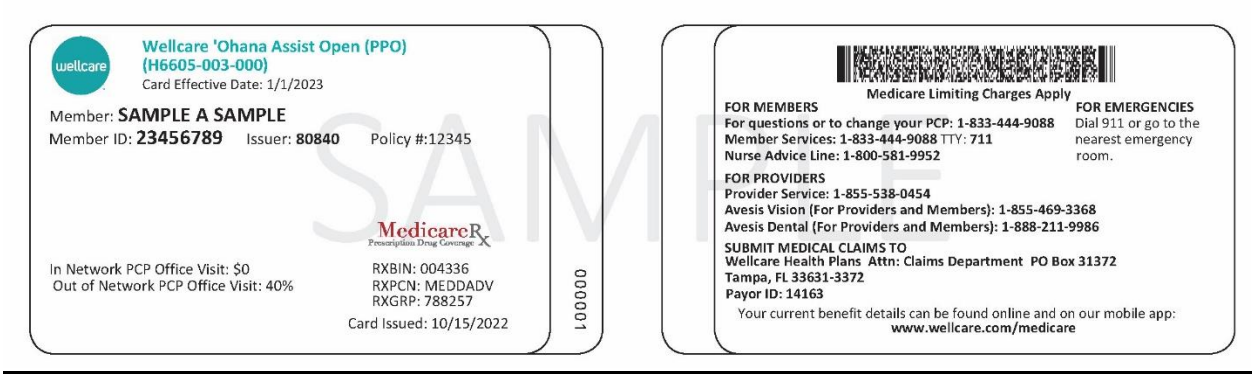
Wellcare will comply with laws that protect persons from discrimination or unfair treatment. Wellcare does not discriminate based on a person's race, disability, religion, sex, gender expression or gender identity, military or veteran status, health, ethnicity, creed, age, or national origin.

Upon enrollment with Wellcare, Members are provided with the following:

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

Member Identification Cards

Member identification cards are intended to identify Wellcare Members, the type of plan they have and facilitate their interactions with healthcare Providers. Information found on the Member ID card may include the Member's name, ID number, plan type, PCP's name and telephone number, local market contact information, and claims filing address. Possession of the Member ID card does not guarantee eligibility or coverage. Providers are responsible for ascertaining the current eligibility of the cardholder.



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* (EOC) booklet and are outlined below.

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 their 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 affect the way they are treated
- Appeal medical or administrative decisions Wellcare has made by using the grievance 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 doctors 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 doctor'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 EOC booklet
- Inform Wellcare if they move
- Inform Wellcare of any questions, concerns, problems or suggestions by calling the Customer Service Department listed in their EOC booklet

Changing Primary Care Providers

Members may change their PCP selection at any time by calling Wellcare's Customer Service Department.

Women's Health Specialists

PCPs may also provide routine and preventive healthcare services that are specific to Members. If a Member selects a PCP who does not provide these services, they have 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, Deaf, Interpreter and Sign Language Services

Hard-of-hearing, deaf, interpreter and sign language services are available to Wellcare Members through Customer Service. PCPs should coordinate these services for Members and contact Customer Service if assistance is needed. Please refer to the *Quick Reference Guide* for the Customer Service telephone numbers.

Section 4: Quality Improvement

Overview

The 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 Dual 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 disease and care management, chronic care improvement program, preventive and clinical health)
- Coordination/Continuity of Care
- Practitioner Availability and Accessibility
- Preventive and clinical health
- Quality of care and service utilization
- Cultural Competency
- Credentialing
- Patient Safety and Quality of Care
- Appeals/Grievances/Complaints
- Member Experience
- Provider Experience
- Components of operational service
- Contractual, regulatory and accreditation reporting requirements
- Pharmacy

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 Wellcare's QI programs. Practitioner and Provider contracts, or contract addenda, also require that Practitioners and Providers allow Wellcare the use of their performance data for quality improvement activities.

The QI Program reflects a continuous quality improvement (CQI) philosophy and mode of action. CQI processes identified in the QI Program Description, Work Plan and Annual Evaluation are approved by the applicable Committees and conducted to accomplish identified goals. The QI Program Description defines program structure, accountabilities, scope, responsibilities, and available resources.

The annual QI Work Plan identifies specific activities and initiatives to be undertaken by Wellcare and the performance measures to be evaluated throughout the year. Work Plan activities align with contractual, accreditation and/or regulatory requirements and identify measurements to accomplish goals.

The Annual Quality Improvement 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 prior years trending as appropriate. A copy of the Annual Quality Improvement and Utilization Management Program Evaluation contact: **AccreditationMedicareOperations@centene.com**. The Annual 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 Quality Improvement and Utilization Management Committee (QIUMC)

Each QI process is continually improved by analyzing and acting to achieve consistency across the enterprise, thus becoming more efficient and effective. The Plan-Do-Study-Act (PDSA) method of CQI is used throughout the organization. Under the PDSA approach, multiple indicators of quality of care and service are reviewed and analyzed against benchmarks of quality clinical care and service delivery. When variations are noted, root cause analysis, action plans and re-measurement occur to ensure progress toward established goals.

The CQI strategy noted above is demonstrated in the structure of the QI Program's committees and sub-committees, the QI Program Description, Work Plan and Annual Evaluation. The strategy incorporates the continuous tracking and trending of quality indicators to help ensure outcomes are being measured and goals are attained. Monitoring of quality of care interventions and outcomes through HEDIS® performance measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2] surveys, while also using current knowledge and clinical experience to monitor external quality review studies, periodic medical record reviews, clinical management and quality initiatives. Previously identified issues Action Plans are issued annually based on performance on each measure within the work plan.

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

Key Program Functions, Activities and Initiatives

Wellcare is continuously assessing data and information to improve the level of care provided to their Members. Some of the programs/initiatives in place include, but are not limited to:

- Access/Availability Monitoring
- Appeals/Concerns/Complaints/Grievances
- Member Experience
- Provider Experience
- Behavioral Health Services
- Utilization Management
- Population Health Management including: care and disease management Model of Care
- Patient Safety
- Continuity and Coordination of Care
- Clinical Indicators and Initiatives
- Credentialing and Peer Review
- Pharmacy and Therapeutics
- Preventive and Clinical Health Guidelines
- Delegation
- Cultural Competency

Access/Availability Monitoring

Wellcare monitors geographic access through the production of GeoAccess reports and maps. Reports are generated using the specific access standards per regulatory agencies and/or accrediting bodies to help achieve compliance and meeting of Members' needs.

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/or 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.

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

For purposes of Network Adequacy, audits are performed by a contracted vendor on a semi-annual basis to help ensure Members can access Providers within those specific appointment availability timeframes. A review and validation of the survey results received from the vendor is completed to help achieve accuracy and to resolve any outstanding questions/issues. Communication is mailed to Providers who are non-compliant requesting a written response with a corrective action plan or dispute of any non-compliance issues.

In addition, average speed of answer, hold times 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 Quality Improvement and Utilization Management Committee (QIUMC) on a semiannual basis.

Appeals/Concerns/Complaints/Grievances

Appeals and Grievance activities are reported to the Customer Service Quality Improvement Workgroup (CSQIW), and the Quality Improvement and Utilization Management Committee (QIUMC).

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

- To resolve 95% of complaints within compliance and/or accreditation timeframes
- Improve quality of data to facilitate reporting, tracking and trending, and analysis
- Achieve acceptable scores on accreditation, internal, and external audits
- Reduce the volume of unnecessary 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 are reviewed on a periodic basis to determine if a need for further action exists, be it Wellcare 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 Quality Improvement and Utilization Management Committee (QIUMC) a quarterly basis.

Member Experience

Wellcare uses information regarding Member experiences as a way to measure Member satisfaction with 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.

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

Wellcare contracts with a National Committee for Quality Assurance (NCQA) -certified survey vendor to conduct the CAHPS on an annual basis. The survey vendor uses the NCQA-required survey techniques and follows the specifications as required by NCQA and CMS. Wellcare works with the survey vendor to ensure the data are collected timely and appropriately. The results are then sent to CMS via the survey vendor who in turn reports the information to Wellcare. CAHPS results are presented to the Quality Improvement Committee and in turn given to the UMC for review by the external providers.

Please refer to Section 5: Medicare Star Rating for additional information regarding CAHPS.

Provider Experience

An ongoing analysis of Provider complaints is conducted to evaluate Provider satisfaction. In addition, the Provider network is formally surveyed by a certified vendor on an annual basis to assess Provider satisfaction with Wellcare. Wellcare expects Providers to cooperate and participate in this survey process. Results from the survey are analyzed; an action plan is developed and implemented to address the areas identified as needing improvement. The results and action plan are presented to the 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 Clinical Services Organization Health model and are incorporated into the overall care management model program description.

Special populations such as SMI (seriously mentally ill) adults may require additional services and attention that 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 Member back into community. This includes coordination to implement or access services with Network behavioral health Providers or Community Mental Health Clinics (CMHCs);

- Targeted case 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 that of our Utilization and Care Management Programs. It is 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 multi-disciplinary, 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 Wellcare 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 subpopulations
- 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 limited English proficiency
- Stratify Members into programs that fall in one of the following focus areas:
    - Keeping Members Healthy
    - Managing Members with Emerging Risk
    - Patient Safety or Outcomes Across Settings
    - Managing Multiple Chronic Illnesses
- Review and update PHM activities to address Member needs
- Review and update PHM resources to address Member needs

- Review and update activities or resources to address health care disparities for at least one identified population
- Review community resources for integration into program offerings to address Member needs

Annually, Wellcare:

- Completes a Population Assessment
- Uses the Population Assessment to update the Population Health Strategy
- Measures the effectiveness of its PHM programs for each focus area

The population assessments for each market are presented to the 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.

Model of Care

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:

- Complete an annual population assessment to identify the needs of the population and subpopulations so Care Management processes and resources can be updated to address Member needs. Promotion of preventive health services and the management of chronic diseases through Disease Management Programs that encourage the use of services to decrease future morbidity and mortality in Members.
- Conduct comprehensive assessments that identify Member needs and barriers to care.
- Coordinating transitions of care for Members with complex and special needs to assist navigating the complex healthcare system and accessing Provider, public and private community-based resources.
- Improve access to primary and specialty care ensuring that Members with complex health conditions receive appropriate services.
- Consult with appropriate specialized healthcare personnel when needed such as medical directors, pharmacists, social workers, behavioral health professionals, etc.
- Ensure that Members' socioeconomic barriers are addressed

The Model of Care program effectiveness 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 implemented for goal attainment, and reports 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 the SNP plan to evaluate and measure the quality of care, quality outcomes, service, and access for Members. For each metric, benchmarks have been established based on evidence-based medicine found by current literature, standards, and guidelines. A 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 will be reported to the QIUMC for review, feedback, and approval.

Patient Safety and Quality of Care

Wellcare Quality Improvement program includes an emphasis on patient safety and quality of care. The goals of incorporating Patient Safety into Wellcare's QI Program are to:

- Promote patient safety as an integral component of healthcare delivery
- Reduce Member instances of potential quality issues that put patient safety at risk

Wellcare's objectives of focusing on Patient Safety are to:

- Inform Providers regarding Wellcare's progress toward patient safety initiatives
- Encourage the practitioner and Provider community to adopt processes to improve safe clinical practices
- Promote Members to be participants in the delivery of their own safe healthcare
- Communicate patient safety best practices

The scope of the Patient Safety Plan encompasses review of medical and pharmaceutical care and also administrative issues, such as Provider and patient interactions. The source of data to monitor aspects of patient safety could encompass but is 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 under- and over-utilization
- Care and Disease Management program participation
- Pharmaceutical management practices
- Member communication; and
- Provider/practitioner actions to improve patient safety.

All Member demographic groups, care settings and types of services are included in Patient Safety activities.

Continuity and Coordination of Care

Wellcare, in accordance with federal and state regulations, ensures that its Members' care is directed and coordinated by a Primary Care Physician (PCP). The Company also complies with Centers for Medicare and Medicaid (CMS) requirements, applicable federal and state regulations, and state specific Medicaid contracts regarding partnership with Wellcare's Providers in coordinating appropriate services for Members requiring continuity and coordination of care. Wellcare is responsible for the management, continuity and coordination between medical and behavioral healthcare for all Members.

Wellcare's activities encourage the PCP relationship to be the Member's Provider "home." This strategy promotes one Provider having comprehensive knowledge of the Member's healthcare needs, whether it is disease or preventive care in nature. Through contractual language and Program components, PCPs are educated regarding their responsibilities.

With coordination of care, healthcare interventions can be more consistent with an individual's overall physical and/or behavioral health. There becomes fewer opportunities for negative medication interactions, side effects, complications, and polypharmacy. It promotes patient-centered care, improves a Member's overall physical and mental well-being, decreases hospitalizations and ensures an appropriate and smooth transition of care. Effective coordination of care depends on clear and timely communication among the PCP, specialist, behavioral health practitioners and facilities. Effective communication allows for better decision making regarding treatment interventions, decreases the potential for fragmentation of treatment and improves Member health outcomes.

Coordination of care is a continual quality process that requires ongoing monitoring and evaluation in the delivery of high-quality, high-value, patient-centered care to Members. Wellcare uses a variety of mechanisms to monitor continuity and coordination of care. Wellcare works collaboratively with medical and behavioral health practitioners to monitor and improve coordination between medical and behavioral healthcare. The metrics chosen to identify areas that contribute to continuity and coordination of care include, but are not limited to:

Specific Area Monitored	Description of Monitor	Frequency
Movement between practitioners	HEDIS – Comprehensive Diabetes Care – Retinal Eye Exam (EED)	Annual
Movement between practitioners	HEDIS- UOP- Use of Opioids Multiple Prescribers, Multiple Pharmacies	Annual
Movement between settings	HEDIS FMC- Follow Up after Emergency department Visit for People with High Risk Multiple Chronic Conditions.	Annual
Movement between settings	HEDIS – Medication Reconciliation Post-Discharge (MRP)	Annual
Exchange of Information	Provider Satisfaction Survey – Receipt of Feedback/Reports and Sending Feedback Reports to and from Behavioral Health Clinicians for Mutual Patients as well as their timeliness.	Annual
Appropriate Diagnosis, Treatment, and Referral of Behavioral Disorders Commonly Seen in Primary Care	HEDIS – Antidepressant Medication Management – Acute Phase (AMM)	Annual
Appropriate Use of Psychotropic Medications	HEDIS – Potentially Harmful Drug-Disease Interactions in the Elderly – Dementia + Prescription of Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine Hypnotics, or Anticholinergic Agents (DDE)	Annual
Management of Treatment Access and Follow-Up for Enrollees with Coexisting Disorders	HEDIS – Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	Annual
Primary or Secondary Preventive Behavioral Healthcare Program Implementation	Depression Screening for Members with a Chronic Health Condition	Annual

Specific Area Monitored	Description of Monitor	Frequency
Special Needs of Members with Severe and Persistent Mental Illness	HEDIS – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)	Annual

The National Continuity and Coordination of Care Steering Committee is comprised of medical directors from medical and behavioral health arenas and corporate leadership from Quality, Utilization Management, Care Management, and Population Health Solutions. The Steering Committee reviews and analyzes data and guides the National Continuity and Coordination of Care Work Group in identifying barriers to adequate continuity and coordination of care and markets that have successfully implemented interventions to overcome such barriers.

The mission of the Continuity and Coordination of Care Steering Committee and Work Group is to ensure that Wellcare continues to serve Members by establishing high quality programs and processes that enable proper coordination of care between medical and behavioral health Providers. The vision of the group is to establish and maintain a position as a leader in government-sponsored healthcare programs through organizational collaboration with primary care and behavioral health practitioners to improve coordination of integrated healthcare. The work group encourages the monitoring of Member experience to ensure desired health outcomes for our Members.

Preventive Health and Clinical Practice Guidelines

Wellcare uses Clinical Practice Guidelines (CPGs) to help Providers and Members make decisions about appropriate healthcare for specific clinical circumstances and behavioral health services. The CPG Grid is reviewed at least annually or upon significant new scientific evidence or changes in national standards.

To provide consistent quality healthcare to Members, Wellcare adopts CPGs. While clinical judgment may supersede the CPGs, the guidelines aid Providers by focusing on procedures, pre-appraised resources and informational tools to assist in applying 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.

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., Clinical Policy Committee, QI Behavioral Health Clinical Policy Subcommittee, Plan Quality Committee, etc.); or
- Consideration of comments from practitioners to whom guidelines were circulated.

When there are differing opinions noted by national organizations, Wellcare defaults 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 Clinical Policy Committee is consulted for assistance in guideline sourcing or development.

The CPG Grid is posted at **wellcare.com/Hawaii/Providers/Clinical-Guidelines/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

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 focus of the review may include, without limitation, patient safety issues, clinical and/or preventive guideline compliance, over- and under-utilization of services, confidentiality practices and inclusion of consideration of Member input into treatment plan decisions. The review process allows for identification of the Provider's level of compliance with contractual, accreditation, and regulatory standards achieved. Provider training is conducted as needed to facilitate greater compliance in assessments. Providers are expected to cooperate with Wellcare in allowing access to, and review of, medical records for all QI activities requested.

Cultural Competency

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

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

Wellcare is committed to the development, strengthening, and sustaining of healthy Provider/Member relationships. Members are entitled to dignified, appropriate care. Provider services should meet the unique needs of every enrollee regardless of race, ethnicity, culture, language proficiency, or disability. In all interactions, providers are expected to act in a manner that is sensitive to the ways in which the 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 services
    - To support informing members of their right to access free language services, it is recommended that providers post nondiscrimination notices and language assistance taglines in lobbies and on websites. Language assistance taglines notify individuals of the availability of language assistance for the top 15 languages utilized in the state as identified by Section 1557 of the ACA, and include at least one tagline in 18 point font.
- Provide medical care with consideration of the members' primary language, race ethnicity and culture;

- Participate in cultural competency training annually and ensure that office staff routinely interacting 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, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, gender identity, 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, religion, age, national origin ancestry, marital status, sexual orientation, health status, income status, program membership, physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- denying a member a covered service or availability of a facility; and
- 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 Wellcare By 'Ohana Health Plan's 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: **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**.
- The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) website at: **hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy.** Providers can find free online courses on topics such as addressing health literacy, cultural competency and limited English proficiency.

Cultural Competency Survey

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

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

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

To obtain language services for a member, contact Wellcare Provider Services. Face-to-face and American Sign Language services should be requested as soon as possible, or at least 5 business days before the appointment. All providers (Medical, Behavioral, Pharmacy, etc.) can request language services by calling our Provider Customer Contact Center or (TDD/TTY 711).

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, contact Wellcare at **1-888-505-1201** (TDD/TTY: 711), or your Provider Relations Representative.

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:

- Exclusion from participation in the benefits of services, programs or activities of a public entity.
- Denial of the benefits of services, programs or activities of a public entity.

- 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 one hundred eighty (180) days after Wellcare has identified the barrier.

Providers are also required to:

- Provide Interpretation Services in all languages, including American and Mexican 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 a day seven days a week; or through other formats, such as real-time captioning or augmentative & 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 not be 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 & 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, 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.

Call your 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	A 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 you happen to not have a disability at this time in your life, that DOES NOT make you "normal" or "able-bodied". It makes you "non-disabled."

For more information, contact Wellcare at **1-888-505-1201** (TDD/TTY: 711), or your Provider Relations Representative.

The term "disability" means, with respect to an individual. Disability is any substantial limitation of one or more of a person's daily life activities and 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 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 referred location is not accessible and/or not prepared to provide the recommended service

<u>Provider Accessibility Initiative</u>

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 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.

Pharmacy and Therapeutics

Wellcare provides access to quality, cost-effective medications for eligible Members 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, evaluate for patient safety and adjudicate the claim with the appropriate pharmacy Provider payment. Network contracting and the adjudication of pharmacy claims are managed by a pharmacy benefit manager (PBM), CVS Caremark. Wellcare has oversight of the PBM for these functions. Pharmacy provides a prescription drug formulary that is created and modified through the CVS Caremark Pharmacy and Therapeutics (P&T) Committee. Pharmacy reviews and responds to all drug exception requests or coverage determinations (DERs) and medication appeals (redeterminations) through a formalized process that uses the drug formulary, prior authorization protocols and prescriber supplied documentation. Pharmacy 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 of Members through Medication Therapy Management (MTM) services as well as quality initiatives that include, but are not limited to, Member and prescriber outreach and coordinated efforts with Quality Improvement Organizations (QIOs).

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 following provisions shall apply in the event that 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 which Wellcare discovers the recall.

6. For Class 2 Recalls, Members and authorized prescribers shall be notified within 30 calendar days of the date which Wellcare discovers 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

The purpose of the Chronic Care Improvement Program (CCIP) is to facilitate improvement in the quality of care and quality of life of Wellcare's medically compromised Members by coordinating care and benefits across the continuum of care, fostering adherence to a plan of care, disease education, and advocacy. The program is designed to meet the Member's healthcare needs and improve outcomes in a cost-effective process. Wellcare care management services focus on the Member as a whole to include their complex medical, behavioral health and socioeconomic needs to achieve optimal outcomes. Medicare Members usually have multiple and complex medical needs that require frequent and/or costly treatment. Population-specific chronic illnesses addressed in the Wellcare CCIP include diabetes in the Medicare population. All Medicare Members are outreached and encouraged to participate in the Care Management program.

The methodology to identify Members appropriate for the CCIP includes but is not limited to: review of data captured in the initial and subsequent annual Health Risk Assessment (HRA), referrals from Providers, discharge planners, UM, and other healthcare entities, Member self-referral and claims and encounter data mining using an internally developed algorithm.

The program uses evidence-based guidelines, care management assessments/re-assessments, and Member specific goals with the objective to improve Member outcomes. Evaluation of program effectiveness includes satisfaction survey results, measurement/ assessment and improvement of established performance measures and health outcomes.

When a Medicare Member enrolls with Wellcare, an initial comprehensive HRA is completed within the first 90 days of enrollment to capture needed information. A secondary assessment

is conducted to gather additional needed information. The completed HRA information, as well as the secondary assessment, is used to develop the Member care plan. A plan of care is completed with the Member and shared with the PCP, specialists (if any exist), and other Members of the Interdisciplinary Care Team (ICT).

For Members identified as part of the CCIP, a care plan is developed and collaboratively agreed upon with the Member (when feasible) and the ICT. A follow-up schedule is identified and documented. Disease-/condition-specific education materials and tools for self-management are mailed to the Member as needed.

On follow-up calls the care manager addresses Member progress in meeting the short- and long-term goals established. This is documented in the medical record and any significant health status changes are shared with the ICT.

Medical Records

Providers should maintain medical records that are comprehensive and reflect all aspects of care for each Member. These records are to be stored in a secure location for the period of time required under the Agreement. Documentation in the Member's medical record is to be completed in a timely, legible, current, detailed and organized manner which conforms to good professional medical practice and in accordance with all applicable laws. Records should be maintained in a manner that permits effective, professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment.

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

Medical records must be signed and dated.

Confidentiality of Member information must be maintained at all times. Records are to be stored securely with access granted to authorized personnel only. Access to records should be granted to Wellcare or its representatives without a fee, to the extent permitted by state and

federal law and the applicable provider agreement. Providers should have procedures in place to permit the timely access and submission of medical records to Wellcare upon request.

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, a Member or the Member's representative is entitled to one free copy of their medical record, and additional copies shall be made available to Members upon request and Providers may assess a reasonable cost.

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, and your Agreement with Wellcare.

Diamond Designation™ Program

The health plan evaluates the care provided within 12 different specialty areas with quality emphasized over efficiency. Provider evaluations are determined and reported at a medical practice/group level. The Diamond Designation™ Program is updated annually. Program Year 2022 became effective April of 2022.

Program Specialty Types

Cardiology	Neurology
Counselors	Orthopedic Surgery
Endocrinology	Podiatry
Gastroenterology	Psychiatry
General Surgery	Psychology
Nephrology	Pulmonology

Many primary care Providers want to understand more about the quality and efficiency of specialty physicians and other clinicians. Evaluation results from the Diamond Designation™ Program are made available to primary care Providers as information for them to consider as they make decisions to refer patients to specialty care.

The Diamond Designation™ Program methodology for evaluation is based on national standards and incorporates feedback from physicians and other clinicians. The health plan seeks to produce evaluation results that are as accurate as possible. However, due to the risk of error, the health plan informs primary care Providers that the designation results should not be the sole basis of their decision-making. 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 **wellcare.com/Hawaii/Providers/Medicare/Diamond-Designation-Program**. This site includes a full description of the most current methodology used in determining Program designations 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 **DiamondDesignation@wellcare.com**.

Web Resources

Wellcare periodically updates clinical, coverage, and preventive guidelines as well as other resource documents posted on Wellcare's website. Please check Wellcare's website frequently for the latest news and updated documents at **wellcare.com/Hawaii/Providers.** For a copy of the Medicare Quality and Utilization Management Program Evaluation please email: **AccreditationMedicareOperations@centene.com.**

Section 5: Medicare Star Ratings

Overview

The Centers for Medicare & Medicaid Services (CMS) uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the health care 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, **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 Rating 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 and Changes in the Health Plan's PerformanceHealth plan customer service

Part D

5. Drug Plan Customer Service
6. Member Complaints and Changes in the Drug Plan's Performance
7. Member Experience with the Drug Plan
8. Drug Safety and Accuracy of Drug Pricing

How Can Providers Help to improve Star Ratings?

- Continue to encourage patients to obtain preventive screenings annually or as recommended including but not limited to:
    - Breast and/or Colon Cancer Screening
    - Annual Flu Vaccine

- With respect to patients with chronic conditions, Providers should continue to monitor and assess the well-being of those patients 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 to talk to your patients and document interventions regarding topics such as: improving or maintaining their mental and physical health; issues with bladder control and fall prevention
- Create office practices to identify noncompliant patients at the time of their appointment
- 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; complete post hospitalization medication reconciliation
- Identify opportunities for you or your office to have an 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 utilizes 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 health care industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but 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), and use of Disease Modifying Anti-Rheumatic Drugs for Members with Rheumatoid Arthritis, 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: Comprehensive Diabetes Care (screenings and results including HbA1c, nephropathy, dilated retinal eye exams, and blood pressures), 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 each year. Prompt cooperation with the MRR process is greatly needed and appreciated.

As a reminder, sharing of protected health information (PHI) that is used or disclosed for purposes of treatment, payment or health care 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.
- If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement Department.

Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

The CAHPS survey is a Member satisfaction survey that is included as a part of the Star rating 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
- Appointment availability and appointment wait times
- Whether the Member's personal doctor is informed and up to date on care received from specialist

Wellcare uses information regarding Member experiences as a way 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 rating program. The goal of the Medicare HOS is to gather data to help target quality improvement.

The HOS assesses practitioners and 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 includes:

- 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 patients' 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 5 stars in all domains. The Quality Improvement Committee receives Star rating results annually.

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 Clinical Services Department's review guidelines, Wellcare's adverse determination process, the assessment of new technology, and delegation oversight.

The UM program includes components of prior authorization and 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 for such care.

Wellcare does not reward its associates, practitioners, physicians, or other individuals or entities performing UM activities for rendering denial of coverage, services or care determinations. Wellcare does not provide for financial incentives, encourage or promote under-utilization.

Medically necessary services furnished in a hospital on an inpatient basis are ones that cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a Provider has prescribed, recommended, or approved medical, behavioral or allied health goods or services does not, in itself, make such goods or services medically necessary or a covered service/benefit.

Prior Authorization

Prior authorization allows for efficient use of covered services and ensures that Members receive the most appropriate level of care in the most appropriate setting. Prior authorization may be required to be obtained by the Member's PCP, treating specialist, or facility. Wellcare provides a process in order to make a determination of medical necessity and benefits coverage for inpatient and outpatient services prior to services being rendered. Prior authorization requirements apply to pre-service decisions.

Reasons for requiring Prior Authorization may include:

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

Prior authorization is **required** for elective or non-emergency services as designated by Wellcare. Guidelines for prior authorization requirements by service type may be found on Wellcare's *Quick Reference Guide* at **wellcare.com/Hawaii/Providers/Medicare** via the Authorization Lookup tool at **wellcare.com/Hawaii/Providers/Authorization-Lookup** or by calling Customer Service

Some prior authorization guidelines to note:

- The prior authorization request should include the diagnosis to be treated and the CPT code describing the anticipated procedure. If the procedure performed and billed is different from that on the request but within the same family of services, a revised request is not required.

An authorization may be given for a series of visits or services related to an episode of care. The prior authorization request should outline the plan of care.

Providers may submit requests for authorization by:

- Submitting an online authorization request via Wellcare's secure provider portal at **wellcare.com/Hawaii/Providers** (this option provides faster service)
- Faxing a properly completed *Inpatient, Outpatient, Durable Medical Equipment (DME) and Orthotic and Prosthetic*, or *Home Health and Skilled Therapy Services Authorization Request Form*; or
- Contacting Wellcare via phone for inpatient notifications and urgent outpatient services.

Forms for the submission of notifications and authorization requests can be found at **wellcare.com/en/Hawaii/Providers/Medicare/Forms**.

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

- Member name and ID number
- The requesting Provider's demographics
- Diagnosis code(s) and place of service
- Services being requested and *Physician's Current Procedural Terminology, 4th Edition* (CPT-4) code(s)
- The recommended Provider's demographics to provide the service

- Medical history and any pertinent medical information related to the request, including current plan of treatment, progress notes as to the necessity, effectiveness, and goals

For the appropriate contact information, refer to the *Quick Reference Guide*.
All forms are located at **wellcare.com/Hawaii/Providers/Medicare**.

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

The POS option allows Members of designated products to use Providers outside of the Wellcare network for additional cost. The Member will pay more to access services outside the network except for emergency services. Authorization is not required for services covered under the Member's POS benefit. The Provider utilizing the Member's POS benefit must inform the Member that there is a higher cost sharing.

It is recommended that an authorization be requested for the following situations:

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

Contact UM via Customer Service for any questions pertaining to the POS option. See the *Quick Reference Guide* for contact information.

Notification

Notifications are communications to Wellcare with information related to a service rendered to a Member or a Member's admission to an acute facility. Notification is required for an unplanned Member's admission to a hospital. This enables Wellcare to log the hospital admission and follow up with the facility on the following business day to receive clinical information. Notification can be submitted by fax, phone, or via the secure, online portal at **wellcare.com/Hawaii/Providers** for registered Providers. The notification information should include Member demographics, facility name and admitting diagnosis.

Concurrent Review

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

Wellcare provides oversight for Members receiving acute care services in facilities mentioned above to determine the initial/ongoing medical necessity, appropriate level of care, appropriate length of stay, and to facilitate a timely discharge.

Concurrent review is initiated as soon as Wellcare is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the Member, complexity, treatment plan and discharge planning activity. The continued length of stay authorization will occur concurrently based on Milliman Clinical Guidelines (MCG) criteria for appropriateness of continued stay to:

- Ensure that services are provided in a timely and efficient manner
- Make certain that established standards of quality care are met
- Implement timely and efficient transfer to 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 care manager

Concurrent review decisions are made using the following criteria:

- MCG (formerly Milliman Care Guidelines®) severity of illness/intensity of service criteria
- Clinical Policies [Clinical Coverage Guidelines (CCGs)]

These review criteria are used as guidelines. 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.

Frequency of telephonic reviews will be based 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.

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

Clinical information is requested to support the appropriateness of the admission, continued length of stay, level of care, treatment, and discharge plans.

When a hospital determines that a Member no longer needs inpatient care, but is unable to obtain the agreement of the physician, the hospital may request a Quality Improvement Organization (QIO) review. Prior to requesting a QIO review, the hospital should consult with Wellcare.

Discharge Planning

Wellcare identifies and provides the appropriate level of care as well as medically necessary support services for Members upon discharge from an inpatient setting. 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 provide for continuity of care when transitioning Members 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:

- Durable Medical Equipment (DME)
- Transfers to an appropriate level of care, such as an inpatient nursing rehabilitation (INR) facility, (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 which Wellcare may perform:

- Retrospective Review initiated by Wellcare
  Wellcare requires periodic documentation including, but not limited to, the medical record, UB and/or itemized bill to complete an audit of the Provider-submitted coding, treatment, clinical outcome and diagnosis relative to a submitted claim. On request, medical records should be submitted to Wellcare to support accurate coding and claims submission.
- Retrospective Review initiated by Providers
  Wellcare will review post-service requests for authorization of inpatient admissions or outpatient services 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. The PCP must document the reason for the referral and the name of the specialist in the Member's record. The specialist must document receipt of the request for a consultation. Wellcare does not require a written referral as a condition of payment for most services. No pre-communication with Wellcare is necessary. If the 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, regardless of medical group or independent practice association affiliation.

Criteria for Utilization Management Determinations

The UM Department uses nationally recognized review criteria that are based on sound scientific medical evidence. Providers 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:

- MCG (formerly Milliman Care Guidelines®)
- Clinical Policies [Clinical Coverage Guidelines (CCGs)]
- Medical necessity
- Member benefits
- Local and federal statutes and laws
- Medicare guidelines
- Hayes Health Technology Assessment

The 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. When the above criteria do not address the individual Member's needs or unique circumstance, the medical director will use clinical judgment in making the determination.

The review criteria and guidelines are available to Providers upon request. Members and Providers may request a copy of the criteria used for a specific determination of Medical Necessity by contacting Customer Service at **1-888-505-1201.**

The medical review criteria stated below are updated and approved at least annually by the clinical policy committee, medical advisory committee, and 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 development or adoption of UM criteria and on instructions for applying the criteria.

Wellcare is responsible for:

- Requiring consistent application of review criteria for authorization decisions
- Consulting 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
Milliman Clinical Guidelines (MCG)	Annually
Ingenix Complete Guide to Medicare Coverage Issues	Quarterly
Hayes, Inc. Online™ (Medical Technology)	Ongoing
Medicare Carrier and Intermediary Coverage Decisions	Ongoing
Medicare National Coverage Decisions	Ongoing
Federal Statutes, Laws and Regulations	Ongoing

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, sub-acute care facilities, or home care in Wellcare's service area to support the Member after hospital discharge
- Coverage of benefits for SNFs, sub-acute 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, the Clinical Services staff (review nurse, care manager) will conduct individual case conferences to determine the most appropriate alternative service for that Member. The medical director may also use their clinical judgment in completing the service authorization request.

All new medical technology or questionable experimental procedures will require review by the medical director prior to approval to establish guidelines where applicable.

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 normal 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 that are maintained within the Clinical Services Department. Refer to *Quick Reference Guide*.

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 ensures 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 14 calendar days after Wellcare receives the request for service. An extension may be granted for 14 additional calendar days if the Member requests an extension, or if Wellcare justifies a need for additional information and documents 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 request 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. An extension may be granted for 14 additional calendar days if the Member requests an extension, or if Wellcare justifies a need for additional information and documents how the delay is in the interest of the Member.

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

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 both Provider and Member. 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 Clinical Services' UM Department. The Member may request a copy of the criteria used for a specific determination of medical necessity by contacting Customer Service.

Peer-to-Peer Requests

Wellcare provides an opportunity for the Provider to request a peer-to-peer review. The requesting Provider will have the opportunity to discuss the decision with the clinical peer reviewer making the determination or with a different clinical peer if the original reviewer cannot be available.

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 Providers available;
- 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, and Members must be informed of their right to call 911
  - 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

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

Wellcare honors any written documentation of prior authorization of ongoing Covered Services for a period of 90 calendar days after the effective date of enrollment.

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

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

Wellcare cannot 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 inpatient 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.

Wellcare will take immediate action to address any identified urgent medical needs.

Continued Care with a Terminated Provider

When a Provider terminates or is terminated without cause, Wellcare will allow 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.

Wellcare will inform the Provider that care provided after termination shall continue under the same terms, conditions and payment arrangements as in the terminated contract.

If an obstetrical Provider terminates without cause and requests an approval for treatment of a pregnant Member who is currently in treatment, the Member will be allowed to, when medically necessary, continue care according to the specific state regulations. For Medicare, the Member will be permitted to continue care until the Member's postpartum visit is completed.

If a Provider is terminated for cause, Wellcare will direct the Member immediately to another participating Provider for continued services and treatment.

Continuity of Care

Wellcare maintains and monitors a panel of PCPs from which the Member may choose a personal PCP. All Members may choose and/or change their PCP to another participating Wellcare Medicare PCP 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:

- Provide or arrange for necessary specialist care, and in particular, 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

- Ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all Members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Wellcare uses the provision of translator services and interpreter services
- Establish and maintain written standards, including coverage rules, practice guidelines, payment policies, and UM that allow for individual medical necessity determinations
- Provide coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services
- 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 surgical/medical opinion in any instance when the Member disagrees with their Provider's opinion of the reasonableness or necessity of surgical procedures or is subject to a serious injury or illness. The second surgical/medical opinion, if requested, is to come from a Provider chosen by the Member who may select:

- A Provider who is participating with Wellcare
- A non-participating Provider located in the same geographical service area of Wellcare, if a participating Provider is not available

If Wellcare's network is unable to provide necessary services to a particular Member, Wellcare will adequately and timely cover these services out-of-network for the Member for as long as Wellcare is unable to provide them. Wellcare will be financially responsible for a second surgical/medical opinion.

Members must inform their PCP of their desire for a second surgical/medical 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 as a result of the second surgical/medical opinion will be conducted by participating Wellcare Providers. The PCP will review the second surgical/medical opinion and develop a treatment plan for the Member. If the PCP disagrees with the second surgical/medical 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 surgical/medical 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 (QIO) Review Process

Wellcare will ensure Members receive written notification of termination of service from Providers 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* which 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 should 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 services 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 (12 p.m.) of the first 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 (12 p.m.) of the day before coverage ends. Upon notification by the QIO that a Member has requested an appeal, Wellcare will issue a *Detailed Explanation of Non-Coverage* which indicates why services are either no longer reasonable or necessary or are no longer covered.

Coverage of Provider 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), 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 upon release if sooner.

The OMB approved Medicare Outpatient Observation Notice and accompanying form instructions can be found 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 work with the hospitals to ensure 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* (IM) 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 (12 a.m.) 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, 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* 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 on the basis of 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.

Wellcare is financially responsible for coverage of services, regardless of whether it has delegated responsibility for authorizing coverage or termination decisions to its Providers.

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 Clinical Services 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, UM functions, Provider questions, comments or inquiries. Wellcare is available Monday–Friday, 8 a.m. to 4:30 p.m. Hawai'i Standard Time by calling Customer Service. The medical director and/or UM leadership are available for urgent UM issues after hours and weekends.

For more information on contacting the Clinical Services Department via Customer Service, refer to the *Quick Reference Guide*.

Care Management Program

Overview

Wellcare offers comprehensive and social determinants of healthcare management services to facilitate patient assessment, planning and advocacy to improve health outcomes for patients. Wellcare trusts Providers will help coordinate the placement and cost-effective treatment of patients who are eligible for Wellcare's Care Management Programs. For specific information on Care Management Programs for dual-eligible Members, or Model of Care, see *Section 13: Dual-Eligible Members* in this Manual.

Wellcare care management is 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.

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 teams are led by specially trained registered nurse and licensed clinical social worker care managers who assess the Member's risk factors, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the care plan.

The care managers work collaboratively with PCPs and 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

- Self-referral
- Referral from a family member
- After completing a Health Risk Assessment (HRA)
- Data mining for Members with high utilization or high risk for admission/re-admission

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 to identify the best ways to fill any identified gaps or barriers to improve access and adherence to the Provider's plan of care.
- **Service Facilitation and Coordination** – working with community resources to facilitate Member adherence with the plan of care. Activities may be as simple as reviewing the plan with the Member and/or caregiver, or as complex as arranging services, transportation and follow-up care.
- **Member Advocacy** – advocating on behalf of the Member within the complex labyrinth of the healthcare system. Care managers help Members seek the services to optimize their health. Care management emphasizes continuity of care for Members through the coordination of care among physicians and other Providers.

Members commonly identified for Wellcare's Care Management Program 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 (e.g., Acquired Immune Deficiency Syndrome [AIDS])
- **Transplantation** – organ failure, donor matching, post-transplant follow-up
- **Complex Discharge Needs** – Members discharged home from acute inpatient or SNF with multiple service and coordination needs (e.g., 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 Member's needs. Reasons for discharge from the Care Management Program may include:

- The Member is meeting primary care plan goals
- The Member has declined additional care management services
- The Member has disenrolled from Wellcare
- The Member cannot be contacted by Wellcare

Provider Access to Care Management

Refer to *Access to Care and Disease Management Programs* in the *Disease Management Program* 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 a chronic condition, 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 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 decline to participate.

To refer a Member for complex care management:

- Call: **1-888-505-1201**
- Online: **wellcare.com/Hawaii**

Disease Management Program

Overview

Embedded in Care Management, Disease Management (DM) is a population-based strategy that involves consistent care across the continuum for Members with certain disease states. Elements of the program include educating the Member about the particular disease and self-management techniques, monitoring the Member for adherence to the treatment plan and

consistently using validated, industry-recognized evidence-based *Clinical Practice Guidelines* by the treatment team and the disease manager.

The DM Program includes the following conditions:

- Asthma – adult and pediatric
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Diabetes – adult and pediatric
- Hypertension (HTN)

Additional programs available include smoking cessation.

Candidates for Disease Management

Wellcare encourages referrals from Providers, Members, hospital discharge planners and others in the healthcare community.

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

Disease-specific *Clinical Practice Guideline*s adopted by Wellcare can be found at **https://www.wellcare.com/en/Hawaii/Providers/Clinical-Guidelines/CPGs.**

Access to Care and Disease Management Programs

Wellcare's Transition Needs Assessment (TNA) Program helps new Members 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, the Provider may call the care

management referral line. For more information on the Care Management referral line, see the *Quick Reference Guide.*

Section 7: Claims and Encounters

Overview

The focus of Wellcare's Claims Department is to process claims in a timely manner. Wellcare has established a toll-free phone number for Providers to call the Customer Service Department (found at the bottom of this page). For more information, see the *Quick Reference Guide* on Wellcare's website.

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

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

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

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

Providers can register using PaySpan's enhanced Provider registration process at **payspan.com.** The *How to Register* with PaySpan webinar occurs several times. Providers can register for the date and time that works best for them by contacting PaySpan directly.

PaySpan Health Support can be reached via email at **providersupport@payspanhealth.com**, by phone at **1-877-331-7154** or on the web at **payspanhealth.com.**

Timely Claims Submission

Providers must submit Clean Claims within the time set forth in the Agreement. 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 Wellcare.

The following items can be accepted as proof of a "clean" claim 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 listed on the page

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 claims submissions, with the exception of atypical Providers. Atypical Providers must pre-register with Wellcare before submitting claims to avoid NPI rejections. Wellcare will reject claims without the Tax ID and NPI. More information on NPI requirements, including the Health Insurance Portability and Accountability Act of 1996's (HIPAA) NPI Final Rule Administrative Simplification, is available on the CMS website at **cms.gov**.

Taxonomy

Providers must submit claims with the correct taxonomy code consistent with Provider's specialty and services being rendered in order to increase appropriate adjudication. Wellcare may reject the claim or pay it at the lower reimbursement rate if the taxonomy code is incorrect or omitted.

Preauthorization number

If a preauthorization number was obtained, 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

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. 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. For more information on paper submission of claims, refer to the *Quick Reference Guide*.

For more information on Wellcare's Covered Services, refer to Wellcare's website at **wellcare.com/Hawaii/Providers.**

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 **wellcare.com/Hawaii/Providers/Medicare/Claims.**

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 Wellcare's unique payer ID numbers used to identify Wellcare on electronic claims submissions, or to contact Wellcare's EDI team, see the *Provider Resource Guide* at **wellcare.com/Hawaii/Providers/Medicare.**

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/Hawaii/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 have the capability 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.

Paper Claims Submissions

Providers are to submit claims to Wellcare electronically in accordance with the Agreement. For assistance in creating an EDI process, contact Wellcare's EDI team by referring to the *Quick Reference Guide*.

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
- In accordance with the Wellcare Optical Character Recognition (OCR), 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, hand-write, or stamp any extraneous data on the form
        - In black ink
        - Large, dark font such as, PICA or ARIAL in 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

CMS Fact Sheet about CMS-1500 02/12 Version:
cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837P-CMS-1500.pdf

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

Claims Processing

Readmission

Wellcare may choose to review claims if data analysis deems it appropriate. 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 make all necessary adjustments to the claim, including recovery of payments which are not supported by the medical record. Wellcare may recoup overpayments from Providers who do not submit the requested medical records or who do not remit the overpayment amounts identified by Wellcare.

Three Day Payment Window

Wellcare follows the CMS guidelines for outpatient services treated as inpatient services (including but not limited to: Outpatient services followed by admission before midnight of the following day, preadmission diagnostic services, and other preadmission services). Please refer to the CMS *Medicare Claims Processing Manual* for additional information.

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 vendor. 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 claims 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 pay Clean Claims in accordance with the terms of the Agreement.

Rate Updates

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

- The effective date of the change
- 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 paid.

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 CMS guidance. Providers shall bill primary insurers for items and services they provide to a Member before they submit claims for the same items or services to Wellcare. Any balance due after receipt of payment from the primary payer should be submitted to Wellcare for consideration and the claim must include information verifying the payment amount received from the primary plan. COB information can be submitted to Wellcare by an EDI transaction with the COB data completed in the appropriate COB elements. Only paper submitters need to send a copy of the EOB. Wellcare may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services to the extent permitted by applicable laws. Providers shall follow Wellcare's policies and procedures regarding subrogation activity.

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

- 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 **wellcare.com/Hawaii/Providers/Medicare/Claims**
- Wellcare has information on file to suggest the Member has other insurance, Wellcare may deny the claim.

- The primary insurance has terminated, the Provider is responsible for submitting the initial claim with proof that coverage was terminated. In the event a claim was denied for other coverage, the Provider must resubmit the claim with proof that coverage was terminated.
- 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.

The Order of Benefit Determination grid below for MA Members outlines when Wellcare would be the primary or secondary payer:

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 less 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

Member	Condition	Pays First (Primary)	Pays Second (Secondary)
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
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 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

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 (e.g., CMS) and state agencies have the ability to impose significant financial sanctions on Wellcare. Wellcare requires all delegated entities, including capitated, third party vendor and fee for service Providers, to submit encounter data to Wellcare, even if they are reimbursed through a capitated arrangement.

Timely and Complete Encounters Submission

Unless otherwise stated in the Agreement, delegated entities and Providers should submit timely, 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 apply to both corrected claims (error correction encounters) and cap-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 through 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 editing to ensure that the encounter has all the required information and that the information is accurate.

For more information on Workgroup for Electronic Data Interchange (WEDI) SNIP edits, refer to the *Transaction Compliance and Certification* white paper at **wedi.org**. For more information on submitting encounters electronically, refer to the *Companion Guides* at **wellcare.com/Hawaii/Providers/Medicare/Claims**.

Delegated entities, including capitated, third party vendor and fee for service Providers, who are also subcontractors are required to comply with any additional encounters' validations as defined by CMS.

Encounters Submission Methods

Delegated entities, including capitated, third party vendor and fee for service 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, refer to Wellcare's website at **wellcare.com/Hawaii/Providers/Medicare**.

Submitting Encounters Using DDE

Delegated entities, including third party vendor and fee for service Providers, may submit their encounter information directly to Wellcare using the DDE portal. The DDE tool can be found on the secure, online provider portal at **ohanahealthplan.com/provider/medicare/claims**. For more information on free DDE options, refer to the *Wellcare Provider Resource Guide* at **wellcare.com/Hawaii/Providers/Medicare**.

Encounters Data Types

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

- Dental – 837D format
- Professional – 837P format
- Institutional – 837I format
- Pharmacy – NCPDP format

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

Encounters submitted to Wellcare from a delegated entity or 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 state
- Replaced or overlaid encounter – An encounter that is updated or corrected within the system

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 to exceed the Member's responsibility, the Provider must reimburse the Member the excess amount. The Provider may determine an excess amount by referring to the Explanation of Payment (EOP).

For certain Benefit Plans, Member expenses are limited by a maximum out-of-pocket amount. For more information on maximum out-of-pocket amounts, and responsibilities of a Provider of care to a Medicare Member, refer to *Section 2: 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.

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

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

Hospital Acquired Conditions are additional non-payable conditions listed on the CMS website at **cms.gov** and include such events as an air embolism, falls and catheter-associated urinary tract infection.

Healthcare 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 request must be made in writing, clearly stating the specific reason for requesting the reopening. It is the responsibility of the Provider to submit the requested documentation within 90 days of the denial to re-open the case.

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.

Disputed Claims

The claims payment dispute process addresses claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Claim payment disputes for par Providers must be submitted to Wellcare in writing within 90 calendar days of the date of denial of the EOP for participating Providers.

Please provide the following information on the written Provider dispute:

- Date(s) of service
- Member name
- Member ID number and/or date of birth
- Claim number
- Provider name
- 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)

To initiate the process, please refer to the *Quick Reference Guide* at **wellcare.com/Hawaii/Providers/Medicare**.

Corrected or Voided Claims

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

How to submit a corrected or voided claim electronically:

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

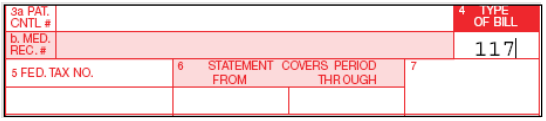
These codes are not intended for use for original claim submission or rejected claims.

To submit a corrected or voided claim via paper:

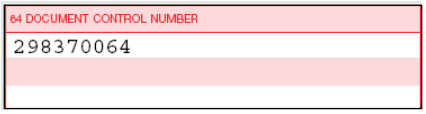
- For Institutional claims, the Provider must include Wellcare's original claim number and bill the frequency code per industry standards.

Example:

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



Box 64 – Place the claim number of the prior claim in Box 64



- For Professional claims, Provider must include Wellcare's original claim number and bill frequency code per industry standards. When submitting a corrected or voided claim, enter the appropriate bill frequency code left-justified in the left-hand side of Box 22.

Example:

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

Please note: If "corrected claim" is handwritten, stamped or typed on the claim form without the appropriate Frequency Code "7" or "8" along with the Original Reference Number as indicated above, the claim will be considered an original first-time claim submission.

The correction or void process involves two transactions:

1. The original claim will be negated – paid or zero payment (zero net amount due to a 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.
2. The corrected or voided claim will be processed with the newly submitted information and noted "*Adjusted per corrected bill*." This process will pay out the newly calculated amount on this corrected or voided claim with a new claim number.

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

Reimbursement

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).

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; 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 modifier '62' added.

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 Professionals

Wellcare follows CMS reimbursement guidelines regarding Allied Health Professionals.

Medicare Overpayment Recovery

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

Wellcare will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, Wellcare will 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. However, no such time limit shall apply to overpayment recovery efforts which are based on a reasonable belief of fraud, waste or abuse or other intentional misconduct or required or authorized by or at the request of a governmental agency.

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.

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, the Provider can send a corrected claim (refer to the corrected claim section of the Manual); contact Customer Service at the phone number listed at the bottom of this page to arrange an offset against future payments; or send a refund and explanation of the overpayment to:

Wellcare Comprehensive Health Management
Recovery/Cost Containment Unit (CCU)
P.O. Box 947945
Atlanta, GA 30394-7945

For more information on contacting Customer Service, see the *Quick Reference Guide* at **wellcare.com/Hawaii/Providers/Medicare**.

Benefits During Disaster and Catastrophic Events

In the event of a presidential emergency declaration, a presidential (major) disaster declaration, a declaration of emergency or disaster by a governor, or an announcement of a public health emergency by the Secretary of Health and Human Services – but absent an 1135 waiver by the Secretary – Wellcare will:

- Allow Part A/B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities (note that Part A/B benefits must, per 42 CFR 422.204(b)(3), be furnished at Medicare-certified facilities)
- Waive in full, requirements for authorization or pre-notification
- Temporarily reduce Wellcare-approved out-of-network cost sharing to in-network cost-sharing amounts
- Waive the 30-calendar-day notification requirement to Members as long as all the changes (such as reduction of cost sharing and waiving authorization) benefit the Member

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency timeframe has not been closed 30 calendar days from the initial declaration, and if CMS has not indicated an end date to the disaster or emergency, Wellcare should resume normal operations 30 calendar days from the initial declaration.

Type of Claim	Modifier
An institutional claim	*Condition Code* will be DR or Modifier CR
A professional claim	*Modifier* will be CR Code

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 **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

Credentialing is the process by which the appropriate Wellcare peer review bodies evaluate the credentials and qualifications of practitioners including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/healthcare delivery organizations. For purposes of *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.

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 of care or services to its Members.

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, a timely notification of the credentialing decision is forwarded to the Provider.

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

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

Practitioner Rights

Practitioner Rights are listed below and 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 **credentialinginquiries@wellcare.com**. 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/ Recredentialing 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 Timeframe

In the event the credentials verification process reveals information submitted by the practitioner that differs from the verification information obtained by Wellcare, the practitioner has the right to review the information that was submitted in support of 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
- 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** – Physicians (M.D., D.O., D.P.M.) must maintain Board Certification in the specialty being practiced as a Provider for Wellcare, or must have verifiable educational/training from an accredited training program in the specialty requested.
- **Hospital-Admitting Privileges** – Specialist practitioners shall have hospital-admitting privileges at a Wellcare-participating hospital (as applicable to specialty). PCPs may have hospital-admitting privileges or may enter into a formal agreement with another Wellcare-participating Provider who has admitting privileges at a Wellcare-participating hospital, for the admission of Members.
- **Ability to Participate in Medicaid and Medicare** – Providers must have the ability to participate in Medicaid and Medicare. Any individual or entity excluded from participation in any government program is not eligible for participation in any Wellcare plan. Existing Providers who are sanctioned, and thereby restricted from participation in any government program, are subject to immediate termination in accordance with Wellcare policy and procedure 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. At the time of initial credentialing, Wellcare reviews the opt-out listing maintained on the designated carrier's website to determine whether a Provider has opted out of Medicare. The opt-out website is monitored on an ongoing/quarterly basis by 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 recordkeeping criteria

SIEs are conducted for:

- Unaccredited facilities
- Initial credentialing requirements
- 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 by, Wellcare.

Allied Health Professionals

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

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

- ARNPs
- Certified Nurse Midwives (CNM)

- PAs
- Osteopathic Assistants (OA)

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

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

Ancillary Healthcare Delivery Organizations

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

Recredentialing

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

Updated Documentation

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

Office of Inspector General Medicare/Medicaid Sanctions Report

On a regular and ongoing basis, Wellcare or its designee accesses the listings from the Office of Inspector General (OIG) Medicare/Medicaid Sanctions (exclusions and reinstatements) Report, for the most current available information. This information is cross-checked against Wellcare's network of Providers. If participating Providers are identified as being currently sanctioned, 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 regular and ongoing basis, Wellcare, or its designee, contacts state licensure agencies to obtain the most current available information on sanctioned Providers. This information is cross-checked against the network of Wellcare Providers. If a network Provider is identified as being currently under sanction, appropriate action is taken in accordance with Wellcare policy and procedure. If the sanction imposed is revocation of license, the Provider is subject to immediate termination. Notifications of termination are given in accordance with contract and Wellcare policies and procedures.

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

Credentialing and Peer Review

Credentialing is the process by which peers evaluate an individual applicant's background, education, training, experience, demonstrated ability, patient admitting capabilities, licensure, regulatory compliance and health status (as applicable). This evaluation is performed through primary and secondary source verifications obtained in accordance with regulatory, accreditation and Wellcare Corporate's policy and procedure. Information and documentation for 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 Corporate that may include certification, licensure, and/or accreditation, as applicable to Provider type. Recredentialing 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 are incorporated in the recredentialing 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.

Wellcare's Credentialing and Peer Review Committee is the principal physician committee that reviews and makes recommendations on credentialing, recredentialing, 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. The Credentialing Committee reports to the Consolidated Medicare QI Committee.

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 in the event 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 thereby to the Provider dispute resolution peer review panel process:

- Suspension of participating practitioner status for reasons associated with clinical care, conduct, or service
- Revocation of participating practitioner status for reasons associated with clinical care, conduct, or service
- Non-renewal of participating practitioner status at time of 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 and or second-level dispute resolution peer review panel, are provided to the practitioner. Notification to the practitioner will be mailed by an overnight carrier or certified mail, with return-receipt requested.

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 there from, 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. In the event the findings are positive for the practitioner, the second-level panel review shall be waived.

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

Within 10 calendar days of the request for a second-level peer review panel hearing, the medical director or 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.

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 make the appropriate report to the National Practitioner Data Bank and state licensing agency as appropriate and if applicable.

Delegated Entities

All Providers who are 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.

Section 9: Reconsiderations (Appeals)

Appeals

Provider Retrospective Appeals Overview

A Provider may appeal a claim or utilization review denial on their own behalf by mailing or faxing Wellcare a letter of appeal or an appeal form with supporting documentation such as medical records. Appeal forms are located at **wellcare.com/Hawaii/Providers/Medicare/Forms**.

Non-Participating Providers have 60 calendar days from Wellcare's original 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. The only acceptable proof of timely filing is a registered postal receipt signed by a representative of Wellcare, or a similar receipt from other commercial delivery services.

Participating Providers have 90 calendar days from Wellcare's original claim denial to file a Provider Dispute. Disputes after that time will be denied for untimely filing. If the Provider feels that the Dispute 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 Wellcare, or a similar receipt from other commercial delivery services.

Upon receipt of all required documentation, Wellcare has up to 60 calendar days to review the appeal or dispute and conformity to Wellcare guidelines and to render a decision to reverse or affirm. Required documentation includes a properly executed Waiver of Liability (from non-participating providers only), the Member's name and/or ID 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 and disputes received without the necessary documentation will not be reviewed by Wellcare due to lack of information. It is the responsibility of the Provider to provide the requested documentation within 60 calendar days of the denial to review the appeal. Records

and documents received after that time will not be reviewed and the appeal or dispute will remain closed.

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

Provider Retrospective Appeals Decisions

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

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

Affirmation of Initial Denial
If it is determined during the review that the Provider did not comply with Wellcare protocols and/or that 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 letter. The Provider may also request a copy of the clinical rationale used in making the appeal decision by sending a written request to the appeals address listed in the decision letter.

Member 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. A reconsideration may also be filed on the Member's behalf by an authorized representative or a Provider. 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 Provider 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 60 days from the date of the Notice of Action. If the Member's request is made orally, Wellcare will mail an acknowledgment letter to the Member to confirm the facts and basis of the 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
- 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.

Wellcare ensures that decision-makers assigned to reconsiderations were not involved in reconsiderations of previous levels of review. When deciding a reconsideration based on lack of Medical Necessity, a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeal involving clinical issues, the reviewers will be healthcare professionals with clinical expertise in treating the Member's condition/disease or will seek advice from Providers 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. The Member and the person representing the Member must sign and submit the AOR form to the Plan. The form is located at **wellcare.com/Hawaii/Providers/Medicare/Forms.**

Types of Appeals

A Member may request a standard pre-service, retrospective, or an expedited appeal.

Standard and expedited pre-service appeals are requests for services that Wellcare has determined are not Covered Services, are not Medically Necessary, or are otherwise outside of the Member's Benefit Plan. These appeals can be submitted by the Provider on behalf of the Member.

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.

Only pre-service appeals are eligible to be processed as expedited appeals.

Appeal Decision Timeframes

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

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

Standard Pre-Service and Retrospective Reconsiderations

A Member may file a reconsideration request either verbally or in writing within 60 calendar days of the date of the adverse determination by contacting Customer Service.

A Member may also present their appeal in person. To do so, the Member must call Wellcare to advise that the Member would like to present the reconsideration in-person or via the telephone. 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 60 calendar days, then good cause must be shown in order for Wellcare to accept the late request. Examples of good cause include, but are not limited to:

- The 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

Expedited Reconsiderations

To request an expedited reconsideration, a Member or a Provider (regardless of whether the Provider is affiliated with Wellcare) 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 provides instructions about the expedited grievance process and its timeframes
- 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

Member Reconsideration Decisions

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

Please note that these reconsideration levels do not apply to Participating Provider Retrospective Claims Disputes.

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. The IRE has 30 days from receipt of the standard pre-service appeal to issue a final determination. The IRE has 60 days from receipt of the retrospective appeal 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. In the event 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 also notify the Member or Member's representative in writing that the services are approved along with an authorization number or that the claim has been paid.

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. In the event 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.

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.

Section 10: Grievances

Provider

Medicare Advantage Providers are not able to file a grievance per CMS guidance.

Member Grievance Overview

The Member may file a grievance. A grievance may also be filed on the Member's behalf by an authorized representative or a Provider with the Member's written consent. All grievance rights described in *Section 10* of this Manual that apply to Members will also apply to the Member's authorized representative or 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. The Member and the person representing the Member must sign the AOR statement. The form is located at **wellcare.com/Hawaii/Providers/Medicare/Forms**.

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

- Provider service including, but 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 *Quick Reference Guide*.

Grievance Resolution

Standard

A Member or Member's representative shall be notified of the decision as expeditiously as the case requires, but no later than 30 calendar days after the date Wellcare receives the verbal or written grievance, consistent with applicable federal law, unless an extension is elected. Once a resolution has been reached, Wellcare will send a closure letter. If Wellcare receives a grievance verbally, the resolution may be given verbally and the Member may not receive a closure letter.

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 is for coverage determination, organization determination or an appeal and 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 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 conducted to ensure that the decision to not apply an expedited review timeframe or extend a review timeframe does not jeopardize the Member's health.

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

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.

Section 11: Compliance and Regulatory Requirements

Compliance Program – 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 Provider employees and Provider sub-contractors and their employees, are required to comply with Wellcare compliance program requirements. Wellcare's compliance-related training requirements include, but are not limited to, 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; and
    - Physical and technical safeguards.
- Fraud, Waste and Abuse (FWA) Training
  - Must include, but 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 sub-contractors 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; and
    - Types of fraud, waste and abuse that can occur.

Providers, including Provider employees and/or Provider sub-contractors, must report to Wellcare any suspected fraud, waste or abuse, misconduct or criminal acts by Wellcare, or any Provider, including Provider employees and/or Provider sub-contractors, or by Wellcare Members. Reports may be made anonymously through the Wellcare Health Plan FWA hotline at **1-866-685-8664**. Details of the corporate ethics and compliance program may be found at **centene.com/who-we-are/ethics-and-integrity.html**.

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 Marketing Guidelines for MA Plans, MA-PDs, PDPs and 1876 Cost Plans* (Marketing Guidelines), including without limitation materials governing "Provider Based Activities" in Section 70.11.1.

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 Marketing Guidelines.

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

Overview

Wellcare has established a Code of Conduct and Business Ethics that outlines ethical principles to ensure that all business is conducted in a manner that reflects an unwavering allegiance to ethics and compliance. Wellcare's Code of Conduct and Business Ethics policy can be found at **centene.com/who-we-are/ethics-and-integrity.html**.

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 operate in accordance with the laws and regulations governing its business and accepted standards of business integrity. All associates, covered persons, participating Providers and other contractors should familiarize themselves with Wellcare's Code of Conduct and Business Ethics. Wellcare associates, covered persons, participating Providers and other contractors of Wellcare are encouraged to report compliance concerns and any suspected or actual misconduct using the Compliance Hotline at **1-800-345-1642**. Report suspicions of fraud, waste and abuse by calling Wellcare's FWA Hotline at **1-866-685-8664**.

Fraud, Waste and Abuse

Wellcare is committed to the prevention, detection and reporting of healthcare fraud and abuse according to applicable federal and state statutory, regulatory and contractual

requirements. Wellcare has developed an aggressive, proactive fraud and abuse program designed to collect, analyze and evaluate data in order to identify suspected fraud and abuse. Detection tools have been developed to identify patterns of problematic healthcare service use, including over-utilization, 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 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 and abuse may be subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized Provider, loss of licensure, and/or civil and/or criminal prosecution, fines and other penalties.

Participating Providers must be in compliance with all CMS rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicaid managed care organization meet annual compliance and education training requirements with respect to FWA. To meet federal regulation standards specific to Fraud, Waste and Abuse (42 CFR § 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.

Providers in our Medicare network 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 suspected fraud, waste and abuse, please refer to the *Quick Reference Guide* or call the confidential and toll-free Wellcare fraud hotline at **1-866-685-8664**. Details of the corporate ethics and compliance program, and how to contact Wellcare fraud hotline, may be found at **centene.com/who-we-are/ethics-and-integrity.html**.

Confidentiality of Member Information and Release of Records

Medical records should be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules and regulations. All consultations or discussions involving the Member or their case should 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 should be trained on HIPAA Privacy and Security regulations. The Provider should ensure there is a procedure or process in place for maintaining confidentiality of Members' medical records and other PHI as defined under HIPAA; and the Provider is following those procedures and/or obtaining appropriate authorization from Members to release information or records where required by applicable state and federal law. Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

Every Provider 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). 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 that is protected under federal or state law

The NPP informs the patient or Member of their Member 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 Customer Service by referring to the *Quick Reference Guide.*

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 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 ten 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 & 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 sub-delegate, and is accountable to federal and state agencies for the performance of all delegated functions. It is the ultimate 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 which 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 will hold 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 monitors 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
- The development and implementation of Corrective Action Plans (CAPs) if the Delegated Entity's performance is substandard or terms of the agreement are violated
- The review and initiation of 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 program
- Tracking and trending internal compliance with oversight standards, entity performance, and outcomes

Section 13: Dual-Eligible Members

Overview

Individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit are often referred to as "dual-eligible Members." These benefits are sometimes referred to as Medicare Savings Programs (MSPs). Dual-eligible Members are eligible for some form of Medicaid benefit, whether that Medicaid coverage is limited to certain costs, such as Medicare premiums, or the full benefits covered under the state Medicaid plan.

Types of Dual-Eligible Members

States administer MSPs for Medicare- and Medicaid-eligible Members with limited income and resources to help pay for their Medicare cost sharing. There are multiple MSP 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 assistance from an award letter they receive from the state Medicaid agency.

For full definitions of the current categories of dual-eligible Members contained herein, see *Section 16: Definitions and Abbreviations* in this Manual.

See the chart below for the different categories of dual-eligible Members:

Medicare Savings Program (MSP) Assistance	Fee-for-service Part A Premium Covered?	Fee-for-service Part B Premium Covered?	Part A and B Cost- Sharing Covered?	Full Medicaid Benefits Provided?
Qualified Medicare Beneficiary (QMB)	YES	YES	YES	NO
QMB Plus (QMB+)	YES	YES	YES	YES
Specified Low-Income Medicare Beneficiary (SLMB)	NO	YES	NO	NO
SLMB Plus (SLMB+)	NO	YES	YES	YES
Qualifying Individual (QI)	NO	YES	NO	NO
Qualified Disabled Working Individual (QDWI)	YES	NO	NO	NO

Medicare Savings Program (MSP) Assistance	Fee-for-service Part A Premium Covered?	Fee-for-service Part B Premium Covered?	Part A and B Cost- Sharing Covered?	Full Medicaid Benefits Provided?
Full Benefit Dual-Eligible Members (FBDE)	YES	YES	YES	YES

In general, QMB, QMB+, SLMB+ and FBDE beneficiaries are considered "zero cost share" dual-eligible Members since they pay no Part A or Part B cost share. Please note, the state Medicaid agency defines all state optional MSP levels and those levels may vary among states. Please contact the Hawai'i Medicaid agency for full MSP information.

Payments and Billing

For all zero cost share, dual-eligible Members (QMB, QMB+, SLMB+ and FBDE), Medicaid is responsible for deductible, coinsurance, and copayment amounts for Medicare Parts A and B Covered Services. The filed cost-sharing amounts related to supplemental benefits (e.g., hearing, vision and extra dental) are the responsibility of the Member.

Providers may not "balance bill" these Members. This means Providers may not bill these Members for either the balance of the Medicare rate or the Provider's customary charges for Part A or B services. The Member is protected from liability for Part A and B charges, even when the amounts the Provider receives from Medicare and Medicaid are less than the Medicare rate or less than the Provider's customary charges. Providers who bill these Members for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions.

Providers agree to accept Wellcare's payment as payment in full or will bill the appropriate state source for the crossover cost-sharing payment. To bill the state, the Provider will submit the EOP provided by Wellcare to the state.

If Wellcare has assumed the state's financial responsibility under an agreement between Wellcare and the state, Wellcare shall be considered the "appropriate state source." If Wellcare has assigned responsibility to a delegated vendor, the delegated vendor shall be considered the "appropriate state source."

DSNP Plans will have a Part B deductible amount applied prior to payment similar to how Medicare operates today. The amount in 2020 is $185. This deductible is considered a cost-sharing amount and covered by the state Medicaid agency or its designee if they have 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 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
- Behavioral health specialty services
- Podiatry services
- Other healthcare professional
- Psychiatric services
- Physical therapy and speech-language pathology services
- Opioid Treatment Services
- Outpatient diagnostic procedures/test/lab services
- Diagnostic radiological services
- Therapeutic radiological services
- Outpatient X-Rays
- Outpatient hospital services
- Ambulatory surgical center (ASC) services
- Outpatient substance abuse
- Outpatient blood services
- Ambulance services
- Durable medical equipment (DME)
- Prosthetics/medical supplies
- End-stage renal disease

- Kidney disease education services
- Diabetes self-management training

Referral of Dual-Eligible Members

When a participating Provider refers a dual-eligible Member to another Provider for services, the Provider should make every attempt to refer the dual-eligible Member to a Provider who participates with both Wellcare and the state Medicaid agency. Providers who participate with the state Medicaid plan can be located at the applicable state's Medicaid website. The Wellcare Medicare Provider Directory displays an indicator when the Provider participates in Medicaid.

Dual-Eligible Members Who Lose Medicaid Eligibility/Status

Many dual-eligible Members belong to Dual Special Needs Plans (DSNPs). For more information on DSNPs, refer to *Section 1: Welcome to Wellcare By 'Ohana.*

CMS requires DSNP 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 impacts the Member responsibility. As of January 1, 2013, Wellcare implemented a six-month Deeming Period for all DSNP plans.

During the deeming period, Wellcare applies the appropriate payment methodology to process claims and pays 100% of the Medicare allowable to protect its Members from cost sharing. Providers must accept Wellcare's payment as payment in full and may not balance bill the Member.

DSNP Care Management Program

Overview

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) became law in July of 2008. MIPPA mandates a HRA, care plan, interdisciplinary care team for Members, and an evaluation of care effectiveness by Wellcare's care management team.

Wellcare's Model of Care (MOC) is tailored specifically to the dual-eligible Members in an effort to meet the populations' functional, psychosocial and medical needs in a Member-centric fashion.

Health Assessment: Conducted by Wellcare By 'Ohana – Wellcare's care management MOC begins with the Health Risk Assessment (HRA). The HRA assesses Member risk in the following areas: functional, psychosocial, behavioral, cognitive, and medical. Once completed, the HRA is stratified into 3 levels: low, moderate and high. The stratification of the HRA indicates Member needs, high and moderate risk are contacted for care management engagement and further assessment. Low risk members receive an individualized care plan (ICP) based on their HRA responses.

Comprehensive Needs Assessment: Conducted by Wellcare By 'Ohana – The care manager telephonically conducts the comprehensive needs assessment with the dual-eligible Member and/or caregiver, if appropriate, in order to collect additional social, medical, and behavioral information to generate a Member-centric ICP. The comprehensive needs assessment is based on *Clinical Practice Guidelines* and allows the care plan to be generated utilizing these guidelines.

Individualized Care Plans: Generated by Wellcare By 'Ohana – Once the Member, and/or caregiver complete the health risk assessment, an ICP is developed reflecting Member specific problems, prioritized goals, and interventions. The ICP tracks dates and goal progress. Contact frequency will vary depending on the stratification of the Member and specific goal timeframes. Low risk member ICPs are developed based on the HRA. In the event a Member is unable to be reached (UTR), an ICP may be developed based on claims, service utilization and pharmacy data. The ICP is shared with Members of the Interdisciplinary Care Team (ICT) for input and updates.

Interdisciplinary Care Team: Wellcare By 'Ohana 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. At a minimum, the ICT includes the Member, the Member's caregiver (if appropriate), the Member's PCP and Wellcare care manager. Other members of the ICT can include specialists, social service support, behavioral health specialists, and/or caregiver and others depending on the Member's specific needs. For members enrolled in care management, 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 twelve (12) months of their enrollment and annually thereafter. The face-to-face encounter is completed for the purpose of delivering health care, care management or care coordination services and can be completed with a treating Provider on the Member's interdisciplinary care team or with Wellcare care management/care coordination staff. Members who cannot be seen by their

treating providers within a 12 month period, either in-person or virtually, should contact Wellcare to schedule a virtual appointment at **1-855-538-0454.**

Care Transitions: Wellcare By 'Ohana and Providers – When Members move from one setting to another, Wellcare By 'Ohana facilitates transitions through communication and coordination with the Member and their usual 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 usual Provider will be notified of the transition and will communicate any needs to assist with a smoother transition process.

Provider Required Participation

To meet the intent of the MIPPA legislation, Providers are required to participate in the MOC for all DSNP plan Members. The expectations 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 packet that can be accessed online at **wellcare.com/Hawaii/Providers/Medicare**.
    - Providers who would like a copy mailed at no cost can contact Customer Service or their Provider Relations representative.
    - Annually, Wellcare will fax or mail the MOC training self-study packet to the fax numbers and practice locations on file.
- Become familiar with Wellcare's *Clinical Practice Guidelines* which are adopted nationally-recognized evidence-based guidelines
- Read newsletters that feature articles regarding the latest treatments for patients
- Review and update the Member care plan faxed by the Care Management Department
- Participate in the ICT for all DSNP Members in a Provider's membership panel and give feedback as appropriate. The care manager will communicate with the members of the ICT for any updates to the ICP and will be available to assist the dual-eligible Member to meet the goals of the ICP

Recap of the benefits of the DSNP Care Management Program:

- All Members are outreached to complete an HRA upon initial enrollment and annually thereafter
- Members are stratified into high, moderate and low risk based on HRA responses
- Low Risk member ICPs are developed based on HRA responses
- High/moderate risk members engaged in care management:
- Member and/or caregiver completes a comprehensive needs assessment with the care manager

- The ICP is developed by the care manager in collaboration with the Member and the care team.
- The ICP is shared with the ICT for review and comments as needed
- The care manager continues to monitor, educate, coordinate care and advocate on behalf of the Member

Section 14: Behavioral Health

Overview

Wellcare provides a behavioral health benefit for Medicare plans. Please refer to the *Quick Reference Guide* for information on how to contact the behavioral health services administrator.

Behavioral Health Program

Some behavioral health services may require prior authorization. This includes all services provided by non-participating providers. For complete information regarding benefits and exclusions, or in the event a Provider needs to contact Wellcare's Customer Service for a referral to a behavioral health Provider, refer to the *Quick Reference Guide* at **wellcare.com/Hawaii/Providers/Medicare**.

Coordination of Care Between Medical and Behavioral Health Providers

PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Conversely, behavioral health Providers may provide physical healthcare services if, and when, they are licensed to do so within the scope of their practice. Behavioral health Providers are required to use the *Diagnostic and Statistical Manual of Mental Disorders* when assessing the Member for behavioral health services and document the diagnosis and assessment/outcome information in the Member's medical record.

Behavioral health Providers are 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 strongly encourages open 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 to ensure Members can obtain needed clinical services within the acceptable appointments waiting times. The provisions below are applicable only to behavioral health Providers and do not replace the provisions set forth in *Section 2: Provider Administrative Guidelines* for medical Providers. Providers not in compliance with these standards will be required to implement corrective actions set forth by Wellcare.

Type of Appointment	Access Standard
Behavioral health Provider – Urgent Care	≤ 48 hours
Behavioral health Provider – Post inpatient discharge	< 7 days
Behavioral health Provider – Initial Routine Care	≤ 10 business days
Behavioral health Provider – Non-life threatening emergency	≤ 6 hours
Behavioral health Provider – Routine Care follow-up	≤21 Days
Behavioral health Provider – Screening and triage of calls	< 30 seconds

All Members receiving inpatient psychiatric services must be scheduled for psychiatric outpatient follow-up and/or continuing treatment, *prior to discharge*, which includes the specific time, date, place and name of the Provider to be seen. The outpatient treatment must occur within seven days from the date of discharge.

In the event that a Member misses an appointment, the behavioral health Provider must contact the Member within 24 hours to reschedule.

Behavioral health Providers are expected to help Members access 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

Wellcare's pharmaceutical management procedures are an integral part of the pharmacy program that promote the utilization of the most clinically appropriate agent(s) to improve the health and well-being of Members. The UM 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, i.e., 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 *Quick Reference Guide.* For more information on Wellcare's benefits, visit **wellcare.com/Hawaii/Providers/Medicare.**

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 & 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 prescription drug products selected by the Pharmacy and Therapeutics (P&T) Committee. The formulary denotes any of the pharmacy UM 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 located at **wellcare.com/Hawaii/Providers/Medicare/Pharmacy**. Practitioners may call **1-888-505-1201** 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 are communicated to Providers via the following:

- Quarterly updates in Provider and Member newsletters
- 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, explaining the medical justification. For contact information, refer to the *Quick Reference Guides* at **wellcare.com/Hawaii/Providers/Medicare**.

For more information on requesting exceptions, refer to the *Coverage Determination* process 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. Erectile dysfunction drugs will meet the definition of a Part D drug when prescribed for medically-accepted indications approved by the Food and Drug Administration (FDA) other than sexual or erectile dysfunction (such as pulmonary arterial hypertension)

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. Generally, 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 the P&T Committee. These programs encourage the use of therapeutically equivalent, lower-cost medication alternatives (first-line therapy) before "stepping up" to less cost-effective alternatives. Step therapy programs are 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.

Medicare Part D 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 (e.g., specific diagnoses, lab values, trial and failure of alternative drug[s]).

Part D drugs requiring prior authorization are designated by the letters “PA” on Wellcare’s formulary.

Quantity Limits

Quantity limits are used so pharmaceuticals are supplied in quantities consistent with FDA-approved dosing guidelines. Quantity limits are used to help prevent billing errors.

Part D drugs that have quantity limits are designated by the letters “QL”, and the quantity permitted, on Wellcare’s formulary.

Therapeutic Interchange

Therapeutic interchange is a Formulary Benefit Management tool which Wellcare utilizes.

Mail Service

Part D drugs that are available through mail order are designated by the letters “MS” in the Requirements/Limits column of Wellcare’s formulary.

Members who utilize Wellcare’s preferred mail service pharmacy, CVS Caremark may be eligible for reduced copayment amounts. A *Member Registration*, *Prescription Mail Order Form* and a *Mail Service Pharmacy Prescription Form* are located at **wellcare.com/Hawaii/Providers/Medicare/Pharmacy**.

Injectable and Infusion Services

Self-injectable medications, specialty medications, and home infusion medications are covered as part of the outpatient pharmacy benefit. Non-formulary injectable medications and those listed on the formulary with a prior authorization will require submission of a request form for review. For more information, refer to the *Obtaining a Coverage Determination Request* section 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.
Please refer to the Member’s summary of benefits for additional information about an additional pharmacy wrap benefit for over-the-counter medications located at **wellcare.com**.

Member Copayments

The copayment and/or coinsurance are based on the drug's formulary status, including tier location, and the Member's subsidy level. Refer to the Member's summary of benefits for the exact copay/coinsurance located at **wellcare.com**.

Coverage Determination Request Process

The goal of Wellcare's Coverage Determination Request program is to promote the appropriate use of medication regimens that are high-risk, have a high potential for misuse or have narrow therapeutic indices, in accordance with FDA-approved indications.

The coverage determination request process is required for:

- Drugs not listed on the formulary
- Drugs listed on the formulary with 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 *Medicare Prescription Drug Coverage Determination Form* and fax it to the Pharmacy Department. The form is at **wellcare.com/Hawaii/Providers/Medicare/Forms.** For the appropriate fax number, refer to the *Quick Reference Guide.*

Coverage determination requests can also be submitted through Electronic Prior Authorization (ePA). Visit **providerportal.surescripts.net/providerportal/** to learn more and get started with ePA.

Wellcare's standard is to respond to coverage determination requests within 72 hours for routine requests and 24 hours for expedited requests from the time when Wellcare receives the request.

The Provider must provide medical history and/or other pertinent information when submitting a *Medicare Prescription Drug Coverage Determination Form* for medical exception.

If the coverage determination request meets the approved P&T committee's protocols and guidelines, 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 them of the approval.

If the coverage determination request is not a candidate for approval based on approved P&T committee protocols and guidelines, it is reviewed by a clinical pharmacist and/or a medical director.

For those 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 **1-888-505-1201** to request a peer-to-peer discussion to address the denial decision letter.

Medication Appeals

To request an appeal of a coverage determination request decision, contact the Pharmacy Appeals Department via fax, mail, in person or phone. Or visit **wellcare.com/Hawaii/Providers/Medicare/Forms**. Refer to the *Quick Reference Guide* for more information.

Once the appeal of the coverage determination request decision has been properly submitted and obtained by Wellcare, the request will follow the appeals process described in *Section 9: Reconsiderations (Appeals)*.

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 physician's 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 – Thursday, 8 a.m. to 7 p.m., and Friday, 8 a.m. to 6 p.m. (ET).

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 Provider Manual shall be construed and/or interpreted as follows, unless otherwise defined in the participation Agreement Providers have with Wellcare By ‘Ohana.

Appeal means a request for 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.

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 as defined in the Provider Contract,

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 as defined in the Provider Contract.

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 benefits.

Formulary means a list of covered drugs 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.

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.

Ineligible Person means as defined in the Agreement.

Medically Necessary or **Medical Necessity** means as defined in the Provider Contract.

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.

Members with Special Healthcare Needs means adults and children who face daily physical, behavioral or environmental challenges that place their health at risk and whose ability to fully function in society is limited.

Wellcare By 'Ohana 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.

PCP means a primary care Provider as defined in the Provider Contract.

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.

QDWI means Qualified Disabled Working Individual whose income is between 135% and 200% of the federal poverty level. These individuals are considered partial dual-eligible Members since they are responsible for paying their Part A and Part B cost sharing. These Members are not eligible to have full Medicaid benefits.

QI means Qualifying Individual whose income is between 120% and 135% of the federal poverty level. These individuals are considered partial dual-eligible Members since they are responsible for paying their Part A and Part B cost sharing. These Members are not eligible to have full Medicaid benefits.

QMB means Qualified Medicare Beneficiary whose income less than or equal to 100% of the federal poverty level. These individuals are considered a zero cost share dual-eligible Members since they are not responsible for paying their Part A or Part B cost sharing. These Members are not eligible to have full Medicaid benefits.

QMB+ means Qualified Medicare Beneficiary whose income is less than or equal to 100% of the federal poverty level. These individuals are considered a zero cost share dual-eligible Members since they are not responsible for paying their Part A or Part B cost sharing. They also are eligible to have full Medicaid benefits.

Reopening means a remedial action taken to reconsider a final determination or decision even though the determination or decision was correct based on the evidence of record.

SLMB means Specified Low-Income Medicare Beneficiary whose income is between 100% and 120% of the federal poverty level. These individuals are considered partial dual-eligible Members since they are responsible for paying their Part A and Part B cost sharing. These Members are not eligible to have full Medicaid benefits.

SLMB+ means Specified Low-Income Medicare Beneficiary whose income is between 100% and 120% of the federal poverty level. They also are eligible to have full Medicaid benefits.

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 sharing.

Abbreviations

ACS – American College of Surgeons
AEP – Annual enrollment period
Agreement – Provider Participation Agreement
AHP – Allied health professional
AIDS – Acquired Immune Deficiency Syndrome
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 and 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*
CSR – Controlled Substance Registration
DDE – Direct data entry
DEA – Drug Enforcement Agency
DM – Disease Management
DME – Durable medical equipment
DOC – Delegation Oversight Committee
DSM-5 – *Diagnostic and Statistical Manual of Mental Disorders*
DSNP – Dual-Eligible Special Needs Plans
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
FWA – Fraud, waste, and abuse
HEDIS® – Healthcare Effectiveness Data and Information Set
HHA – Home health agency
HHS – US Department of Health and Human Services

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
ICD-10-PCS – International Classification of Diseases, 10th Revision, Procedure Coding System
ICP – Individualized Care Plans
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 Programs
NCQA – National Committee for Quality Assurance
NCCI – National Correct Coding Initiative
NDC – National Drug Codes
NIH – National Institutes of Health
NPI – National Provider Identifier
NPP – Notice of Privacy Practice
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

Provider ID – Provider identification number
PT – Physical therapy
QDWI – Qualified Disabled Working Individual
QI – Qualifying Individual
QI Program – Quality Improvement Program
QIO – Quality Improvement Organization
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
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 By ‘Ohana Resources

Wellcare By ‘Ohana Homepage
wellcare.com/hawaii

Provider Homepage
wellcare.com/Hawaii/Providers

Provider Manual and Quick Reference Guide
wellcare.com/Hawaii/Providers/Medicare

Forms and Documents
wellcare.com/Hawaii/Providers/Medicare/Forms

AcariaHealth™ Specialty Pharmacy
acariahealth.com

Job Aids
wellcare.com/Hawaii/Providers

Clinical Practice Guidelines
wellcare.com/Hawaii/Providers/Clinical-Guidelines/CPGs

Clinical Policies [Clinical Coverage Guidelines (CCGs)]
wellcare.com/Hawaii/Providers/Clinical-Guidelines/CCG-List

Claims
wellcare.com/Hawaii/Providers/Medicare/Claims

Quality
wellcare.com/Hawaii/Providers/Medicare/Quality

Training and Education
wellcare.com/Hawaii/Providers/Medicare/Training

www.ohanahealthplan.com