Medicare Advantage Provider Manual

2023

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INTRODUCTION

Welcome to Wellcare. Thank you for participating in our network of high-quality physicians, hospitals and healthcare professionals.

This provider manual is a reference guide for you and your staff servicing members who are enrolled in our Medicare Advantage program for HMO, PPO, or Dual Special Needs (D-SNP) plans.

OVERVIEW

Wellcare is a licensed health maintenance organization (HMO) contracted with the Centers for Medicare and Medicaid Services (CMS) to provide medical and behavioral health services to eligible members. CMS also contracts Wellcare to provide Part D prescription medications to members enrolled in certain health plans which include a Part D benefit.

Wellcare is designed to achieve four main objectives:

- Full partnership between the member, their physician and their Wellcare Care Manager
- Integrated case management (medical, social, behavioral health, and pharmacy)
- Improved provider and member satisfaction
- Quality of life and health outcomes

Wellcare takes the privacy and confidentiality of our members' health information seriously. We have processes, policies, and procedures to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and CMS regulations. The services provided by the contracted Wellcare network providers are a critical component in terms of meeting the objectives above. Our goal is to reinforce the relationship between our members and their primary care physician (PCP). We want our members to benefit from their PCP having the opportunity to deliver high quality care using contracted hospitals and specialists. PCPs are responsible for coordinating our members' health services, maintaining a complete medical record for each member under their care, and ensuring continuity of care. The PCP advises the member about their health status, and medical treatment options, which include the benefits, consequences of treatment or non-treatment, and the associated risks. Members are expected to share their preferences about current and future treatment decisions with their PCP.

KEY CONTACTS AND IMPORTANT PHONE NUMBERS

The following table includes several important telephone and fax numbers available to providers and their office staff. When calling, it is helpful to have the following information available.

1. The provider's NPI number
2. The practice Tax ID Number
3. The member's ID number

Key Contacts and Important Phone Numbers

Wellcare	**Address:** 7700 Forsyth Boulevard Clayton, MO 63105 **Website**: www.wellcareok.com
Provider Services	Phone: 1-833-853-0865 (TTY: 711)
Member Services	Phone: 1-833-853-0865 (TTY: 711)
Medical Management Inpatient and Outpatient Prior Authorization	Fax: N/A
Concurrent Review/Clinical Information	Fax: N/A
Admission/Census Reports/Face Sheets	Fax: N/A
Care Management	Fax: N/A
Behavioral Health Outpatient Prior Authorization	Fax: N/A
24/7 Nurse Advice Line	1-833-853-0865 (TTY: 711)

Interpreter Services	1-833-853-0865
Pharmacy Services	1-888-865-6567 Prior Authorizations: 1-800-867-6564
National Imaging Associates (NIA)	1-800-509-1842 Website: www.RadMD.com
Envolve Vision	www.envolvevision.com
Envolve Dental	www.envolvedental.com
Fraud Waste and Abuse (FWA)	To report suspected fraud, waste and abuse call, 1-866-685-8664
EDI Claims Assistance	For EDI Claim Assistance inquires, call 1-800-225-2573, ext. 6075525 Email: EDIBA@Centene.com
Payspan	Phone: 1-877-331-7154 Email: providersupport@payspanhealth.com

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 provide you with at least 60 days written notice of termination if electing to terminate our agreement without cause, or as described in your Participation Agreement if greater than 60 days. 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, 7 days a week. PCPs must provide backup in case of absence.
- Marketing materials must adhere to CMS guidelines and regulations and cannot be distributed to Wellcare members without CMS and/or Wellcare approvals of the materials and forms.
- Services must be provided to members in a culturally competent manner, including members with limited reading skills, limited English proficiency, members who are deaf or hard of hearing or are blind or have low vision and diverse cultural and ethnic backgrounds.
- Providers will work with Wellcare procedures to inform our members of healthcare needs that require follow-up and provide necessary training in self-care.

- Providers will document in a prominent part of the member's medical record whether the member has executed an advance directive.

- Providers must provide services in a manner consistent with professionally recognized standards of care.

- Providers must cooperate with Wellcare to disclose to CMS all information necessary to evaluate and administer the program, and all information CMS may need to permit members to make an informed choice about their Medicare coverage.

- Providers must cooperate with Wellcare in notifying members of provider contract terminations.

- Providers must cooperate with the activities of any CMS-approved independent quality review or improvement organization.

- Providers must comply with any Wellcare medical policies, QI programs and medical management procedures.

- Providers will cooperate with Wellcare in disclosing quality and performance indicators to CMS.

- Providers must cooperate with Wellcare procedures for handling grievances, appeals, and expedited appeals.

- Providers must request prior authorization from the plan if the provider believes an item or service may not be covered for a member or could only be covered under specific conditions. If the provider does not request prior authorization, the claim may be denied, and the provider will be liable for the cost of the service. Note: if the item or service is never covered by the plan as clearly denoted in the member's Evidence of Coverage, no prior notice of denial is required, and the member may be held responsible for the full cost of the item or service.

- Providers must allow CMS or its designee access to records related to Wellcare services for a period of at least ten (10) years following the final date of service or termination of this agreement, unless a longer period is required by applicable state or federal law.

- Provider must comply with all CMS requirements regarding the accuracy and confidentiality of medical records.

- Provider shall provide services in accordance with Wellcare policy: (a) for all members, for the duration of the Wellcare contract period with CMS, and (b) for members who are hospitalized on the date the CMS contract with Wellcare terminates, or, in the event of an insolvency, through discharge.

- Provider shall disclose to Wellcare all offshore contractor information with an attestation for each such offshore contractor, in a format required or permitted by CMS.

SECURE WEB PORTAL

Wellcare offers a robust secure web portal with functionality that will be critical to serving members and to ease administration for the Wellcare product for providers. Provider Services will be able to assist and provide education regarding this functionality. The portal can be accessed at www.wellcareok.com.

Functionality

All users of the secure web portal must complete a registration process. The secure web portal is separate across Wellcare health plans and will require registration for each state.

Once registered, providers may:

- Check eligibility
- View the specific benefits for a member
- View benefit details including member cost share amounts for medical, Pharmacy, dental, and vision services
- View demographic information for the providers associated with the registered TIN such as: office location, office hours and associated practitioners
- Update demographic information (address, office hours, etc.)
- View and print patient lists (primary care providers). This patient list will indicate the member's name, member ID number, date of birth and the product in which they are enrolled
- Submit authorizations and view the status of authorizations that have been submitted for members
- View claims and the claim status
- Submit individual claims, batch claims or batch claims via an 837 file
- View and download Explanations of Payment (EOP)
- View a member's health record including visits (physician, outpatient hospital, therapy, etc.), medications, and immunizations
- View gaps in care specific to a Member including preventive care or services needed for chronic conditions
- Send secure messages to Wellcare staff

Disclaimer

Providers agree that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

CREDENTIALING AND RE-CREDENTIALING

The credentialing and re-credentialing process exists to verify that participating practitioners and providers meet the criteria established by Wellcare, as well as applicable government regulations and standards of accrediting agencies.

If a practitioner/provider already participates with in the Medicaid product, the practitioner/provider will NOT be separately credentialed for the Wellcare product.

Notice: In order to maintain a current practitioner/provider profile, practitioners/providers are required to notify Wellcare of any relevant changes to their credentialing information in a timely manner but in no event later than 10 days from the date of the change.

The following information must be on file:

- Signed attestation as to correctness and completeness, history of license, clinical privileges, disciplinary actions, and felony convictions, lack of current illegal substance use and alcohol abuse, mental and physical competence, and ability to perform essential functions with or without accommodation;
- Current malpractice insurance policy face sheet, which includes insured dates and the amounts of coverage;
- Current controlled substance registration certificate, if applicable;
- Current drug enforcement administration (DEA) registration certificate for each state in which the practitioner will see Wellcare members;
- Completed and signed w-9 form;
- Current Educational Commission for Foreign Medical Graduates (ECFMG) Certificate, if applicable;
- Curriculum vitae listing, at minimum, a five-year work history if work history is not completed on the application with no unexplained gaps of employment over six months for initial applicants;
- Signed and dated release of information form not older than 120 days; and
- Current clinical laboratory improvement amendments (CLIA) certificate, if applicable.

Wellcare will primary source verify the following information submitted for credentialing and re-credentialing:

- License through appropriate licensing agency;
- Board certification, or residency training, or professional education, where applicable;
- Malpractice claims and license agency actions through the National Practitioner Data Bank (NPDB); and

- Federal sanction activity, including Medicare/Medicaid services (OIG-Office of Inspector General, Preclusion List).

For providers (hospitals and ancillary facilities), a completed Facility/Provider – Initial and Re-credentialing Application and all supporting documentation as identified in the application must be received with the signed, completed application.

Once the clean application is received, the Credentialing Committee will usually render a decision on acceptance following its next regularly scheduled meeting.

Primary care practitioners cannot accept member assignments until they are fully credentialed.

Credentials Committee

The Credentials Committee including the Medical Director, or their physician designee has the responsibility to establish and adopt necessary criteria for participation, termination, and direction of the credentialing procedures, including participation, denial, and termination. Committee meetings are held at least quarterly and more often as deemed necessary.

Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Re-credentialing

Wellcare conducts practitioner/provider re-credentialing at least every 36 months from the date of the initial credentialing decision and most recent re-credentialing decision. The purpose of this process is to identify any changes in the practitioner's/provider's licensure, sanctions, certification, competence, or health status which may affect the practitioner's/provider's ability to perform services under the contract. This process includes all practitioners, facilities and ancillary providers previously credentialed and currently participating in the network.

In between credentialing cycles, Wellcare conducts provider performance monitoring activities on all network practitioners/providers. This monthly inquiry is designed to monitor any new adverse actions taken by regulatory bodies against practitioners/providers in between credentialing cycles. Additionally, Wellcare reviews monthly reports released by the state, CMS and Office of Inspector General to identify any network practitioners/providers who have been newly sanctioned or excluded from participation in Medicare or Medicaid.

A provider's agreement may be terminated if at any time it is determined by the Wellcare Credentials Committee that credentialing requirements or standards are no longer being met.

Practitioner Right to Review and Correct Information

All practitioners participating within the network have the right to review information obtained by Wellcare to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank Healthcare Integrity and Protection Data

Bank, CAQH, malpractice insurance carriers and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Practitioners have the right to correct any erroneous information submitted by another party (other than references, personal recommendations, or other information that is peer review protected) in the event the provider believes any of the information used in the credentialing or re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner.

To request release of such information, a written request must be submitted to the Credentialing Department.

The Credentials Committee will then include any additional information received from the Practitioner as part of the credentialing or re-credentialing decision.

Practitioner Right to Be Informed of Application Status

All practitioners who have submitted an application to join have the right to be informed of the status of their application upon request. To obtain application status, the practitioner should contact the Provider Relations Representative at 1-833-853-0865 or www.wellcareok.com.

Practitioner Right to Appeal Adverse Re-credentialing Determinations

Applicants who are existing providers and who are declined continued participation due to adverse re-credentialing determinations (for reasons such as appropriateness of care or liability claims issues) have the right to request an appeal of the decision. Requests for an appeal must be made in writing within 30 days of the date of the notice.

All written requests should include additional supporting documentation in favor of the applicant's appeal or reconsideration for participation in the network.

Provider Non-Discrimination

We do not limit the participation of any provider or facility in the network, and/or otherwise discriminate against any provider or facility based solely on any characteristic protected under state or federal discriminate laws. We also do not discriminate for reimbursement or indemnification of any provider who is acting within the scope of their license or certification under applicable state law, solely on the basis of that license or certification. If Wellcare declines to include individual or groups of providers in our network, we will give the affected providers written notice of the reason for its decision.

Furthermore, we do not and have never had a policy of terminating any provider who:

- Advocated on behalf of a member;
- Filed a complaint against us; or
- Appealed a decision of ours.

PROVIDER ADMINISTRATION AND ROLE OF THE PROVIDER

Primary Care Providers

The primary care provider (PCP) is the cornerstone of Wellcare's care delivery model. The PCP serves as the Medical Home for the member. The Medical Home concept addresses an approach to care in which the PCP is the primary coordinate of all care for each member and uses a holistic, patient-centered approach to treatment. The Medical Home should assist in establishing a patient-provider relationship and ultimately better health outcomes. The PCP is responsible for providing all primary care services for Wellcare's members, including, but not limited to:

- Supervision, coordination, and provision of care to each assigned member;
- Initiation of referrals for medically necessary specialty care;
- Maintaining continuity of care for each assigned member;
- Maintaining the member's medical record, including documentation for all services provided to the member by the PCP, as well as any specialists, behavioral health or other referral services; and
- Screening for behavioral health needs at each visit and when appropriate, initiate a behavioral health referral.

Care managers will partner with the PCP not only to ensure the member receives any necessary care but to also assist the PCP in providing a Medical Home for the patient.

All PCPs may reserve the right to state the number of patients they are willing to accept into their practice. Since assignment is based on the member's choice, Wellcare does not guarantee a PCP will receive a set number of patients. PCPs may contact Provider Services if they, choose to change their panel size or close their panel to accept only established patients. If Wellcare determines that a PCP fails to maintain quality, accessible care, Wellcare reserves the right to close the PCP panel if necessary and re-assign members to a new PCP.

Specialist as the Primary Care Provider

When medically necessary care is needed beyond the scope of what the PCP can provide, PCPs are encouraged to initiate and coordinate the care members receive from specialist providers. ***Paper referrals are not required.***

In accordance with federal and state law, providers are prohibited from making referrals for designated health services to healthcare providers with which the provider, the member, or a member of the provider's family or the member's family has a financial relationship.

Specialty Care Provider

The Specialty Care Provider agrees to partner with the member's PCP and Care Manager to deliver care. Some key roles of specialty providers include:

- Rendering services requested by the PCP
- Communicating with the PCP regarding medical findings in writing
- Confirming member eligibility and benefit level prior to rendering services
- Providing a consultation report to the PCP within 60 days of the consult

Most visits to specialists do not require a prior authorization. While most specialists will require a written referral from the member's PCP, it is not required for the claim to be reimbursed by Wellcare. Specialists may elect to limit their practice to established patients only upon request to Provider Services.

Members may self-refer to an OB/GYN for their annual well checkup or for care related to pregnancy.

Specialty Care Physicians include, but are not limited to:

- Cardiology
- Gynecology and Related Services
- Endocrinology
- Gastroenterology
- Geriatrics
- Neurology
- Nephrology
- Oncology
- Ophthalmology
- Orthopedics
- Podiatry
- Pulmonology
- Rheumatology
- Urology

Mental Health Providers

Medicare recognizes the following practitioners who are eligible under Part B to furnish diagnostic and/or therapeutic treatment for mental, psychoneurotic, and personality disorders:

- Psychiatrist or other physicians (medical doctors [MD] and doctors of osteopathy [DO], particularly psychiatrists
- Clinical psychologists (CP)
- Clinical social workers (CSW)
- Clinical nurse specialists (CNS)

- Nurse practitioners (NP)
- Physician assistants (PA)
- Certified nurse-midwives (CNM)
- Independently Practicing Psychologist (IPP)

Independently Practicing Psychologists (IPP) Hospitals

Hospitals are essential in delivering care to members. For this reason, Wellcare may contract with hospitals in the member service areas; however, any facility can be used in the case of an emergency. Additionally, Wellcare contracts with rehabilitation facilities, ambulatory surgery center, and other facilities needed to manage the health care of its members. Some responsibilities of hospitals include:

- Coordination of discharge planning with Wellcare Utilization Management staff
- Coordination of mental health /substance abuse care with the PCP and appropriate community providers
- Eligibility and benefit authorization before services are rendered
- Communication of all relevant medical information to member PCPs
- Communication of all emergent hospital admission to Wellcare Utilization Management staff within 48 hours of admission

Providers are encouraged to have privileges at Wellcare's contracted facility or agreements with hospitalist groups to care for their members who are hospitalized. Providers should review the Provider Directory for a list of contracted hospitals and associated facilities.

Ancillary Providers

Ancillary providers cover a wide range of services from therapy services to laboratory. The following are services provided by ancillary providers:

- Durable Medical Equipment
- Hospice Care
- Home Health
- Laboratory
- Prosthetics and Orthotics
- Radiology

- Therapy (Physical, Occupational, Speech)
- Some critical areas of responsibilities for ancillary providers include:
- Obtaining member eligibility and benefit level prior to rendering services
- Know limitations and/or benefit exclusions applicable to member
- Communicate all relevant medical information to member's PCP

PHYSICIAN INCENTIVE PROGRAMS

On an annual basis and in accordance with Federal Regulations, Wellcare must disclose to the Centers for Medicare and Medicaid Services, any Physician Incentive Programs that could potentially influence a physician's care decisions. The information that must be disclosed includes the following:

- Effective date of the Physician Incentive Program
- Whether services not covered by Wellcare are covered under Physician Incentive Program
- Type of Incentive Arrangement i.e. withhold, bonus, capitation
- If Incentive Arrangement involves withhold or bonus, what percentage of withhold or bonus
- Amount and type of stop-loss protection
- Patient panel size
- Description of the pooling method, if applicable
- For capitation arrangements, provide the amount of the capitation payment that is broken down by percentage for primary care, referral and other services
- The calculation of substantial financial risk (SFR)
- Whether Wellcare does or does not have a Physician Incentive Program
- The name, address and other contact information of the person at Wellcare who may be contacted with questions regarding Physician Incentive Programs

Physician Incentive Programs may not include any direct or indirect payments to providers and/or provider groups who create inducements to limit or reduce the provision of necessary services. In addition, Physician Incentive Programs that place providers and/or provider groups at significant financial risk may not operate unless there is adequate stop-loss protection, member satisfaction surveys and satisfaction of disclosure requirements satisfying the Physician Incentive Program regulations.

Substantial financial risk (SFR) occurs when the incentive arrangement places the provider and/or provider group at risk beyond the risk threshold which is the maximum risk if the risk is based upon the use or cost of referral services. The risk threshold is set at 25% and does not include amounts based solely on factors other than a provider and/or provider group's referral levels. Bonuses, capitation, and referrals may be considered incentive arrangements that result in SFR.

If you have questions regarding the Physician Incentive Program Regulations, please contact your Provider Partnership Manager.

First-Tier and Downstream Providers

Through written agreement, Wellcare may delegate certain functions or responsibilities in accordance with CMS regulations 42 CFR § 422.504 to First-Tier, downstream, and delegated entities. These functions and responsibilities include but are not limited to contract administration and management, claims submission, claims payment, credentialing and re-credentialing, network management, and provider training. Wellcare oversees and is accountable for these responsibilities specified in the written agreement and will impose sanctions or revoke delegation if the entities' performance is inadequate. Wellcare will ensure written agreements which specify these responsibilities by Wellcare and the delegated entity are clear and concise. Agreements will be kept on file by Wellcare for reference.

Member Notifications

Medicare providers are required in certain circumstances to provide notifications to their patients about various aspects of their care. This section outlines some of the most common member notifications required by Medicare providers. For a comprehensive list of notification requirements, please review Chapter 30 (Financial Liability Protections) of the Medicare Claims Processing Manual, available on www.cms.gov.

NOTICE OF MEDICARE NON-COVERAGE (NOMNC)

Scope

The expedited determination process is available to beneficiaries in Original Medicare whose Medicare covered services are being terminated in the following settings. All beneficiaries receiving services in these settings must receive a Notice of Medicare Non-Coverage (NOMNC) before their services end:

- Home Health Agencies (HHAs)
- Comprehensive Outpatient Rehabilitation Services (CORFs)
- Hospice
- Skilled Nursing Facilities (SNFs)-- Includes services covered under a Part A stay, as well as Part B services provided under consolidated billing (i.e. physical therapy, occupational therapy, and speech therapy). A NOMNC must be delivered by the SNF at the end of a Part A stay or when all of Part B therapies are ending.

Provider Delivery of the NOMNC

Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per §260.2. A NOMNC must be delivered even if the beneficiary agrees with the termination of services. Medicare providers are responsible for the delivery of the NOMNC.

Required Delivery Timeframes

The NOMNC should be delivered to the beneficiary at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.

Detailed Explanation of Non-Coverage

The Detailed Explanation of Non-Coverage (DENC)

Medicare providers are responsible for the delivery of the DENC to beneficiaries who request an expedited determination by the QIO. The DENC must contain the following information:

- The facts specific to the beneficiary's discharge and provider's determination that coverage should end.
- A specific and detailed explanation of why services are both no longer reasonable and necessary or no longer covered.
- A description of, and citations to, the Medicare coverage rule, instruction, or other policies applicable to the review.

The delivery must occur in person by close of business of the day the QIO notifies the provider that the beneficiary has requested an expedited determination. A provider may also choose to deliver the DENC with the NOMNC.

Required Notification to Members for Observation Services

Scope

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 if sooner upon release. The OMB approved Medicare Outpatient Observation Notice and accompanying form instructions can be found at www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html

Notice of Hospital Discharge Appeal Rights

Hospitals must issue the ***Important Message*** within two calendar days of admission, obtain signature of the patient or the signature of their authorized representative, and provide a signed follow-up copy to the patient as far in advance of discharge as possible, but not more than two calendar days before discharge.

Provider-Preventable Conditions

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

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 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 or hospitalizations and other services related to these non-covered procedures.

MEMBER SELECTION OR ASSIGNMENT OF PCP

Wellcare gives members the freedom to select the healthcare provider of their choice. Services from in-network providers are covered in based on contracted provisions, fee schedule, and any standard coding and claim guidelines, with exception of member cost sharing or co-pays. Or until the maximum out-of-pocket is met, out-of-network care is covered only in an emergency. Members are generally responsible for the full cost of care received from out-of-network providers.

Practitioners/providers must be credentialed prior to accepting or treating members, unless prior authorization has been obtained. Primary care physicians (PCPs) cannot accept member assignments until they are fully credentialed.

All PCPs reserve the right to state the number of members they are willing to accept into their panel. Wellcare does not and is not permitted to guarantee that any provider will receive a certain number of members.

The PCP to member ratio shall not exceed the following:

- Physicians 1: 2,500
- Nurse Practitioner 1: 1,250
- Physician Assistant 1: 1,250

PCPs and specialists who want to change their panel status (open, closed, existing members only) must notify Provider Services. Please note that PCPs and specialists may not refuse acceptance of new members if the panel status is open.

prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Wellcare members.

APPOINTMENT AVAILABILITY

The following standards are established regarding appointment availability:

Type of Care	Accessibility Standard*
PRIMARY CARE	
Emergency	Same day or within 24 hours of member's call
Urgent care	Within 2 days of request
Routine	Within 14 days of request
SPECIALTY REFERRAL	
Emergency	Within 24 hours of referral
Urgent care	Within 3 days of referral
Routine	Within 45 days of referral
MATERNITY	
1st trimester	Within 14 days of request
2nd trimester	Within 7 days of request
3rd trimester	Within 3 days of request
High-risk pregnancies	Within 3 days of identification or immediately if an emergency exists
DENTAL	
Emergency	Within 24 hours of request
Urgent care	Within 3 days of request
Routine	Within 45 days of request

The in-office wait time is less than 45 minutes, except when the provider is unavailable due to an emergency.

The following are behavioral health appointment access guidelines:

Appointment Type	Description	Standard*
Immediate	Behavioral health services provided within a time frame indicated by behavioral health condition, but no later than 2 hours from identification of need or as quickly as possible when a response within 2 hours is geographically impractical	Within 2 hours – may include telephonic or face-to-face interventions

Urgent	Behavioral health services provided within a time frame indicated by behavioral health condition but no later than 24 hours from identification of need	Within 2 hours
Routine – initial assessment	Appointment for initial assessment with a BHP within 7 days of referral or request for behavioral health services	Within 7 days of referral
Routine – first behavioral health service	Includes any medically necessary covered behavioral health service including medication management and/or additional services	Within 7 days of assessment
Appointments for psychotropic medication		The member's need for medication is assessed immediately and if clinically indicated, the member is scheduled for an appointment within a time frame that ensures: • The member does not run out of any needed psychotropic medications; or • The member is evaluated for the need to start medications to ensure that the member does not experience a decline in their behavioral health condition.
Referrals or requests for psychotropic medications	Screening, consultation, assessment, medication management, medications, and/or lab testing services, as appropriate	Assess the urgency of the need immediately. If clinically indicated, provide an appointment with a BHP within a time frame indicated by clinical need, but no later than 30 days from the referral/initial request for services.

Non-emergency transportation		• Member must not arrive sooner than one hour before their scheduled appointment; and • Member must not have to wait for more than one hour after the conclusion of their appointment for transportation home or to another pre-arranged destination.

Telephone Arrangements

Providers must be accessible to members 24 hours a day, seven (7) days a week.

- **After hours services**
  - Answering services must meet language requirements.
  - Should be able to reach the PCP or other designated medical provider.
  - All calls need to be returned within 30 minutes.
- **Answering machine**
  - Should be on after business hours.
  - Should direct members to call another number to reach the PCP or other designated medical provider.
  - A live person should be available to answer the designated phone number; another recording is not acceptable.
- **Transferred phone call**
  - Calls can be transferred to another location where a live person will be able to assist and can contact the PCP or another designated medical provider.
  - All calls need to be returned within 30 minutes.

Providers are required to develop and use telephone protocol for all of the following situations:

- Answering the member's telephone inquiries on a timely basis;
- Prioritizing appointments;
- Scheduling a series of appointments and follow-up appointments as needed by a member;
- Identifying and rescheduling cancelled and no-show appointments;
- Identifying special member needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs for non-compliant individuals who are mentally incapacitated;

- Scheduling continuous availability and accessibility of professional, allied and supportive medical/dental personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence; and

- After-hours calls should be documented in a written format in either an after-hour call log or some other method and transferred to the member's medical record.

Note: If after-hours urgent care or emergent care is needed, the PCP or their designee should contact the urgent care or emergency center to notify the facility.

Wellcare will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program.

Training Requirements

Information on training opportunities will be posted on our website at www.wellcareok.com. The following training courses are required by CMS as well as Wellcare:

- Annual Fraud, Waste and Abuse Training within 90 days of contracting and annually thereafter;

- Annual Compliance Training within 90 days of contracting and annually thereafter;

- Annual Model of Care Training within 90 days of contracting and annually thereafter;

- Cultural Competency Training; and

- Other State Required Training.

Missed Appointments and Other Charges

Wellcare may charge "administrative fees" to Medicare Advantage members for missed appointments with contracting providers and for not paying contracting providers required cost-sharing at the time of service.

Contracted and non-contracted providers may charge a fee for missed appointments, provided such fees apply uniformly to all Medicare and non-Medicare patients. This applies even if the Medicare Advantage Organization (MAO) itself does not charge an administrative fee for missed appointments.

WELLCARE BENEFITS

Wellcare covers all benefits through fee-for-service Medicare plus more. All services are subject to benefit coverage, limitations and exclusions as described in the applicable Wellcare coverage guidelines.

Access a copy of the Member's Evidence of Coverage to verify the covered services specific to each plan on the Wellcare portion of our website at www.wellcareok.com. Please contact Provider Services at Wellcare Medicare HMO Phone: 1-855-766-1572 (TTY: 711) Wellcare Dual Medicare (HMO DSNP) & Wellcare Dual Medicare Essentials (HMO DSNP) Phone: 1-833-541-0767 (TTY: 711) with any questions you may have regarding benefits.

The following is a partial list of services not covered under Parts A and B, however, may be covered under a supplemental benefit:

- Acupuncture
- Hearing Aids
- Routine Foot Care
- Emergency care while traveling outside of the United States
- Routine Dental Care
- Routine Eye Care
- Custodial Care

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 the member against the required criteria below. All criteria must be met, and the completed attestation form must be received before the member receives access to benefits.
    a. Criteria include:
        i. A need for intensive Care Management
            1. Member has had 2 or more inpatient admissions in the last 60 days, or member has had 3 or more emergency room visits in the last 60 days
        ii. A high risk for hospitalization

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

iii. Currently diagnosed with one or more qualifying chronic conditions

1. Member 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 our public forms page) indicating if the member 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.

Once all criteria are met, Wellcare will send a letter to the member that confirms approval or denial of SSBCI and instructions on how to activate the member benefits.

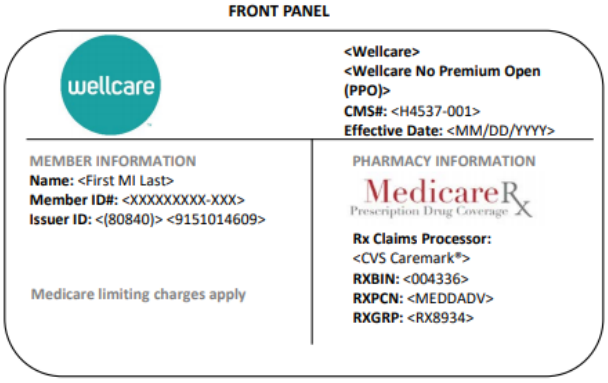
VERIFYING MEMBER BENEFITS, ELIGIBILITY, AND COST SHARES

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 Wellcare 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 your eligibility report, please contact Provider Services at Wellcare Medicare HMO Phone:1-855-766-1572 (TTY: 711) Wellcare Dual Medicare (HMO DSNP) & Wellcare Dual Medicare Essentials (HMO DSNP): 1-833-541-0767 (TTY: 711)

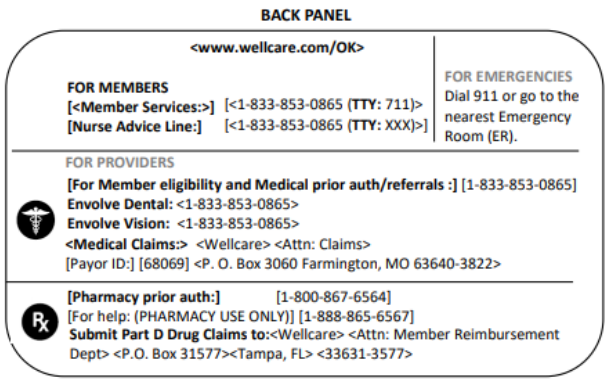
Member Identification Card

Below is a sample member identification card.

Front



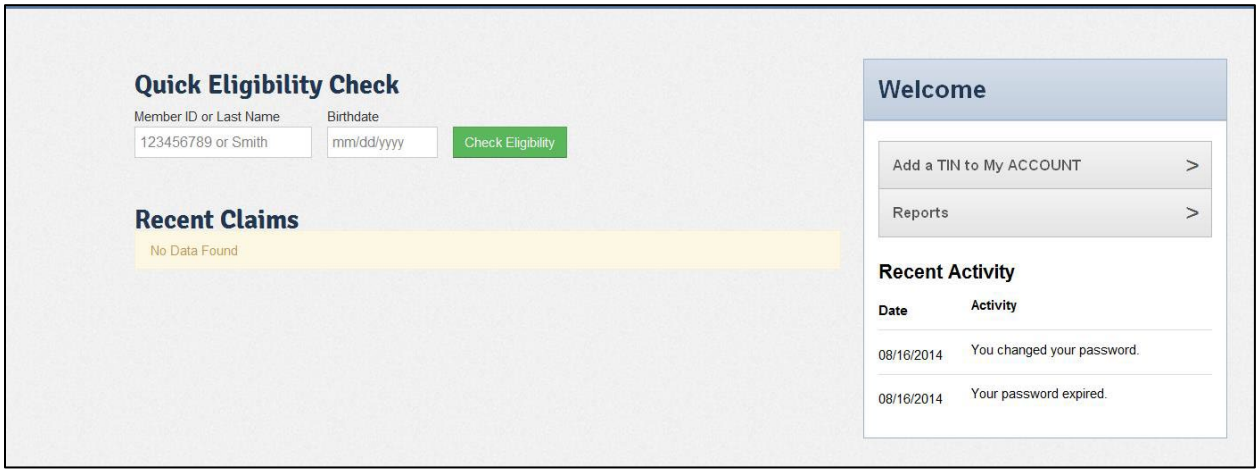
Back



NOTE: Presentation of a member ID card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are rendered.

Preferred Method to Verify Benefits, Eligibility, and Cost Shares

The preferred method to verify member benefits, eligibility, and cost share information is through the Wellcare secure web portal found at www.wellcareok.com. Using the Portal, registered providers can quickly access member status. Eligibility checks can be performed using Member ID or last name, DOB, and date of service. Information on the web portal is updated every 24 hours.



Other Methods to Verify Benefits, Eligibility and Cost Shares

Toll Free Interactive Voice Response (IVR) Line at: Wellcare Medicare HMO Phone: 1-833-853-0865 (TTY: 711) Wellcare Dual Medicare (HMO DSNP) & Wellcare Dual Medicare Essentials (HMO DSNP) Phone: 1-833-853-0866 (TTY: 711)	• Provider and member information can be sent through the IVR validation process, so Providers do not have to re-enter information • Providers may also opt to use speech capability or touch-tone keypad prompts to enter the member ID number and the month of service to check eligibility.
Provider Services at: Wellcare Medicare HMO Phone: 1-833-853-0865 (TTY: 711) Wellcare Dual Medicare (HMO DSNP) & Wellcare Dual Medicare Essentials (HMO DSNP) Phone: 1-833-853-0866 (TTY: 711)	• If a member's eligibility cannot be confirmed using the secure portal or the IVR line, call Provider Services. • Follow the menu prompts to speak to a Provider Services Representative. • Member ID number or last name and DOB are needed to authenticate verification.

MEDICAL MANAGEMENT

Care Management

Care Management is a collaborative process to assess, plan, implement, coordinate, monitor, and evaluate options and services to meet an individual's health needs, using communication and available resources to promote quality, cost effective outcomes. Service/Care Coordination and Care Management are member-centered, goal-oriented, culturally relevant, and logically managed processes to help ensure that a member receives needed services in a supportive, effective, efficient, timely and cost-effective manner.

An initial Health Risk Assessment (HRA) will be completed by phone, in person or member's preferred method of communication within 90 days of the member's enrollment date. The HRA will be the basis of the Care Plan and will be available for your review via the Provider Portal. Wellcare Care Management teams support physicians by tracking adherence with the individual care plan (ICP), and facilitating communication between the PCP, member, managing physician, and the Care Management team. The Care Manager also facilitates referrals and links to community Providers, such as local health departments and Division of Aging. The managing physician maintains responsibility for the member's ongoing care needs. The Wellcare Care Management team will contact the PCP, and/or, managing physician if the member is not following the plan of care or requires additional services.

All Wellcare members with identified needs are assessed for Care Management enrollment. Members with needs may be identified via HRA, clinical rounds, referrals from other Wellcare staff members, hospital census, and direct referral from Providers, self-referral or referral from other Providers.

Care Management Process

Wellcare's Care Management process for high risk, complex, or catastrophic conditions contains the following key elements:

- Screen and identify members who potentially meet the criteria for Care Management
- Assess the member's risk factors to determine the need for Care Management
- Notify the member and their PCP of the member's enrollment in Wellcare's Care Management program
- Develop and implement an ICP treatment plan that is inclusive of preventative services to improve quality and accommodates the specific cultural and linguistic needs of the member
- Establish with the member the ICP problems, goals and interventions to meet desired member outcomes
- Refer and assist the member in ensuring timely access to providers
- Coordinate medical, residential, social and other support services
- Monitor care/services and promote medication adherence

- Coordinate transition of care and medication reconciliation post hospitalization
- Revise the ICP as necessary
- Assess the member's satisfaction with Complex Care Management services
- Track plan outcomes
- Follow-up post discharges from Care Management
- Referring a member to Wellcare Care Management: Providers are asked to contact an Wellcare Care Manager to refer a member identified in need of Care Management intervention.

Interdisciplinary Care Team (ICT)

The Wellcare Care Managers will coordinate the member's care with the Interdisciplinary Care Team (ICT). The ICT is generally comprised of multidisciplinary clinical and nonclinical staff chosen by the member. Our integrated care management approach allows non-medical personnel to perform non-clinical based health service coordination and clerical functions and permits the licensed professional staff to focus on the more complex and clinically based service coordination needs. The purpose of the ICT is to coordinate the plan of care with the member. Our program is member centric with the PCP being the primary ICT point of contact for the member's treatment and medical care. Provider responsibilities include:

- Communicate with, and respond to communication from Wellcare regarding the member's care plan, including accepting meeting invitations when applicable;
- Maintaining copies of the ICP, ICT communications, medication reconciliation summary and transition of care notifications in the member's medical record when received;
- Collaborating and actively communicating with Wellcare Care Managers, members of the ICT, and members and caregivers;
- Inpatient Care: Care Managers will coordinate with facilities to assist members with coordinating an appropriate discharge plan meeting the member's needs. Wellcare will then notify the PCP of the transition of care and anticipated discharge date to ensure members receive the appropriate follow-up care;
- Emergency Department (ED) Utilization: The PCP collaborates with the Care Manager for enrollment in Care Manager for enrollment in Care Management and Disease Management Programs where opportunities are identified;
- Transition of Care: Managing transition of care for discharged members may include but is not limited to face to face or telephonic contact with the member or their representative in the hospital prior to discharge to discuss the discharge plan; and

- ICT Training: All internal and external ICT members will be trained annually on the current Model of Care.

HMO Special Needs Plan (SNP) Model of Care (MOC) and Care Management

The MOC provides the basic framework under which Wellcare will meet the needs of our Medicare members. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each member are identified and addressed through the plan's care management practices. The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes. Your role in the Model of Care is very important. Every SNP member must have:

- Initial (within 90 days of enrollment) and annual Health Risk Assessment (HRA)
- Individualized Care Plan (ICP)

Integrated Care Team participation and guidance in the development of the ICP and attendance at the ICT meeting is necessary to:

- Promote improved member outcomes and condition self-management
- All SNP members remain in Care Management as required by CMS

Purpose

To improve quality, reduce costs, and improve the member experience:

- Ensure members have full access to the services they are entitled
- Improve the coordination between the federal government and state requirements
- Develop innovative care coordination and integration models
- Eliminate financial misalignments that lead to poor quality and cost shifting

Model of Care Elements include:

- MOC 1: SNP Population
- MOC 2: Care Coordination and Care Transitions protocol
- MOC 3: Provider Network
- MOC 4: Quality Measurement

Health Risk Assessment:

- Every SNP member receives a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment, and at minimum annually, or more frequently with any significant change in condition or transition of care.

- The HRA collects information about the member's medical, psychosocial, cognitive, and functional needs, and behavioral health history.

- The HRA determines the member's level of health and functioning.

- Wellcare with the help of the member/designated caregiver and the member's provider(s), develops an ICP for each SNP member.

- Following the HRA, all SNP members who choose to participate in the Case Management Program will:

    - Participate with a care manager to develop and agree upon their ICP. This will be shared with the members of the ICT for input and finalization of the member's care plan.

    - Receive regular telephonic contact with their assigned care manager to monitor progress/regression towards goals of the care plan.

    - Benefit from ongoing communication between the care manager and other members of the ICT.

    - Receive at minimum, an annual HRA.

Individualized Care Plan

All SNP members must have an Individualized Care Plan (ICP) which is developed in conjunction with the member/caregiver, Primary Care Physician and other members of the health care team including the Interdisciplinary Care Team (ICT). The ICP includes:

- Problems, interventions and goals

- Specific services and benefits to be provided

- Measurable outcomes

Members receive monitoring, service referrals, and condition specific education. Care Manager's and PCP's work closely together with the member and their family to prepare, implement and evaluate the Individualized Care Plan (ICP). Wellcare disseminates evidence-based clinical guidelines and conducts studies to:

- Measure member outcomes

- Monitor quality of care

- Evaluate the effectiveness of the Model of Care (MOC)

SNP members who can't be contacted by Wellcare or who refuse the Care Management Program will have an initial communication plan created and sent to their practitioner. This plan is to obtain additional information about the member in order to individualize the member's care plan. We encourage the PCPs to discuss care management participation with their members and refer them to us at any time.

All SNP members who undergo a transition of care from one setting to any other setting may receive:

- Communication from care management
- Contact after discharge from one level of care to the next or home
- Education on transition and transition prevention
- Providers will receive communication about the member's transition and any other status changes related to the member's health.

Utilization Management

The Utilization Management Program's goals are to optimize members' health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UM Program aims to provide services that are a covered benefit, medically necessary, appropriate to the member's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Medical Necessity

The fact that a physician may prescribe, authorize, or direct a service does not itself make it medically necessary or a covered benefit under the contract.

Medical necessity determinations will be made in a timely manner by thorough review by Wellcare clinical staff using nationally recognized criteria, Medicare National and Local Coverage Determinations and evidenced based clinical policies to determine medical necessity and appropriate level of care for services. Medical policies are developed through periodic review of generally accepted standards of medical practice and updated at least on an annual basis. Current medical policies are available on our website.

Medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine. These include services which are:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition
- Compatible with the standards of acceptable medical practice in the community

- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and severity of the symptoms

- Not provided solely for the convenience of the member or the convenience of the healthcare provider or hospital

In the event that a member may not agree with the medical necessity determination, a member has the opportunity to appeal the decision. Please refer to the "Grievance Process" section of the provider manual.

Prior Authorization

Prior authorization requires that the provider or practitioner make a formal medical necessity determination request to Wellcare prior to the service being rendered. Members may submit a request for organization determination. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health services proposed, including the setting in which the proposed care will take place.

Prior authorization is required for only those procedures/services for which the quality of care or financial impact can be favorably influenced by medical necessity or appropriateness review such as non-emergent inpatient admissions, all out-of-network services, and certain outpatient services, ancillary services, and specialty injectable as described on the prior authorization list. Prior authorization is not required for emergency services or urgent care services.

Services Requiring Prior Authorization

To see a list of services that require prior authorization please visit the Wellcare website at www.wellcareok.com and use the Pre-Screen Tool or call the Authorization Department with questions. Failure to obtain the required prior authorization or pre-certification may result in a denied claim or reduction in payment. We will suspend the need for prior authorization requests during an emergency/disaster where providers are unable to reach Wellcare for an extended period and when, acting in good faith, providers need to deliver services to our members. Wellcare does not reward providers, practitioners, employees who perform utilization reviews, or other individuals for issuing denials of authorization, service, or care. Neither network inclusion nor hiring and firing practices influence the likelihood or perceived likelihood for an individual to deny or approve benefit coverage. Wellcare affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. There are no financial incentives to deny care or encourage decisions that result in underutilization.

Note: All out-of-network services require prior authorization excluding emergency room services, urgent care when the PCP is not available, and out of area dialysis.

Submitting Prior Authorization Requests

The preferred method for submitting authorization requests is through the Secure Web Portal at www.wellcareok.com. The provider must be a registered user on the Secure Web Portal. (If a provider is already registered for the Secure Web Portal for one of our other products, that registration will grant the provider access to Wellcare). If the provider is not already a registered user on the Secure Web Portal and

needs assistance or training on submitting prior authorizations, the provider should contact Provider Relations.

Prior authorization requests may be called to Wellcare at Medicare (HMO) 1-833-853-0865 or Wellcare Dual Medicare (HMO DSNP) & Wellcare Dual Medicare Essentials (HMO DSNP) Phone: 1-833-853-0866 (TTY: 711).

Prior authorization requests may be faxed to 1-833-829-0342. The fax authorization form can be found on our website at www.wellcareok.com.

Timeframes for Prior Authorization Requests and Notifications

Service Type	Timeframe
Elective/scheduled admissions	Required five (5) business days prior to the scheduled admission date
Emergent inpatient admissions	Notification required within one (1) business day
Emergency room and post stabilization, urgent care and crisis intervention	Notification requested within one (1) business day

The requesting or rendering provider must provide the following information to request authorization (regardless of the method utilized):

- Member's name, date of birth and ID number
- Provider's NPI number, taxonomy code, name and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- The procedure code(s). **Note:** If the procedure codes submitted at the time of authorization differ from the services actually performed, it is recommended that within 72 hours or prior to the time the claim is submitted that you phone Medical Management at 1-833-853-0865 or to update the authorization otherwise, this may result in claim denials.
- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date, if the request is for a surgical procedure
- Discharge plans

Utilization Determination Timeframes

Utilization management decision making is based on appropriateness of care and service and the covered benefits of the plan. Wellcare does not reward providers or other individuals for issuing denials of authorization.

Authorization decisions are made as expeditiously as possible. Wellcare utilizes the specific timeframes listed below. In some cases, it may be necessary for an extension to extend the timeframe below. You will be notified if an extension is necessary. Please contact Wellcare if you would like a copy of the policy for utilization management timeframes.

Level of Urgency

Type	Timeframe
Standard	Expeditiously as the member's health condition required, but no later than 14 calendar days after receipt of request
Standard Extension	Up to 14 additional calendar days (not to exceed 28 calendar days from receipt of original request)
Expedited	Expeditiously as the member's health condition requires, but no later than Within 72 hours after receipt of request
Expedited Extension	Add 11 days up to 14 additional calendar days (not to exceed 17 calendar days after receipt of original request)
Concurrent	As soon as medically indicated; usually within one (1) business day of request depending on the plan's policy

Standard Organization Determinations

Standard organization determinations are made as expeditiously as the member's health condition requires, but no later than 14 calendar days after we receive the request for service. An extension may be granted for 14 additional calendar days if the member requests an extension, or if we justify the need for additional information and documents that the delay is in the best interest of the member.

Expedited Organization Determinations

Expedited organization determinations are made when the member or their provider believes that waiting for a decision under the standard timeframe could place the member's life, health or ability to regain maximum function in serious jeopardy. The determination will be made as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the member or provider's request. An extension may be granted for 14 additional calendar days if the member requests an extension, or if we justify a need for additional information and document how the delay is in the best interest of the member. Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the member has already received. Expedited urgent requests must be called to Wellcare Medicare HMO Phone: 1-833-853-0865 (TTY: 711) Wellcare Dual Medicare (HMO DSNP) & Wellcare Dual Medicare Essentials (HMO DSNP): 1-833-853-0866 (TTY: 711).

Concurrent Review

Concurrent review is defined as any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of treatments. Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care. Decisions are made as expeditiously as the member's health condition requires, generally within one (1) business day of receipt.

Retrospective Review

A retrospective review is any review of care or services that have already been provided to a member. This includes acute hospital stays when initial notification is received after the member has been discharged.

The requestor must submit a claim for payment. If the claim is denied, the provider and/or member will also have the ability to file an appeal. Wellcare will complete a medical necessity review when authorization or timely notification to Wellcare was not obtained due to extenuating circumstances. Circumstances may include Unable to Know situations - member was unconscious at presentation, member did not have their Wellcare ID card or indicated other coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service; or Not Enough Time Situations the member requires immediate medical services and prior authorization cannot be completed prior to service delivery. If a clinical review is warranted due to extenuating circumstances, a decision will be made within 30 calendar days following receipt of all necessary information.

Utilization Review Criteria

Wellcare's Medical Director or other health care professional, with appropriate clinical expertise in treating the member's condition or disease, will review all potential adverse determinations and make a decision in accordance with currently accepted medical or health care practices, taking into account special circumstances of each case that may require deviation from NCD, LCD, nationally recognized criteria, or other standards mentioned above. Wellcare's Clinical Policies are posted at www.wellcareok.com. Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 1-833-853-0865. Providers have the opportunity to discuss any adverse decisions with a Wellcare physician or other appropriate reviewer at the time of an adverse determination. The Medical Director may be contacted by calling Wellcare at 1-833-853-0865 and asking for the Medical Director. A Wellcare

Care Manager may also coordinate communication between the Medical Director and the requesting provider.

Utilization management decision making is based on appropriateness of care and service and the existence of coverage. Wellcare does not provide financial incentives and does not reward providers or other individuals for issuing denials of authorizations.

Pharmacy

Pharmacy covered services for Wellcare members vary based on the plan benefits. Information regarding the member's pharmacy coverage can be found via our secure online Provider Portal. Additional resources available on the website include the Wellcare formulary, Pharmacy Benefit Manager Provider Manual, and Medication Request/Exception Request form.

Wellcare formulary is designed to assist contracted healthcare prescribers with selecting the most clinically and cost-effective medications available. The formulary provides instruction on the following:

- Which drugs are covered, including restrictions and limitations;
- The Pharmacy Management Program requirements and procedures;
- An explanation of limits and quotas;
- How prescribing providers can request an exception; and
- How Wellcare conducts generic substitution, therapeutic interchange and step-therapy.

The Wellcare formulary does not:

- Require or prohibit the prescribing or dispensing of any medication.
- Substitute for the professional judgment of the physician or pharmacist.
- Relieve the physician or pharmacist of any obligation to the member.

The Wellcare formulary will be approved initially by the Pharmacy and Therapeutics Committee (P & T), led by the Pharmacist and Medical Director, with support from community based primary care providers and specialists. Once established, the formulary will be maintained by the P & T Committee, using quarterly meetings, to ensure that Wellcare members receive the most appropriate medications. The Wellcare formulary contains those medications that the P & T Committee has chosen based on their safety and effectiveness. If a physician feels that a certain medication merits addition to the list, the formulary Change Request policy can be used as a method to address the request. The P & T Committee would review the request, along with supporting clinical data, to determine if the drug meets the safety and efficacy standards established by the Committee. Copies of the formulary are available on our website, www.wellcareok.com. Providers may also call Provider Services for hard copies of the formulary.

The majority of prescriptions will be covered based on the Medicare formulary. In addition, Wellcare will assist with the following:

- Transitions of prescription drugs
- Quality Assurance
- Utilization Management (including Prior Authorization Requirements)
- Exceptions and Appeals
- Locating a nearby pharmacy

- Information about formulary changes

- Out-of-Network Coverage

Pharmacy Transition Policy

Under certain circumstances and following CMS requirements, Wellcare can offer a temporary supply of a drug if the drug is not on the formulary or is restricted in some way. To be eligible for a temporary supply, members must meet the requirements below:

- The drug the member has been taking is no longer on the Wellcare formulary or the drug is now restricted in some way

- The member must be in one of the situations described below:

    - For those members who were enrolled with Wellcare last year and are not in a long-term care facility: We will cover a temporary supply of the drug one time only during the first 90 days enrolled in Wellcare of the calendar year. This temporary supply will be for a maximum of a 30-day supply, or less if the prescription is written for fewer days. The prescription must be filled at a network pharmacy.

    - For those members who are new to Wellcare and are not in a long-term care facility: Wellcare will cover a temporary supply of the drug one time only during the first 90 days of the membership in Wellcare. This temporary supply will be for a maximum of a 30-day supply, or less if the prescription is written for fewer days. The prescription must be filled at a network pharmacy.

    - For those who are new Wellcare members and are residents in a long-term care facility: We will cover a temporary supply of the drug during the first 90 days of membership in Wellcare. The first supply will be for a maximum of a 31-day supply, or less if the prescription is written for fewer days.

    - For those who have been a member of Wellcare for more than 90 days, are a resident of a long-term care facility and need a supply right away; Wellcare will cover one 31-day supply or less if the prescription is written for fewer days. This is in addition to the above long-term care transition supply. An exception or prior authorization should also be requested at the time the prescription is filled.

Pharmacy Prior Authorization Requirements

Wellcare has a team of doctors and pharmacists to create tools to help provide quality coverage to Wellcare members. The tools include, but are not limited to prior authorization criteria, clinical edits and quantity limits. Some examples include:

- **Age Limits:** Some drugs require a prior authorization if the member's age does not meet the manufacturer, FDA, or clinical recommendations.

- **Quantity Limits:** For certain drugs, Wellcare limits the amount of the drug we will cover per prescription or for a defined period of time.

- **Prior Authorization:** Wellcare requires prior authorization for certain drugs. (Prior Authorization may be required for drugs that are on the formulary or drugs that are not on the formulary and were approved for coverage through our exceptions process.) This means that approval will be required before prescription can be filled. If approval is not obtained, Wellcare may not cover the drug.

- **Generic Substitution:** When there is a generic version of a brand-name drug available, our network pharmacies will automatically give the generic version, unless the brand-name drug was requested. If the brand-name drug is not on the formulary, an exception request may be required for coverage. If the brand-name drug is approved, the member may be responsible for a higher co-pay.

Wellcare can make an exception to our coverage rules, please refer to the Comprehensive Formulary. When requesting a utilization restriction exception, submit a supporting statement along with a completed Request for Medicare Prescription Drug Coverage Determination form which can be found at www.wellcareok.com. In order to ensure your patient receives prompt, you must use the Medicare specific Wellcare form and fax it to the number identified on the form. Generally, Wellcare must make a decision within 72 hours of getting the supporting statement. Providers can request an expedited (fast) exception if the member's health could be seriously harmed by waiting up to 72 hours for a decision. If the request to expedite is granted, Wellcare must provide a decision no later than 24 hours after receiving the prescriber's or prescribing doctor's supporting statement.

Second Opinion

Members or a healthcare professional with the member's consent may request and receive a second opinion from a qualified professional within the Wellcare network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider only upon receiving a prior authorization from the Wellcare Utilization Management Department.

Health Care

Members may see a network provider, who is contracted with Wellcare to provide health care services directly, without prior authorization for:

- Medically necessary maternity care

- Covered reproductive health services

- Preventive care (well care) and general examinations

- Gynecological care

- Emergency care
- Follow-up visits for the above services

If the member's health care provider diagnoses a condition that requires a prior authorization to other specialists or hospitalization, prior authorization must be obtained in accordance with Wellcare's prior authorization requirements.

Emergency Medical Condition

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant member, the health of the member or their unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part.

ENCOUNTERS AND CLAIMS

Encounter Reporting

An encounter is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services, they provided our members. For example, if you are the PCP for a Wellcare Member and receive a monthly capitation amount for services, you must file an encounter (also referred to as a "proxy claim") on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or "proxy claim" is paid at zero-dollar amounts. It is mandatory that your office submits encounter data. Wellcare utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by HFS and by CMS. Encounters do not generate an EOP.

A claim is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim. Claims will generate an EOP. Providers are required to submit either an encounter or a claim for each service that you render to a Wellcare Member.

CLAIMS

In general, Wellcare follows the Center for Medicare and Medicaid Services (CMS) billing requirements for paper, electronic data interchange (EDI), and secure web-submitted claims. Wellcare is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary upfront rejections or denials on the explanation of payment if not submitted correctly. **Claims will be rejected or denied if not submitted correctly.**

Verification Procedures

All claims filed with Wellcare are subject to verification procedures. These include, but are not limited to, verification of the following:

- All required fields are completed on an original CMS 1500 Claim Form (02/12), CMS 1450 (UB-04) Claim Form, EDI electronic claim format, or claims submitted on our Secure Provider Portal, individually or batch;
- All claim submissions will be subject to 5010 validation procedures based on CMS Industry Standards;
- Claims must contain the CLIA number when CLIA waived or CLIA certified services are provided. Paper claims must include the CLIA certification in Box 23 when CLIA waived or CLIA certified services are billed. For EDI submitted claims, the CLIA certification number must be placed in: X12N 837 (5010 HIPAA version) loop 2300 (single submission) REF segment with X4 qualifier or X12N 837 (5010 HIPAA version) loop 2400 REF segment with X4 qualifier, (both laboratory services for which CLIA certification is required and non-CLIA covered laboratory tests); and
- DME Claims require Referring Provider.

All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for:

- Date of Service
- Provider Type and/or provider specialty billing
- Age and/or sex for the date of service billed
- Bill type
- All Diagnosis Codes are to their highest number of digits available.

National Drug Code (NDC) is billed in the appropriate field on all claim forms when applicable. This includes the quantity and type. Type is limited to the list below:

- F2 – International Unit
- GR – Gram
- ME – Milligram
- ML – Milliliter
- UN - Unit

Principal diagnosis billed reflects an allowed principal diagnosis as defined in the volume of ICD-10-CM for the date of service billed.

For a CMS 1500 Claim Form, this criterion looks at all procedure codes billed and the diagnosis they are pointing to. If a procedure points to the diagnosis as primary, and that code is not valid as a primary diagnosis code, that service line will deny.

All inpatient facilities are required to submit a Present on Admission (POA) Indicator. Claims will be denied (or rejected) if the POA indicator is missing. Please reference the CMS Billing Guidelines regarding POA for more information and for excluded facility types. Valid 5010 POA codes are:

- N – No
- U – Unknown
- W – Not Applicable
- Y - Yes

Member is eligible for services under Wellcare during the time period in which services were provided.

Services were provided by a participating provider, or if provided by an "out-of-network" provider authorization has been received to provide services to the eligible member. (Excludes services by an "out-of-network" provider for an emergency medical condition; however, authorization requirements apply for post-stabilization services.)

An authorization has been given for services that require prior authorization by Wellcare.

Third party coverage has been clearly identified and appropriate COB information has been included with the claim submission.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service;

- The service provided is a covered benefit under the member's contract on the date of service and prior authorization processes were followed; and

- Payment for services is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in the guide.

Clean Claim Definition

A clean claim is a claim that does not require external investigation or development to obtain information not available on the claim form or on record in Wellcare's systems in order to adjudicate the claim. Clean claims must be filed within the timely filing period.

Non-Clean Claim Definition

Any claim that does not meet the definition of a clean claim is considered a non-clean claim. Non-clean claims typically require external investigation or development in order to obtain all information necessary to adjudicate the claim.

Upfront Rejections vs. Denials

Upfront Rejection

An upfront rejection is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located in the Appendix of this Manual. A list of common upfront rejections can be located in Appendix I of this Manual. Upfront rejections will not enter our claims adjudication system, so there will be no Explanation of Payment (EOP) for these claims. The provider will receive a letter or a rejection report if the claim was submitted electronically.

Denial

If all edits pass and the claim is accepted, it will then be entered into the system for processing**.** A denial is defined as a claim that has passed edits and is entered into the system, however, has been billed with invalid or inappropriate information causing the claim to deny. An EOP will be sent that includes the denial reason. A list of common delays and denials can be found listed below with explanations in Appendix II.

Timely Filing

Participating providers must submit first time claims within 180 days of the date of service. Claims received outside of this timeframe will be denied for untimely submission.

Who Can File Claims?

All providers who have rendered services for Wellcare members can file claims. It is important that providers ensure Wellcare has accurate and complete billing information on file. Please confirm with the Provider Services department or Provider Partnership Manager that the following information is current in our files:

- Provider Name (as noted on current W-9 form)

- National Provider Identifier (NPI)
- Group National Provider Identifier (NPI) (if applicable)
- Tax Identification Number (TIN)
- Taxonomy code (This is a required field when submitting a claim)
- Physical location address (as noted on current W-9 form)
- Billing name and address (as noted on current W-9 form)

We recommend that providers notify Wellcare 60 days in advance of changes pertaining to billing information. If the billing information change affects the address to which the end of the year 1099 IRS form will be mailed, a new W-9 form will be required. Changes to a provider's TIN and/or address are NOT acceptable when conveyed via a claim form.

Electronic Claims Submission

Providers are encouraged to submit clean claims and encounter data electronically. Wellcare can receive an ANSI X12N 5010 837 professional, institutional transaction. In addition, we can generate an ANSI X12N 835 electronic remittance advice and deliver it securely to providers electronically or in paper format, dependent on provider preference. For more information on electronic claims and encounter data filing and the clearinghouses Wellcare has partnered with, contact:

Wellcare
c/o Centene EDI Department
1-800-225-2573, extension 6075525
or
e-mail: EDIBA@centene.com

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers who bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Wellcare has the ability to receive coordination of benefits (COB or secondary) claims electronically. Wellcare follows the 5010 X12 HIPAA Companion Guides for requirements on submission of COB data.

The Wellcare Payer ID is 68069. For a list of the clearinghouses that we currently work with, please visit our website at www.wellcareok.com.

Specific Data Record Requirements

Claims transmitted electronically must contain all of the required data of the X12 5010 Companion Guides. Please contact the clearinghouse you intend to use and ask if they require additional data record requirements.

Electronic Claim Flow Description & Important General Information

In order to send claims electronically to Wellcare, all EDI claims must first be forwarded to one of Wellcare's clearinghouses. This can be completed via a direct submission to a clearinghouse, or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and plan specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a clearinghouse error report. It is very important to review this error report daily to identify any claims that were not transmitted to Wellcare. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to Wellcare and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Wellcare by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are upfront rejected and sent back on a daily basis to the clearinghouse. The clearinghouse in turn forwards the upfront rejection back to its trading partner (the intermediate EDI clearinghouse or provider). It is very important to review this report daily. The report shows rejected claims; these claims must be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily.

Since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to Wellcare.

If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor Customer Service Department.

Rejected electronic claims may be resubmitted electronically once the error has been corrected. Be sure to submit the rejected claim as an original claim.

Invalid Electronic Claim Record Upfront Rejections/Denials

All claim records sent to Wellcare must first pass the clearinghouse proprietary edits and plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by Wellcare. In these cases, the claim must be corrected and re-submitted within the required filing deadline as previously mentioned in Timely Filing section of this Manual. It is important that you review the acceptance or claim status reports received from the clearinghouse in order to identify and re-submit these claims accurately.

Questions regarding electronically submitted claims should be directed to our EDI BA Support at 1-800-225-2573 Ext. 6075525, or via e-mail at EDIBA@centene.com. If you are prompted to leave a voice mail, you will receive a return call within 24 business hours.

The full Companion Guides can be located on the Executive Office of Health and Human Services (EOHHS) on the state specific website.

Specific Electronic Edit Requirements – 5010 Information

- Institutional Claims – 837Iv5010 Edits
- Professional Claims – 837Pv5010 Edits

Corrected EDI Claims

- CLM05-3 Required 7 or 8.
- IN 2300 Loop/REF segment is F8; Ref 02 must input original claim number assigned.
- Failure to include the original claim number will result in upfront rejection of the adjustment (error code 76).

Exclusions

The following inpatient and outpatient claim types are excluded from EDI submission options and must be filed on paper:

- Claim records requiring supportive documentation or attachments i.e., consent forms. (Note: COB claims can be filed electronically)
- Medical records to support billing miscellaneous codes
- Claims for services that are reimbursed based on purchase price i.e., custom DME, prosthetics. Provider is required to submit the invoice with the claim.
- Claims for services requiring clinical review i.e., complicated or unusual procedure. Provider is required to submit medical records with the claim.
- Claim for services requiring documentation and a Certificate of Medical Necessity i.e., oxygen, motorized wheelchairs.

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact

Submitting Claims through clearinghouses Wellcare Payer ID number for all clearinghouses • Medical - 68069 • Behavioral Health - 68068	We use Availity as our primary clearinghouse, which provides us with an extensive network of connectivity. You are free to use whatever clearinghouse you currently do as Availity maintains active connections with a large number of clearinghouses.
General EDI Questions:	Contact EDI Support at 1-800-225-2573 Ext. 6075525 or via e-mail at EDIBA@Centene.com
Claims Transmission Report Questions:	Contact your clearinghouse technical support area.
Claim Transmission Questions (Has my claim been received or rejected?):	Contact EDI Support at 1-800-225-2573 Ext. 6075525 or via e-mail at EDIBA@Centene.com
Remittance Advice Questions:	Contact Provider Services or the Secure Provider Portal.
Provider Payee, UPIN, Tax ID, Payment Address Changes:	Notify Provider Service in writing (W9).

Important Steps to a Successful Submission of EDI Claims:

1. Select a clearinghouse to utilize.
2. Contact the clearinghouse regarding what data records are required.
3. Verify with Provider Services that the provider is set up in the Wellcare system prior to submitting EDI claims.
4. You will receive two (2) reports from the clearinghouse. ALWAYS review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to Wellcare, and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by Wellcare. ALWAYS review the acceptance and claims stats report for rejected claims. If rejections are noted, correct and resubmit.
5. MOST importantly, all claims must be submitted with providers identifying the appropriate coding. See the CMS 1500 (02/12) and CMS 1450 (UB-04) Claims Forms instructions and claim form for details.

Online Claim Submission

For providers who have internet access and choose not to submit claims via EDI or paper, Wellcare has made it easy and convenient to submit claims directly to Wellcare on the Secure Provider Portal at www.wellcareok.com.

You must request access to our secure site by registering for a username and password. If you have technical support questions, please contact Provider Services.

Once you have access to the secure portal, you may file first time claims individually or submit first time batch claims. You will also have the capability to find, view, and correct any previously processed claims. Detailed instructions for submitting via Secure Web Portal are also stored on our website; you must login to the secure site for access to this manual.

Paper Claim Submission

The mailing address for first time claims, corrected claims and requests for reconsideration:

Wellcare
Attn: Claims
P.O. Box 3060
Farmington, MO 63640-3822

Wellcare encourages all providers to submit claims electronically. The Companion Guides for electronic billing are available in the Appendix section of this Manual. Paper submissions are subject to the same edits as electronic and web submissions.

All paper claims sent to the claim's office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected. If a paper claim has been rejected, provider should correct the error and resubmit the paper claim as an original claim. If the paper claim passes the specific edits and is denied after acceptance, the provider should submit the denial letter with the corrected claim.

Acceptable Forms

Wellcare only accepts the original red and white CMS 1500 (02/12) and CMS 1450 (UB-04) paper claims forms. Other claim form types will be upfront rejected and returned to the provider. This includes black and white forms, as well as form with handwriting.

Professional providers and medical suppliers complete the CMS 1500 (02/12) Claim Form and institutional providers complete the CMS 1450 (UB-04) Claim Form. Wellcare does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms must be typed with either 10 or 12 Times New Roman fonts, and on the required original red and white version to ensure clean acceptance and processing. Black and white forms, handwritten and nonstandard forms will be upfront rejected and returned to provider. To reduce document handling time, do not use highlights, italics, bold text or staples for multiple page submissions. If you have questions regarding what type of form to complete, contact Provider Services.

Important Steps to Successful Submission of Paper Claims:

1. Complete all required fields on an original, red CMS 1500 (Version 02/12) or CMS 1450 (UB-04) Claim Form. NOTE: Non-red and handwritten claim forms will be rejected back to the provider.

2. Ensure all Diagnosis Codes, Procedure Codes, Modifier, Location (Place of Service); Type of Bill, Type of Admission, and Source of Admission Codes are valid for the date of service.
3. Ensure all Diagnosis and Procedure Codes are appropriate for the age of sex of the member.
4. Ensure all Diagnosis Codes are coded to their highest number of digits available
5. Ensure member is eligible for services during the time period in which services were provided.
6. Ensure that services were provided by a participating provider or that the "out-of-network" provider has received authorization to provide services to the eligible member.
7. Ensure an authorization has been given for services that require prior authorization by Wellcare.

Claims missing the necessary requirements are not considered "clean claims" and will be returned to providers with a written notice describing the reason for return.

Corrected Claims, Requests for Reconsideration or Claim Disputes

All requests for corrected claims, reconsiderations or claim disputes must be received within 180 days from the date of explanation of payment or denial is issued. Prior processing will be upheld for corrected claims or provider claim requests for reconsideration or disputes received outside of the 180 days corrected claim filing limit unless a qualifying circumstance is offered, and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

- A catastrophic event that substantially interferes with normal business operation of the provider, or damage or destruction of the provider's business office or records by a natural disaster, mechanical, administrative delays or errors by Wellcare or the Federal and/or State regulatory body.
- The member was eligible; however, the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all of the following conditions are met:
- The provider's records document that the member refused or was physically unable to provide their ID Card or information
- The provider can substantiate that they continually pursued reimbursement from the patient until eligibility was discovered
- The provider has not filed a claim for this member prior to the filing of the claim under review

Below are relevant definitions.

- **Corrected claim** – A provider is submitting a correction to the original claim

- **Request for Reconsideration** – Provider disagrees with the original claim outcome (payment amount, denial reason, etc.)

- **Claim Dispute** – Provider disagrees with the outcome of the Request for Reconsideration

Corrected Claims

All requests for corrected claims must be received within 180 calendar days from the date of explanation of payment or denial is issued. Corrected claims must clearly indicate they are corrected in one of the following ways:

- Submit a corrected claim via the secure Provider Portal - Follow the instructions on the portal for submitting a correction.

- Submit a corrected claim electronically via a Clearinghouse

- Institutional Claims (UB): Field CLM05-3=7 and Ref*8 = Original Claim Number

- Professional Claims (CMS): Field CLM05-3=7 and REF*8 = Original Claim Number

- Submit a corrected paper claim to:

Wellcare
Attn: Corrected Claims
P.O. BOX 3060
Farmington, MO 63640-3822

- The original claim number must be typed in field 22 (CMS 1500) and in field 64 (UB-04) with the corresponding frequency codes (7 = replacement or corrected; 8 = voided or cancelled) in field 22 of the CMS 1500 and in field 4 of the UB-04 form.

- Corrected claims must be submitted on standard red and white forms. Handwritten corrected claims will be upfront rejected.

Request for Reconsideration

A request for reconsideration is a communication from the provider about a disagreement with the manner in which a claim was processed. All requests for reconsideration must be received within 180 calendar days from the date of explanation of payment or denial is issued. Generally, medical records are not required for a request for reconsideration. However, if the request for reconsideration is related to a code audit, code edit or authorization denial, medical records must accompany the request for reconsideration. If the medical records are not received, the original denial will be upheld.

Reconsiderations may be submitted in the following ways:

1. Form - Providers may utilize the Request for Reconsideration form found on our website (preferred method).

2. Phone call to Provider Services - This method may be utilized for requests for reconsideration that do not require submission of supporting or additional information. An example of this would be when a provider may believe a particular service should be reimbursed at a particular rate, but the payment amount did not reflect that particular rate.

3. Written Letter - Providers may send a written letter that includes a detailed description of the reason for the request. In order to ensure timely processing, the letter must include sufficient identifying information which includes, at a minimum, the member's name, member's ID number, date of service, total charges, provider name, original EOP, and/or the original claim number found in box 22 on a CMS 1500 form or field 64 on a UB-04 form. The corresponding frequency code should also be included with the original claim number (7 = replacement or corrected; 8 = voided or cancelled) in field 22 of the CMS 1500 and in field 4 of the UB-04 form.

Requests for reconsideration and any applicable attachments must be mailed to:

Wellcare
Attn: Request for Reconsideration
PO BOX 3060
Farmington, MO 63640-3822

Claim Dispute

A claim dispute should be used only when a provider has received an unsatisfactory response to a request for reconsideration.

A claim dispute must be submitted on a claim dispute form found on our website. The claim dispute form must be completed in its entirety. The completed claim dispute form may be mailed to:

Wellcare
Attn: Claim Dispute
PO BOX 4000
Farmington, MO 63640-4400

If the corrected claim, the request for reconsideration or the claim dispute results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.

Wellcare shall process, and finalize all corrected claims, requests for reconsideration and disputed claims to a paid or denied status in accordance with law and regulation.

Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

Wellcare partners with specific vendors to provide an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers

and allows online enrollment. Providers are able to enroll after they have received their completed contract or submitted a claim. Please visit our website for information about EFT and ERA or contact Provider Services.

Benefits include:

- **Elimination of paper checks** - all deposits transmitted via EFT to the designated bank account
    - Convenient payments & retrieval of remittance information
    - Electronic remittance advices presented online
    - HIPAA 835 electronic remittance files for download directly to a HIPAA-Compliant Practice Management for Patient Accounting System
- **Reduce accounting expenses –** Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying
- **Improve cash flow –** Electronic payments can mean faster payments, leading to improvements in cash flow
- **Maintain control over bank accounts** - You keep TOTAL control over the destination of claim payment funds. Multiple practices and accounts are supported
- **Match payments to advices quickly –** You can associate electronic payments with electronic remittance advices quickly and easily
- **Manage multiple Payers –** Reuse enrollment information to connect with multiple Payers Assign different Payers to different bank accounts, as desired

For more information, please visit our provider home page on our website at www.wellcareok.com. If further assistance is needed, please contact our Provider Services department at Wellcare Medicare HMO Phone: 1-833-853-0865 (TTY: 711) Wellcare Dual Medicare (HMO DSNP) & Wellcare Dual Medicare Essentials (HMO DSNP) 1-833-853-0866 (TTY: 711)

Risk Adjustment and Correct Coding

Risk adjustment is critical, and a requirement defined in CFR42 (Section 42 of the Code of Federal Regulations) and the Medicare Modernization Act, that will help ensure the long-term success of the Medicare Advantage program. Accurate calculation of risk adjustment requires accuracy, documentation completeness, and specificity in diagnostic coding. Providers should, at all times, document and code according to CMS regulations and follow all applicable coding guidelines CPT, DSM-IV, and HCPCs code sets. Providers should note the following guidelines:

- Code all diagnoses to the highest level of specificity using the 4th and 5th digits, when applicable and defensible through chart audits and medical assessments

- Code all documented conditions that co-exist at the time of the encounter/visit, and require or affect patient care, treatment, or management

- Ensure that medical record documentation is clear, concise, consistent, complete and legible and meets CMS signature guidelines (each encounter must stand alone)

- Submit claims and encounter information according to the requirements specified in your contract or this provider manual

- Alert Wellcare of any erroneous data submitted and follow Wellcare 's policies to correct errors as set forth in your contract or this provider manual

- Provide ongoing training to your staff regarding appropriate use of ICD coding for reporting diagnoses

Coding of Claims/ Billing Codes

Wellcare requires claims to be submitted using codes from the current version of ICD-10-CM, ASA, DRG, CPT, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. Below are some code related reasons a claim may reject or deny:

- Code billed is missing, invalid, or deleted at the time of services

- Code inappropriate for the age or sex of the member

- Diagnosis code missing the 4th and 5th digit as appropriate

- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary

- Code billed is inappropriate for the location or specialty billed

- Code billed is a part of a more comprehensive code billed on same date of service

Written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Wellcare.

Newborn services provided in the hospital will be reimbursed separately from the mother's hospital stay. A separate claim needs to be submitted for the mother, and their newborn.

Billing from independent provider-based Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) for covered RHC/FQHC services furnished to members should be made with specificity regarding diagnosis codes and procedure code / modifier combinations.

Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist.

However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

For more information regarding billing codes, coding, and code auditing/editing, please contact Wellcare Provider Services at 1-833-853-0865.

CODE EDITING

Wellcare uses HIPAA-compliant code auditing software to improve accuracy and efficiency in claims processing, payment, and reporting. The software detects and documents coding errors on provider claims prior to payment by analyzing CPT, HCPCS, ICD-10, modifier and place of service codes against correct coding guidelines. While code auditing software is a useful tool to ensure provider compliance with correct coding, it will not wholly evaluate all clinical patient scenarios. Consequently, Wellcare uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. Wellcare may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

Wellcare may request medical records or other documentation to verify that all procedures and/or services billed are properly supported in accordance with correct coding guidelines.

CPT and HCPCS Coding Structure

The Healthcare Common Procedure Coding System (HCPCS) is a set of health care procedure codes based on the American Medical Association's (AMA) Current Procedural Terminology (CPT). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding.

1. ***Level I HCPCS Codes (CPT):*** This code set is maintained by the AMA. CPT codes are a 5- digit, uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are updated (added, revised, and deleted) on an annual basis.

2. ***Level II HCPCS Codes*:** The Level II set of HCPCS codes is used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment, orthotics and prosthetics, etc.). The Level II set is an alphanumeric coding system which is maintained by CMS. These codes are updated on an annual basis.

3. ***Miscellaneous/Unlisted Codes:*** These codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with miscellaneous or unlisted codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claims' submission. If records are not received, the provider will receive a denial indicating that medical records are required. The medical documentation should clearly define the procedure performed including, but not limited to, office notes, operative report, and pathology report and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) to accurately describe the service or procedure rendered. Clinical validation also includes identifying and reviewing other procedures and services billed on the claim that may be related to the miscellaneous code. For example, if the miscellaneous code is determined to be the primary procedure, then other procedures and services that are integral

to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.

4. ***Temporary National Codes*:** These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are considered temporary and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H and T code ranges.

5. ***Modifiers:*** Modifiers are used to indicate additional information about the HCPCS, or CPT code billed. On occasion, certain procedures require more explanation because of special circumstances. For example, modifier -24 is appended to evaluation and management services to indicate that a patient was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

International Classification of Diseases (ICD-10)

ICD-10 is an alphanumeric system used by providers to classify diagnoses and symptoms. These codes consist of three to seven digits, which allows for a high level of specificity in coding a wide range of health problems.

Revenue Codes

These 4-digit numeric codes are utilized by institutional providers to represent services, procedures, and/or supplies provided in a hospital or facility setting. Claims submitted with revenue codes should indicate a corresponding procedure code.

Edit Sources

The claims editing software contains a comprehensive set of rules addressing coding inaccuracies such as: unbundling, frequency limitations, fragmentation, upcoding, duplication, invalid codes, mutually exclusive procedures and other coding inconsistencies. Each rule is linked to a generally accepted coding principle. Guidance surrounding the most likely clinical scenario is applied. This information is provided by clinical consultants, health plan medical directors, current research, etc.

- The following sources are utilized in determining correct coding guidelines for the software: Centers for Medicare & Medicaid Services (including National Correct Coding Initiative (NCCI) Policy Manual and Claims Processing Manual guidelines as well as current PTP and MUE tables)

- American Medical Association (CPT, HCPCS, and ICD-10 guidelines and publications including CPT manual, AMA website, CPT Assistant, CPT Insider's View, etc.)

- Public domain specialty provider associations (such as American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons, American College of Obstetricians and Gynecologists, etc.).

- State provider manuals, fee schedules, periodic provider updates (bulletins/transmittals)

- CMS coding resources such as National Physician Fee Schedule, Provider Benefit Manual, MLN Matters and Provider Transmittals

- Health Plan policies and provider contract considerations

- In addition to nationally recognized coding guidelines, the software has flexibility to allow business rules that are unique to the needs of individual product lines

Code Editing and the Claims Adjudication Cycle

Code editing is the final step in the claims adjudication process. Once a claim has completed all previous adjudication steps (such as benefits and member/provider eligibility review), the claim is ready for analysis.

As a claim progresses through the code editing cycle, each service line on the claim is processed through the code editing rules engine and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim as well as previously paid claims found in the member/provider history.

Depending upon the code edit applied, the software will make the following recommendations:

Deny: Code editing rule recommends the denial of a claim line. The appropriate explanation code is documented on the provider's explanation of payment along with reconsideration/appeal instructions.

Pend: Code editing recommends that the service line pend for clinical review and validation. This review may result in a pay or deny recommendation. The decision is documented on the provider's explanation of payment along with reconsideration/appeal instructions

Replace and Pay: Code editing recommends the denial of a service line and a new line is added and paid. In this scenario, the original service line is left unchanged on the claim and a new line is added to reflect the software recommendations. For example, an incorrect CPT code is billed for the member's age. The software will deny the original service line billed by the provider and add a new service line with the correct CPT code, resulting in a paid service line. This action does not alter or change the provider's billing, as the original billing remains on the claim.

Code Editing Principles

The below principles do not represent an all-inclusive list of the available code editing principles, but rather an area sampling of edits which are applied to physician and/or outpatient facility claims.

Unbundling

PTP Practitioner and Hospital Edits

CMS has designated certain combinations of codes that are generally not separately reimbursable on the same date of service. These are known as Procedure-to-Procedure (PTP) and/or Column 1/Column II edits. Within the PTP edit category, there are Practitioner edits (applicable to claims submitted by physicians, non-physician practitioners, and ambulatory surgical centers) and Hospital edits (applicable to hospitals, skilled nursing

facilities, home health agencies, outpatient physical therapy, speech-language pathology, and comprehensive outpatient rehabilitation facilities).

The procedure code listed in column I is the most comprehensive code; reimbursement for the column II code is subsumed into the payment for the comprehensive code. The column II code is considered an integral component to the successful outcome of the column I code.

While these code pairs should not be billed together under most circumstances, there are circumstances when an NCCI-associated modifier may be appended to the column II code to indicate a significant and separately identifiable or distinct service. When these modifiers are used, prepay clinical validation will be performed to ensure that services are reported appropriately. For more information on the PTP edits, please visit www.cms.gov.

Medically Unlikely Edits (MUEs) for Practitioners, DME Providers and Facilities

An MUE is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. These edits are based on CPT/HCPCS code descriptions, anatomic specifications, nature of the service/procedure, nature of the analyte, equipment prescribing information and clinical judgment. Not all HCPCS/CPT codes have an MUE limit.

Code Bundling Rules Not Sourced to CMS NCCI Edit Tables

Many specialty medical organizations and health advisory committees have developed rules around how codes should be used in their area of expertise. These rules are published and are available for use by the public-domain. Procedure code definitions and relative value units are considered when developing these code sets. Rules are specifically designed for professional and outpatient facility claims editing.

Procedure Code Unbundling

Two or more procedure codes are used to report a service when a single, more comprehensive should have been used. The less comprehensive code will be denied.

Mutually Exclusive Editing

These are combinations of procedure codes that may differ in technique or approach but result in the same outcome. The procedures may be impossible to perform anatomically. Procedure codes may also be considered mutually exclusive when an initial or subsequent service is billed on the same date of service. The procedure with the highest RVU is considered the reimbursable code.

Incidental Procedures

These are procedure code combinations that are considered clinically integral to the successful completion of the primary procedure and should not be billed separately.

Global Surgical Period Editing/Medical Visit Editing

CMS publishes rules surrounding payment of an evaluation and management service during the global surgical period of a procedure. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB).

Procedures are assigned a 0, 10 or 90-day global surgical period. Procedures assigned a 90-day global surgery period are designated as major procedures. Procedures assigned a 0- or 10-day global surgical period are designated as minor procedures.

Evaluation and Management services for a major procedure (90-day period) that are reported 1-day preoperatively, on the same date of service or during the 90-day post-operative period are not recommended for separate reimbursement.

Evaluation and Management services that are reported with minor surgical procedures on the same date of service or during the 10-day global surgical period are not recommended for separate reimbursement.

Evaluation and Management services for established patients that are reported with surgical procedures that have a 0-day global surgical period are not recommended for reimbursement on the same day of surgery because there is an inherent evaluation and management service included in all surgical procedures.

Global Maternity Editing

Procedures with "MMM"

Global periods for maternity services are classified as "MMM" when an evaluation and management service is billed during the antepartum period (270 days), on the same date of service or during the postpartum period (45 days) are not recommended for separate reimbursement if the procedure code includes antepartum and postpartum care.

Diagnostic Services Bundled to the Inpatient Admission (3-Day Payment Window)

This rule identifies outpatient diagnostic services that are provided to a member within three days prior to and including the date of an inpatient admission. When these services are billed by the same admitting facility or an entity wholly owned or operated by the admitting facility; they are considered bundled into the inpatient admission, and therefore, are not separately reimbursable.

Multiple Code Rebundling

This rule analyzes if a provider billed two or more procedure codes when a single more comprehensive code should have been billed to represent all of the services performed.

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the number of times a single code can be reported. There are also codes that are allowed a limited number of times on a single date of service, over a given period of time or during a member's lifetime. State fee schedules also delineate the number of times a procedure can be billed over a given period of time or during a member's lifetime. Code editing will fire a frequency edit when the procedure code is billed in excess of these guidelines.

Duplicate Edits

Code editing will evaluate prospective claims to determine if there is a previously paid claim for the same member and provider in history that is a duplicate to the prospective claim. The software will also look across different providers to determine if another provider was paid for the same procedure, for the same member

on the same date of service. Finally, the software will analyze multiple services within the same range of services performed on the same day. For example, a nurse practitioner and physician bill for office visits for the same member on the same day.

National Coverage Determination Edits

CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services or technologies can be paid under Medicare. These rules evaluate diagnosis to procedure code combinations.

Anesthesia Edits

This rule identifies anesthesia services that have been billed with a surgical procedure code instead of an anesthesia procedure code.

Invalid Revenue to Procedure Code Editing

Identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

Rule evaluates claims billed as an assistant surgeon that normally do not require the attendance of an assistant surgeon. Modifiers are reviewed as part of the claim's analysis.

Co-Surgeon/Team Surgeon Edits

CMS guidelines define whether or not an assistant, co-surgeon or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co or team surgeon.

Add-on and Base Code Edits

Rules look for claims where the add-on CPT code was billed without the primary service CPT code or if the primary service code was denied, then the add-on code is also denied. This rule also looks for circumstances where the primary code was billed in a quantity greater than one, when an add-on code should have been used to describe the additional services rendered.

Bilateral Edits

This rule looks for claims where the modifier -50 has already been billed, but the same procedure code is submitted on a different service line on the same date of service without the modifier -50. This rule is highly customized as many health plans allow this type of billing.

Replacement Edits

These rules recommend that single service lines or multiple service lines are denied and replaced with a more appropriate code. For example, the same provider bills more than one outpatient consultation code for the same member in the member's history. This rule will deny the office consultation code and replace it with a more appropriate evaluation and management service, established patient or subsequent hospital care code. Another example, the rule will evaluate if a provider has billed a new patient evaluation and management code

within three years of a previous new patient visit. This rule will replace the second submission with the appropriate established patient visit. This rule uses a crosswalk to determine the appropriate code to add.

Missing Modifier Edits

This rule analyzes service lines to determine if a modifier should have been reported but was omitted. For example, professional providers would not typically bill the global (technical and professional) component of a service when performed in a facility setting. The technical component is typically performed by the facility and not the physician.

Inpatient Facility Claim Editing

Potentially Preventable Readmissions Edit

This edit identifies readmissions within a specified time interval that may be clinically related to a previous admission. For example, a subsequent admission may be plausibly related to the care rendered during or immediately following a prior hospital admission in the case of readmission for a surgical wound infection or lack of post-admission follow up. Admissions to non-acute care facilities (such as skilled nursing facilities) are not considered readmissions and not considered for reimbursement. CMS determines the readmission time interval as 30 days; however, this rule is highly customizable by state rules and provider contracts.

Administrative and Consistency Rules

These rules are not based on clinical content and serve to validate code sets and other data billed on the claim. These types of rules do not interact with historically paid claims or other service lines on the prospective claim. Examples include, but are not limited to:

Procedure code invalid rules: Evaluates claims for invalid procedure and revenue or diagnosis codes

Deleted Codes: Evaluates claims for procedure codes which have been deleted

Modifier to procedure code validation: Identifies invalid modifier to procedure code combinations. This rule analyzes modifiers affecting payment. As an example, modifiers -24, -25, -26, -57, -58 and -59.

Age Rules: Identifies procedures inconsistent with member's age

Gender Procedure: Identifies procedures inconsistent with member's gender

Gender Diagnosis: Identifies diagnosis codes inconsistent with member's gender

Incomplete/invalid diagnosis codes: Identifies diagnosis codes incomplete or invalid

Prepayment Clinical Validation

Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. An example of Wellcare's clinical validation services is modifier -25 and -59 review. Some code pairs within the CMS NCCI edit tables are allowed for modifier override when they have a correct coding modifier indicator of "1," Furthermore, public-domain specialty organization edits may also be considered for

override when they are billed with these modifiers. When these modifiers are billed, the provider's billing should support a separately identifiable service (from the primary service billed, modifier -25) or a different session, site or organ system, surgery, incision/excision, lesion or separate injury (modifier -59). Wellcare's clinical validation team uses the information on the prospective claim and claims history to determine whether or not it is likely that a modifier was used correctly based on the unique clinical scenario for a member on a given date of service.

The Centers for Medicare and Medicaid Services (CMS) supports this type of prepayment review. The clinical validation team uses nationally published guidelines from CPT and CMS to determine if a modifier was used correctly.

Modifier -59

The NCCI (National Correct Coding Initiative) states the primary purpose of modifier 59 is to indicate that procedures or non-E/M services that are not usually reported together are appropriate under the circumstances. The CPT Manual defines modifier -59 as follows: "Modifier -59: Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

Some providers are routinely assigning modifier 59 when billing a combination of codes that will result in a denial due to unbundling. We commonly find misuse of modifier 59 related to the portion of the definition that allows its use to describe "different procedure or surgery". NCCI guidelines state that providers should not use modifier 59 solely because two different procedures/surgeries are performed or because the CPT codes are different procedures. Modifier 59 should only be used if the two procedures/surgeries are performed at separate anatomic sites, at separate patient encounters or by different practitioners on the same date of service. NCCI defines different anatomic sites to include different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ.

Wellcare uses the following guidelines to determine if modifier -59 was used correctly:

- The diagnosis codes or clinical scenario on the claim indicate multiple conditions or sites were treated or are likely to be treated;

- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas which would result in procedures being performed on multiple body areas and sites.

- Claim history supports that each procedure was performed by a different practitioner or during different encounters or those unusual circumstances are present that support modifier 59 were used appropriately.

To avoid incorrect denials providers should assign to the claim all applicable diagnosis and procedure codes used, and all applicable anatomical modifiers designating which areas of the body were treated.

Modifier -25

Both CPT and CMS in the NCCI policy manual specify that by using a modifier 25 the provider is indicating that a "significant, separately identifiable evaluation and management service was provided by the same physician on the same day of the procedure or other service". Additional CPT guidelines state that the evaluation and management service must be significant and separate from other services provided or above and beyond the usual pre-, intra- and postoperative care associated with the procedure that was performed.

The NCCI policy manual states that "If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.) The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers and A/B MACs processing practitioner service claims have separate edits.

Wellcare uses the following guidelines to determine whether or not modifier 25 was used appropriately. If any one of the following conditions is met then, the clinical nurse reviewer will recommend reimbursement for the E/M service.

- The E/M service is the first time the provider has seen the patient or evaluated a major condition
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed
- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services
- Other procedures or services performed for a member on or around the same date of the procedure support that an E/M service would have been required to determine the member's need for additional services.
- To avoid incorrect denials providers should assign all applicable diagnosis codes that support additional E/M services.

Claim Reconsiderations Related to Code Editing

Claims appeals resulting from claim editing are handled per the provider claims dispute process outlined in this manual. When submitting claims appeals, please submit medical records, invoices and all related information to assist with the appeals review.

If you disagree with a code edit and request claim reconsideration, you must submit documentation (medical records) related to the reconsideration. If medical documentation is not received, the original code edit will be upheld.

The reconsideration may include this type of information:

- Statement of why the service is medically necessary
- Medical evidence which supports the proposed treatment
- How the proposed treatment will prevent illness or disability
- How the proposed treatment will alleviate physical, mental or developmental effects of the patient's illness
- How the proposed treatment will assist the patient to maintain functional capacity
- A review of previous treatments and results, including, based on your clinical judgment, why a new approach is necessary
- How the recommended service has been successful in other patients

Viewing Claims Coding Edits

Code Auditing Tool

A web-based code editing reference tool designed to "mirror" how the code editing product(s) evaluate code and code combinations during the editing of claims. The tool is available for providers who are registered on our secure provider portal. You can access the tool in the Claims Module by clicking "Claim Editing Tool" in our secure provider portal.

This tool offers many benefits:

- PROSPECTIVELY access the appropriate coding and supporting clinical edit clarifications for services BEFORE claims are submitted.
- PROACTIVELY determine the appropriate code/code combination representing the service for accurate billing purposes

The tool will review what was entered and will determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered.

The Code Editing Assistant is intended for use as a "what if" or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information which may be used to determine if an edit is appropriate

The code editing assistant can be accessed from the provider web portal.

Disclaimer: This tool is used to apply coding logic ONLY. It will not take into account individual fee schedule reimbursement, authorization requirements, or other coverage considerations. Whether a code is reimbursable or covered is separate and outside of the intended use of this tool.

Automated Clinical Payment Policy Edits

Clinical payment policy edits are developed to increase claims processing effectiveness, to decrease the administrative burden of prior authorization, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers. The purpose of these policies is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. These policies may be documented as a medical policy or pharmacy policy.

Clinical payment policies are implemented through prepayment claims edits applied within our claims adjudication system. Once adopted by the health plan, these policies are posted on the health plan's provider portal.

Clinical medical policies can be identified by an alpha-numeric sequence such as CP.MP.xxx in the reference number of the policy. Clinical pharmacy policies can be identified by an alpha-numeric sequence such as CP.PHAR.xxx in the reference number of the policy.

The majority of clinical payment policy edits are applied when a procedure code (CPT/HCPCS) is billed with a diagnosis (es) that does not support medical necessity as defined by the policy. When this occurs, the following explanation (ex) code is applied to the service line billed with the disallowed procedure. This ex-code can be viewed on the provider's explanation of payment.

- xE: Procedure Code is Disallowed with this Diagnosis Code(s) Per Plan Policy.

Examples

Policy Name	Clinical Policy Number	Description
Diagnosis of Vaginitis	CP.MP.97	To define medical necessity criteria for the diagnostic evaluation of vaginitis in members ≥ 13 years of age
Urodynamic Testing	CP.MP.98	To define medical necessity criteria for commonly used urodynamic studies
Bevacizumab (Avastin)	CP.PHAR.93	To ensure patients follow selection criteria for Avastin use.

Some clinical payment policy edits may also occur as the result of a single code denial for a service that is not supported by medical necessity. When this occurs, the following explanation (ex) code is applied to the service line billed with the disallowed procedure. This ex-code can be viewed on the provider's explanation of payment.

- xP: Service is denied according to a payment or coverage policy

Policy Name	Clinical Policy Number	Description
Fractional Exhaled Nitric Oxide	CP.MP.103	To clarify that testing for fractionated exhaled nitric oxide (FeNO) is **investigational** for diagnosing and guiding the treatment of asthma, as there is insufficient evidence proving it more than or as effective as existing standards of care**.**

Clinical Payment Policy Appeals

Clinical payment policy denials may be appealed on the basis of medical necessity. Providers who disagree with a claim denial based on a clinical payment policy, and who believe that the service rendered was medically necessary and clinically appropriate, may submit a written reconsideration request for the claim denial using the provider claim reconsideration/appeal/dispute or other appropriate process as defined in this provider manual. The appeal should include this type of information:

1. Statement of why the service is medically necessary.
2. Medical evidence which supports the proposed treatment.
3. How the proposed treatment will prevent illness or disability.

4. How the proposed treatment will alleviate physical, mental or developmental effects of the patient's illness.
5. How the proposed treatment will assist the patient to maintain functional capacity.
6. A review of previous treatments and results, including, based on your clinical judgment, why a new approach is necessary.
7. How the recommended service has been successful in other patients

THIRD PARTY LIABILITY

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the member.

If third party liability coverage is determined after services are rendered, Wellcare will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

BILLING THE MEMBER

Failure to Obtain Authorization

Providers may NOT bill members for services when the provider fails to obtain an authorization and the claim is denied by Wellcare.

No Balance Billing

Providers may not seek payment from Wellcare members for the difference between the billed charges and the contracted rate paid by Wellcare.

Non-Covered Services

Contracted providers may only bill Wellcare members for non-covered services if:

- A request for prior authorization was denied by the plan and the member received a written Notice of Denial of Medical Coverage (form CMS 10003-NDMCP) in advance of receiving the service; or
- The member's Evidence of Coverage clearly states the item or service is never covered by the plan.

Note: the member is not obligated to pay for the service if it is later found that the service was covered by Wellcare at the time it was provided, even if Wellcare did not pay the provider for the service because the provider did not comply with Wellcare requirements.

Qualified Medicare Beneficiaries (QMB) Billing

Wellcare works to ensure that the Medicare members are never inappropriately held financially liable for the care they receive.

Billing of Qualified Medicare Beneficiaries (QMBs) Is Prohibited by Federal Law

Medicare providers and suppliers may not bill Wellcare members enrolled in the QMB program for Medicare cost-sharing. Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances. Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or B deductibles, coinsurance, or copays for any Medicare-covered items and services. Providers and suppliers may bill State Medicaid programs for these costs, but States can limit Medicare cost-sharing payments under certain circumstances. For information about obtaining payment for Medicare cost-sharing, contact the Medicaid agency in the States in which you practice.

Providers and suppliers may also verify a patient's QMB status through State online Medicaid eligibility systems or other documentation, including Medicaid identification cards and documents issued by the State proving the patient is enrolled in the QMB program.

MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights

Providers must comply with the rights of members as set forth below.

1. To participate with providers in making decisions about their health care. This includes working on any treatment plans and making care decisions. The member should know any possible risks, problems related to recovery, and the likelihood of success. The member shall not have any treatment without consent freely given by the member or the member's legally authorized surrogate decision-maker. The member must be informed of their care options

2. To know who is approving and who is performing the procedures or treatment. All likely treatments and the nature of the problem should be explained clearly

3. To receive the benefits for which the member has coverage

4. To be treated with respect and dignity

5. To privacy of their personal health information, consistent with state and federal laws, and Wellcare policies

6. To receive information or make recommendations, including changes, about Wellcare's organization and services, the Wellcare network of providers, and member rights and responsibilities

7. To candidly discuss with their providers appropriate and medically necessary care for their condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from the member's primary care physician about what might be wrong (to the level known), treatment and any known likely results. The provider must tell the member about treatments that may or may not be covered by the plan, regardless of the cost. The member has a right to know about any costs they will need to pay. This should be told to the member in a way that the member can understand. When it is not appropriate to give the member information for medical reasons, the information can be given to a legally authorized person. The provider will ask for the member's approval for treatment unless there is an emergency and the member's life, and health are in serious danger

8. To make recommendations regarding the Wellcare member's rights, responsibilities and policies

9. To voice complaints or appeals about: Wellcare, any benefit or coverage decisions Wellcare makes, Wellcare coverage, or the care provided

10. To participate with practitioners in making decisions about their care and the right to refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by the provider(s) of the medical consequences

11. To see their medical records

12. To be kept informed of covered and non-covered services, program changes, how to access services, primary care physician assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and other Wellcare rules and guidelines. Wellcare will notify members at least before the effective date of the modifications. Such notices shall include the following:

    - Any changes in clinical review criteria
    - A statement of the effect of such changes on the personal liability of the member for the cost of any such changes

13. To have access to a current list of network providers. Additionally, a member may access information on network providers' education, training, and practice

14. To select a health plan or switch health plans, within the guidelines, without any threats or harassment

15. To adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual orientation, national origin or religion

16. To access medically necessary urgent and emergency services 24 hours a day and seven days a week

17. To receive information in a different format in compliance with the Americans with Disabilities Act, if the member has a disability

18. To refuse treatment to the extent the law allows. The member is responsible for their actions if treatment is refused or if the provider's instructions are not followed. The member should discuss all concerns about treatment with their primary care physician or other provider. The primary care physician or other provider must discuss different treatment plans with the member. The member must make the final decision

19. To select a primary care physician within the network. The member has the right to change their primary care physician or request information on network providers close to their home or work.

20. To know the name and job title of people providing care to the member. The member also has the right to know which physician is their primary care physician

21. To have access to an interpreter when the member does not speak or understand the language of the area

22. To a second opinion by a network physician, at no cost to the member, if the member believes that the network provider is not authorizing the requested care, or if the member wants more information about their treatment

23. To execute an advance directive for health care decisions. An advance directive will assist the primary care provider and other providers to understand the member's wishes about the member's health care. The advance directive will not take away the member's right to make their own decisions. Examples of advance directives include:

- Living Will
- Health Care Power of Attorney
- "Do Not Resuscitate" Orders

Members also have the right to refuse to make advance directives. Members may not be discriminated against for not having an advance directive

Member Responsibilities

1. To read their Wellcare contract in its entirety.
2. To treat all health care professionals and staff with courtesy and respect.
3. To give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about their health. The member should make it known whether they clearly understand their care and what is expected of them. The member needs to ask questions of their provider to understand the care they are receiving.
4. To review and understand the information they receive about Wellcare. The member needs to know the proper use of covered services.
5. To show their I.D. card and keep scheduled appointments with their provider and call the provider's office during office hours whenever possible if the member has a delay or cancellation.
6. To know the name of their assigned primary care physician. The member should establish a relationship with their primary care physician. The member may change their primary care physician verbally or in writing by contacting the Wellcare Member Services Department.
7. To read and understand to the best of their ability all materials concerning their health benefits or to ask for assistance if they need it.
8. To understand their health problems and participate, along with their health care providers in developing mutually agreed upon treatment goals to the degree possible.
9. To supply, to the extent possible, information that Wellcare and/or their providers need in order to provide care.
10. To follow the treatment plans and instructions for care that they have agreed on with their health care providers.
11. To understand their health problems and tell their health care providers if they do not understand their treatment plan or what is expected of them. The member should work with their primary care physician to develop mutually agreed upon treatment goals. If the member does not follow the treatment plan, the member has the right to be advised of the likely results of their decision.

12. To follow all health benefit plan guidelines, provisions, policies and procedures.

13. To use any emergency room only when they think they have a medical emergency. For all other care, the member should call their primary care physician.

14. To give all information about any other medical coverage they have at the time of enrollment. If, at any time, the member gains other medical coverage besides Wellcare coverage, the member must provide this information to Wellcare.

15. To pay their monthly premium, all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service.

PROVIDER RIGHTS AND RESPONSIBILITIES

Provider Rights

1. To be treated by their patients, who are Wellcare members, and other healthcare workers with dignity and respect.
2. To receive accurate and complete information and medical histories for members' care.
3. To have their patients, who are Wellcare members, act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.
4. To expect other network providers to act as partners in members' treatment plans.
5. To expect members to follow their health care instructions and directions, such as taking the right amount of medication at the right times.
6. To make a complaint or file an appeal against Wellcare and/or a member.
7. To file a grievance on behalf of a member, with the member's consent.
8. To have access to information about Wellcare quality improvement programs, including program goals, processes, and outcomes that relate to member care and services.
9. To contact Provider Services with any questions, comments, or problems.
10. To collaborate with other health care professionals who are involved in the care of members.
11. To not be excluded, penalized, or terminated from participating with Wellcare for having developed or accumulated a substantial number of patients in Wellcare with high-cost medical conditions.
12. To collect member cost shares at the time of the service.

Provider Responsibilities

Providers must comply with each of the items listed below.

1. To help or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
    - Recommend new or experimental treatments.
    - Provide information regarding the nature of treatment options.
    - Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered.
    - Be informed of risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options.

2. To treat members with fairness, dignity, and respect.

3. To not discriminate against members on the basis of race, color, national origin, limited language proficiency, religion, age, health status, existence of a pre-existing mental or physical disability/condition including pregnancy and/or hospitalization, the expectation for frequent or high-cost care.

4. To maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.

5. To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice and scope of service.

6. To provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.

7. To allow members to request restriction on the use and disclosure of their personal health information.

8. To provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.

9. To provide clear and complete information to members - in a language they can understand - about their health condition and treatment, regardless of cost or benefit coverage, and allow member participation in the decision-making process.

10. To tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.

11. To allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal.

12. To respect members' advance directives and include these documents in their medical record.

13. To allow members to appoint a parent/guardian, family member, or other representative if they can't fully participate in their treatment decisions.

14. To allow members to obtain a second opinion, and answer members' questions about how to access health care services appropriately.

15. To follow all state and federal laws and regulations related to patient care and rights.

16. To participate in Wellcare data collection initiatives, such as HEDIS and other contractual or regulatory programs.

17. To review clinical practice guidelines distributed by Wellcare.

18. To comply with the Wellcare Medical Management program as outlined herein.

19. To disclose overpayments or improper payments to Wellcare.
20. To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
21. To obtain and report to Wellcare information regarding other insurance coverage the member has or may have.
22. To give Wellcare timely, written notice if provider is leaving/closing a practice.
23. To contact Wellcare to verify member eligibility and benefits, if appropriate.
24. To invite member participation in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible.
25. To provide members with information regarding office location, hours of operation, accessibility, and translation services.
26. To object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds.
27. To provide hours of operation to Wellcare members which are no less than those offered to other Medicare patients.

Interference with Health Care Professionals' Advice

Wellcare has a responsibility to uphold the prohibition against interference with health care professionals' advice. We may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, a Wellcare member:

- The member's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions. For more information, please visit the Medicare Managed Care Manual. This information is currently located in Section Interference with Health Care Professionals' Advice to Enrollees Prohibited (Rev. 24, 06-06-03)

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.

As part of Wellcare's Cultural Competency Program, providers must ensure that:

- 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.
- Document member requests for language services and/or refusal of professional language services in the medical record
- Participate in cultural competency education and training at least 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;

- Provide medical care with consideration of the members' primary language, race, ethnicity and culture

- Ensure that treatment plans are developed with consideration of the member's race, country of origin, primary language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, 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 this mainstreaming of members an important component of the delivery of care and expects providers to treat members without regard to race, color, creed, sex, 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

- Providing an 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)

Wellcare provides Cultural Competency related educational opportunities for providers per its secure provider portal. Providers are able to participate in training opportunities administered by the State or nationally recognized organizations found at www.wellcareok.com. Providers are also encouraged to participate in 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: https://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: http://www.thinkculturalhealth.hhs.gov/

- The Health Care Literacy 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 http://www.ahrg.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-tookit/index.html

Language Services

In accordance with Title VI of the Civil Rights Act, Prohibition against national Origin Discriminations, the President's Executive Order 131166, section 1557 of the Patient Protection and Affordable care Act, Wellcare 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 member's preferred language)
- Face to Face non-English interpretation
- American Sign language
- Auxiliary aids including alternate formats such as large print and braille
- Written translations for materials that are critical for obtaining health insurance coverage and access to health care services in non-English prevalent languages

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

To obtain language services for a member, contact Wellcare provider services. For Face to Face and American Sign Language requests, contact Wellcare provider services 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 at: 1-833-853-0865 or 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:

o 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;

o Accompanying adults (minors are excluded) where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances for minimal needs.

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

For more information, call Provider Services toll-free at <XXX-XXX-XXXX> (TDD/TTY: 711).

Provider Accessibility Initiative

Wellcare is committed to providing equal access to quality health care and services that are physically and programmatically accessible for our members with disabilities. In May of 2017, our parent company, Centene, launched a Provider Accessibility Initiative (PAI) to increase the percentage of Centene's providers that meet minimum federal and state disability access standards. One of the goals of the PAI is to improve the accuracy, completeness, and transparency of provider self-reported disability access data in Provider Directories so that members with disabilities have the most accurate, accessible, and up-to-date information possible related to a provider's disability access. To accomplish this, providers are asked to complete a self-report of disability access that will be verified by Western Sky through an onsite Accessibility Site Review (ASR).

- Wellcare's expectation, 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.

Americans with Disabilities Act

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 at <<XXX-XXX-XXXX> (TDD/TTY: 711) 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".

Wellcare strives to assist providers in meeting the requirements in Title II and Title III of the ADA and Section 504 which requires that medical care providers provide individuals:

- Full and equal access to healthcare services and facilities; and

- Reasonable modifications to policies, practices, and procedures when necessary to make healthcare available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services

The term "disability" means, with respect to an individual -

A physical or mental condition that limits a person's movement, senses, or activities. These limitations may be cognitive, developmental, intellectual, mental, physical, sensory, or some combination of these. Disability is any substantial limitation of a person's 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
    a. Professionalism and confidentiality require healthcare providers to take responsibility for the communication
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), a TDD, or use of secure electronic means

The Section 508 Accessibility Standards are a federal law that requires agencies to provide people with disabilities equal access to electronic information and data comparable to those who do not have disabilities. Providers have a responsibility to ensure compliance with Section 508 website requirements.

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 subject 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

General Requirements

General prohibitions against discrimination.

- No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.

- A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability --

- Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;

- Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

- Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;

- Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others;

- Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates on the basis of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program;

- Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards;

- Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, Wellcare, or opportunity enjoyed by others receiving the aid, benefit, or service.

- A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.

- A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:

- That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability;

- That have the purpose or effect of defeating or
- substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or
- That perpetuate the discrimination of another public entity if both public entities are subject to common administrative control and, are agencies of the same State.
- A public entity may not, in determining the site or location of a facility, make selections --
- That have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or
- That have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, program, or activity with respect to individuals with disabilities.
- A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination on the basis of disability.
- A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination on the basis of disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.
- A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.
- A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.
- Nothing in this part prohibits a public entity from providing benefits, services, or advantages to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.
- A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

- Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such individual chooses not to accept.

- Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.

- A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.

- A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

MEMBER GRIEVANCES AND APPEALS

Grievances

A grievance is an expression of dissatisfaction with any aspect of the operations, activities, or behavior of a plan or its delegated entity in the provision of health care or prescription drug services or benefits, regardless of whether remedial action is requested. Members must follow the grievance process as listed below when a member is dissatisfied with the manner in which Wellcare, or a delegated entity provides healthcare services. Grievances may include, but are not limited to:

- An enrollee's involuntary disenrollment by the plan
- Enrollee believes they were misdiagnosed
- Enrollee believes treatment was not appropriated
- Enrollee believes they received, or did not receive, care that adversely impacted or had the potential to adversely impact their health
- A change in premiums or cost sharing arrangements from one contact year to the next
- Lack of quality of the care received
- Plan benefit design
- Difficulty contacting the plan via phone
- The appeals process
- The plan's decision not to expedite a coverage or appeal request
- General dissatisfaction about a co-payment amount, but not a dispute about the amount the enrollee paid or is billed
- General issue about a drug not being on the formulary or listed as an excluded drug
- Calculation of True Out-of-Pocket (TrOOP) costs
- Lack of quality of the care received
- Interpersonal aspects of care

Members or their representative may submit a grievance verbally, in writing, via phone, mail, facsimile, electronic mail, or in person within 60 calendar days after the event. If the grievance meets the necessary criteria, a resolution is delivered to the member as expeditiously as the member's case requires, based on

health status, but no later than 24 hours for expedited grievances and 30 calendar days for standard grievances. Extensions of up to 14 calendar days can be granted for standard grievances if the enrollee requests the extension or if Wellcare justifies the need for additional information and the delay is in the best interest of the member.

Appeals

Members or their representatives may file a formal appeal if they are dissatisfied with a medical care or drug coverage decision made by Wellcare. Appeals must be submitted within 60 days of the decision. Expedited reconsiderations/redeterminations will be made on medical care or drug coverage not yet received if standard deadlines could cause serious harm to the member's health. Standard appeals must be made in writing to the address below. Expedited appeals may also be made in writing or verbally by calling Member Services. Members may request an appeal via the secure web portal if available.

Member Grievance and Appeals Address

Written grievances and appeals must be mailed or faxed to:

Wellcare
Attn: Medicare Grievances and Authorization Appeals (Medicare Operations)
7700 Forsyth Blvd
St. Louis, MO 63105
FAX: 1-844-273-2671

For process or status questions, members or their representatives can contact Member Services at Wellcare Medicare HMO Phone: 1-833-853-0865 (TTY: 711) Wellcare Dual Medicare (HMO DSNP) & Wellcare Dual Medicare Essentials (HMO DSNP): 1-833-853-0866 (TTY: 711).

PROVIDER COMPLAINT AND APPEALS PROCESS

Wellcare Complaint

A Complaint is a verbal or written expression by a provider which indicates dissatisfaction with Wellcare's policies, procedure, or any aspect of Wellcare's functions. Wellcare logs and tracks all complaints/grievances whether received verbally or in writing. A provider has 30 calendar days from the date of the incident, such as the original Explanation of Payment date, to file a complaint. After a complete review of the complaint/grievance, Wellcare shall provide a written notice to the provider within 30 calendar days from the received date of Wellcare's decision. If the complaint is related to claims payment, the provider must follow the process for claim reconsideration or claim dispute as noted in the Claims section of this Provider Manual prior to filing a Complaint.

Providers who wish to file a verbal or written complaint or appeal can do so by the following:

Verbally contact the Provider Services at HMO: 1-833-853-0865 (TTY: 711) or HMO SNP: 1-833-853-0865 (TTY: 711).

To file a written complaint:

Wellcare
Attn: Complaints Dept.
7700 Forsyth Blvd
St Louis, MO 63105

To file a written appeal:

Wellcare
Attn: Appeals
7700 Forsyth Blvd
St Louis, MO 63105

Authorization and Coverage Appeals

An Appeal is the mechanism which allows providers the right to appeal actions of Wellcare such as a prior authorization denial, or if the provider is aggrieved by any rule, policy or procedure or decision made by Wellcare. A provider has 30 calendar days from Wellcare's notice of action to file the appeal. Wellcare shall acknowledge receipt of each appeal within 5 business days after receiving an appeal. Wellcare shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed 60 calendar days from the date Wellcare receives the appeal. Wellcare may extend the timeframe for resolution of the appeal up to 30 calendar days if the member requests the extension or Wellcare demonstrates that there is need for additional information and how the delay is in the member's best interest. For any extension not requested by the member, Wellcare shall provide written notice to the member for the delay.

Expedited appeals may be filed with Wellcare if the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding 72 hours from the initial receipt of the appeal. Wellcare may extend this timeframe by up to an additional 14 calendar days if the member requests the extension or if Wellcare provides satisfactory evidence that a delay in rendering the decision is in the member's best interest.

Providers may also invoke any remedies as determined in the Participating Provider Agreement.

QUALITY IMPROVEMENT

Overview

Wellcare 's Quality Improvement (QI) Program is comprehensive, systematic and continuous. It applies to all Member demographic groups, care settings, and types of services afforded to Medicare Advantage Members, including the 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 Care Management/Disease Management/Chronic Care Improvement Program, Preventive and Clinical Health and Model of Care)
- Coordination/Continuity of Care
- Cultural Competency
- Credentialing and Peer Review
- Patient Safety and Quality of Care
- Appeals, Grievances and Complaints
- Member Experience and Retention
- Provider Experience
- Components of operational service (including customer service/claims, etc.)
- Contractual, regulatory and accreditation reporting requirements
- Behavioral Health Services
- Clinical Indicators and initiatives (including HEDIS®, HOS, and Star ratings)
- Member Record Review
- Delegation
- Pharmacy and Therapeutics
- Network Adequacy and Accessibility®
- Confidentiality and Ethics

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

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

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

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

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

Network Practitioners and Providers are contractually required to cooperate with all Quality Improvement (QI) activities to improve the quality of care and services and member experience. This includes the collection and evaluation of performance data and participation in the Wellcare Health Plan's QI programs. Practitioner and Provider contracts, or a contract addenda, also require that Practitioners and Providers allow the Wellcare Health Plan use of their performance data for quality improvement activities.

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Practitioner Involvement

Wellcare recognizes the integral role that practitioner involvement plays in the success of its QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. Wellcare promotes PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as, but not limited to, Utilization Management Advisory Committee, Credentials Committee, Continuity and Coordination of Care workgroup and select ad-hoc committees.

Network Practitioners and Providers are contractually required to cooperate with all Quality Improvement (QI) activities to improve the quality of care and services and member experience. This includes the collection and evaluation of performance data and participation in the <health plan's> QI programs. Practitioner and Provider contracts, or a contract addendum, also require that Practitioners and Providers allow <health plan> the use of their performance data for quality improvement activities.

Key Program Functions, Activities, and Initiatives

Wellcare continually assesses data and information to improve the level of care provided to its Members. Some of the areas addressed by various programs and initiatives include:

- Network Access/availability monitoring
- Appeals/concerns/complaints/grievances

- Member experience
- Provider experience
- Behavioral health services
- Utilization management
- Cultural competency
- Model of Care
- Patient safety and quality of care
- Continuity and coordination of care
- Delegation
- Clinical indicators and initiatives (HEDIS®, HOS, Star ratings)
- Credentialing and Peer Review
- Pharmacy and therapeutics
- Preventive and clinical health guidelines
- Medical record review
- Delegation oversight
- Cultural competency
- Population health management (including disease and case management, chronic care improvement program, preventive and clinical health, and model of care)
- Components of operational service (customer service/claims, etc.)
- Confidentiality, ethics, regulatory and/or accreditation reporting requirements

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 accrediting bodies to ensure compliance and that the needs of all Members are met.

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

GeoAccess maps and accessibility reports are developed and reviewed for targeted lines of business that adhere to regulatory agencies, accrediting bodies and company requirements. On

at least a semi-annual basis, Wellcare completes GeoAccess analysis to evaluate compliance to geographic access standards and take action as appropriate. Results of the reports are reported into the appropriate committees.

In addition, average speed of answer, 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 QIC on a semiannual basis.

Appeals/Concerns/Complaints/Grievances

The Health Plan provides an appeal process includes both standard and expedited reviews and provides objective resolution for Members and Providers who submit a request for review of an adverse determination. The mission of the Appeals Department is to support the organization's reconsideration process and compliance through the review of all requests for additional review of service and claim denials, as well as provide a mechanism for approval and/or payment for overturned decisions. The Appeals Department establishes and maintains procedures for reviewing all appeals made by enrollees, Providers on behalf of enrollees, appointed representatives, or Providers. In accordance with federal and state laws, an external appeal mechanism may also be available when the Plan makes an adverse decision. Appeals activities are reported to the Customer Service Quality Improvement Workgroup (CSQIW), Utilization Management Advisory Committee (UMAC), and Quality Improvement Committee (QIC). If a trend of medical necessity or benefit coverage overturns is identified, an in-depth review of the decision process will be initiated, and an intervention plan implemented as appropriate. In addition, monthly metrics regarding reasons for the appeal and the reasons for the overturn are presented to stakeholders with appeals volume and overturn rates by top Providers (by volume). Appeals trends are monitored and reviewed through ad-hoc workgroups relating to utilization management, claims, processing errors, and configuration.

Within the Appeals Department, goals are:

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

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.

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

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.

Member Experience

The Member experience data collected through the CAHPS survey addresses leading indicators of Member satisfaction including Getting Needed Care, Getting Appointments and Care Quickly, Customer Service, Care Coordination, Rating of Drug Plan, Getting Needed Prescription Drugs, Flu Vaccination, Pneumonia Vaccination, How Well Doctors Communicate, Rating of Healthcare Quality, and Rating of Health Plan.

Wellcare identifies opportunities for improvement based on the information collected through the CAHPS survey, the BH ECHO® survey, appeals, and grievances.

Wellcare contracts with a NCQA-certified survey vendor to conduct the CAHPS survey on an annual basis, using NCQA-required survey techniques and specifications required by NCQA and CMS. CAHPS results are presented to the QIC and in turn given to the UMAC for review by the external providers.

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

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

Provider Experience

An ongoing analysis of Provider complaints is conducted to evaluate Provider satisfaction. Also, the Provider network is formally surveyed by a certified vendor on an annual basis to assess Provider satisfaction with the Plan. Results are analyzed and an action plan is developed and implemented to address the areas identified as needing improvement. The results and action plan are presented to the QIC and then sent to the UMAC for approval and recommendations

Behavioral Health Services

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

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

- Coordination of services for Members after discharge from state and private facilities to integrate them back into community. This includes coordination to implement or access services with network behavioral health Providers or Community Mental Health Clinics (CMHCs);
- Targeted care management by community mental health Providers for adults in the community with a severe and persistent mental illness.

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

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

Utilization Management

Utilization Management (UM) is an ongoing process of assessing, planning, organizing, directing, coordinating, monitoring and evaluating the utilization of healthcare services. The UM program is a multidisciplinary, comprehensive approach and process to manage resource allocation. The UM process influences systematic monitoring of Medical Necessity and quality, and maximizes the cost effectiveness of the care and service provided to Members. Integral factors in the UM process include:

- Consideration of individual Member clinical needs, including those identified with special healthcare needs, cultural characteristics, safety and preferences
- An available and accessible care delivery system
- A diverse network of qualified Providers
- Clinically sound, evidence-based medical/behavioral health necessity decision-making tools that promote the consistent, efficient and effective use of resources.
- Available and applicable plan benefits
- Communication to the Primary Care Practitioner on file when a Member has a planned or unplanned admission and discharge to an inpatient or subacute level of care.

The scope of the UM program includes an overview of policies, procedures and operation processes related to the delivery of medical care, behavioral healthcare, dental care, and pharmaceutical management, including services and physicians who have an effect on the provision of healthcare. This includes the evaluation of Medical Necessity and the efficient use of medical services, procedures facilities, specialty care, inpatient and outpatient care, home care, skilled nursing services, ancillary services and pharmaceutical services. To help in the coordination of care, Wellcare encourages PCPs, treating Providers and facilities to share and review updated Member records during planned and unplanned admissions upon discharge to another level of care to include treatments performed, medications, test results, and the treatment plan.

The UM program processes include components of prior authorization as well as prospective, concurrent, and retrospective review activities, each of which are designed to provide for an evaluation of healthcare and services based on the Member's coverage and the appropriateness of such care and services and to determine the extent of coverage and payment to Providers of care. Neither Wellcare nor the plans reward its practitioners, Providers, or associates who perform utilization reviews, including those of the delegated entities, for denials. No entity or associate is compensated or otherwise given incentives to encourage denials. Utilization denials (adverse determinations) are based on lack of medical necessity or lack of covered benefits. As part of the UM Program performance measurement data regarding frequency of selected procedures, and Behavioral Health readmissions and admissions are all monitored and reported to QIC or the appropriate sub-committee.

The multidisciplinary staff and practitioners employed by Wellcare conduct UM activities within their legal scope of practice as identified by licensure standards.

Population Health Management

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

and programs to assess Member's needs across the entire membership. The population assessment is used to:

- Assess the characteristics and needs of its Member population including social determinants of health factors
- Identify and assess sub-populations
- Assess the needs of child and adolescent Members
- Assess the needs of Members with disabilities
- Assess the needs of Members with serious and persistent mental illness (SPMI)
- Stratify Members into 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 in each of the focus areas
- Review and update PHM resources to address Member needs in each of the focus areas
- Review community resources for integration into program offerings to address Member needs for each of the focus areas
- Identify and address Members' social determinants of health in each of the focus areas

Annually, the Plan:

- 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 Committee QIC on, at least, an annual basis.

Care Management

The mission of the Care Management department is to educate Members and coordinate timely, cost-effective, evidence based, integrated services for the individual health needs of Members to promote positive clinical outcomes. Integrated program components include complex care management, disease management, behavioral health management and transitional care management. Care Management uses multiple data sets to identify and treat high-risk Members. The department employs a multidisciplinary population health model to approach outlying Members from a variety of perspectives.

Care Management monitors the participation rate of Members being managed, the Members' satisfaction with Care Management, Members' utilization of services, readmission rates, admission rates and high-volume service utilization. Care Management also reviews continuity of care between the Member's behavioral healthcare services and their medical care services,

for those Members who are receiving both. Care Management data is reported to UMAC and QIC on a quarterly basis.

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:

- Completing 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
- Promoting 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
- Conducting of comprehensive assessments that identify Member needs and barriers to care
- Coordinating transitions of care for Members with complex and special needs to assist in navigating the complex healthcare system and accessing Provider, public and private community-based resources
- Improving access to primary and specialty care for Members with complex health conditions so they receive appropriate services
- Consulting with appropriate specialized healthcare personnel when needed such as medical directors, pharmacists, social workers and behavioral health professionals, etc.
- Ensuring that Members' socioeconomic barriers are addressed

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

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

Patient Safety

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

- Prevent harm to Members in healthcare delivery
- Develop organization-wide standards, definitions, processes, and norms
- Promote evidence-based policies and practices

- Disseminate training and re-training of case management/utilization management (both medical and behavioral health) in identifying and reporting potential quality of care issues
- Encourage all associates/Providers to report potential quality of care issues
- Strengthen efforts in providing safer and sustainable healthcare systems
- Reduce Member instances of potential quality of care issues which put patient safety at risk

In focusing on patient safety, the Plan aims to:

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

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

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

The Patient Safety Work Group was established to serve as a proactive, interactive team consisting of Quality Improvement Specialists/Nurse Reviewers from all markets. The group's aim is to build cohesiveness in the PQOC process from identification and investigation to action taken and reporting. The group meets monthly, and action plans and minutes are generated and reviewed by the physician champion and the QIC for approval.

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 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. NCQA requires that accredited organizations monitor and take action, as necessary, to improve continuity and coordination of care across the healthcare network. Wellcare refers to these standards as Medicare Continuity

and Coordination of Care standards. These standards guide the organization in utilizing information at its disposal to facilitate coordination of care and collaboration between medical and behavioral healthcare Providers across its care delivery system.

The Plan's activities encourage the PCP relationship to serve as 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 increased coordination of care, healthcare interventions can be more consistent with an individual's overall physical and/or behavioral health, and there become fewer opportunities for negative medication interactions, side effects, complications, and polypharmacy. Attention to continuity and coordination of care promotes patient-centered care, improves a Member's overall physical and mental well-being, decreases hospitalizations, and ensures appropriate and smooth transitions of care. Effective coordination of care is dependent upon clear and timely communication among PCPs, specialists, 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 of 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. In addition, 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 (CDC)	Annual
Movement between practitioners	HEDIS®- UOP- Use of Opiods 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 from Behavioral Health Clinicians for Mutual Patients	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,	Annual

	Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine Hypnotics, or Anticholinergic Agents (DDE)	
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
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 Medicare 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 Medicare 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 Medicare 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.

MEDICARE STAR RATINGS

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, www.medicare.gov, to help beneficiaries when choosing an MA and MA-PD plan offered in their area. The Star Rating program is designed to promote improvement in quality and recognize providers for demonstrating an increase in performance measures over a defined period of time.

CMS's Star Rating Program is based on measures in 9 different domains

Part C

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

Part D

1. Drug Plan Customer Service
2. Member Complaints and Changes in the Drug Plan's Performance
3. Member Experience with the Drug Plan
4. Drug Safety and Accuracy of Drug Pricing

How Can Providers Help Improve Star Ratings?

- Continue to encourage patients to obtain preventive screenings annually or as recommended including but not limited to:
- Breast and/or Colon Cancer Screening
- Annual Flu Vaccine
- Adult BMI Assessment
- Continue to monitor and assess the health and well-being of patients with known chronic conditions including but not limited to:

- Diabetes Care
- Retinal Eye Exam
- Kidney Disease Monitoring (via urine protein testing or ACE/ARB therapy)
- 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)
- 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
- Rheumatoid Arthritis Management through anti-rheumatic medication therapy
- 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 an 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: Adult BMI Assessment, 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 them 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 certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well practitioners and the plan 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

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 its 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 patients 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

REGULATORY MATTERS

Medical Records

Wellcare requires all providers (physician, hospital and ancillary) to maintain sound medical record keeping practices that are consistent with Wellcare's medical records guidelines. Wellcare requires that records be maintained in compliance with all HIPAA regulations and other federal and state laws. Records must be kept in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review. Whether using paper or electronic record keeping systems, medical records need to be identifiable by the patient's name and be accessible. To ensure the member's privacy, medical records should be kept in a secure location. Wellcare requires providers to maintain all records for members for at least 10 years after the final date of service, unless a longer period is required by applicable state or federal law. Medical records must be accessible at the site of the member's PCP or other provider.

Required Information

To be considered a complete and comprehensive medical record, the member's medical record (file) should include, at a minimum: provider notes regarding examinations, office visits, referrals made, tests ordered, and results of diagnostic tests ordered (i.e. X-rays, laboratory tests). Medical records should be accessible at the site of the member's participating primary care physician or provider. All medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, should be documented and prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the standards set forth below.

- Member's name, and/or medical record number must be on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance must be included.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.

- An up-to-date immunization record is established for pediatric members or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Wellcare practice guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed including instructions to the member.
- Documentation of prenatal risk assessment for pregnant members or infant risk assessment for newborns.
- Signed and dated required consent forms are included.
- Unresolved problems from previous visits are addressed in subsequent visits.
- There is review under- or over utilization of consultants.
- If a consultation is requested, there's a note from the consultant in the record.
- Consultation, laboratory and imagine reports filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement). If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.
- Laboratory and other studies ordered as appropriate are documented.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review.

- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases.

- Health teaching and/or counseling is documented.

- For members 12 years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried).

- Documentation of failure to keep an appointment.

- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.

- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.

- Confidentiality of member information and records are protected.

- Evidence that an advance directive has been offered to adults 18 years of age and older.

Medical Records Release

All member medical records are confidential and must not be released without the written authorization of the member or their parent/legal guardian, in accordance with state and federal law and regulation. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

All release of specific clinical or medical records for Substance Use Disorders must meet Federal guidelines at 42 CFR part 2 and any applicable State Laws.

Compliance Audits for Medical Record Documentation

Wellcare may audit record-keeping practices and individual member medical records in conjunction with ongoing Quality Improvement Program activities, utilizing the standards listed above. Providers scoring less than 80% on medical record audits may be placed under a corrective action plan, subject to additional medical record reviews or referred to Wellcare's Quality Improvement Committee (QIC) for recommendations.

Wellcare encourages providers to request medical records that document care previously provided to members that are new to their panel. This will assist in assuring the member receives continuous care, as well as helping determine the most appropriate course of treatment for the patient.

Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Wellcare members. If the member or member's parent/legal guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, then this should also be noted in the medical record.

Medical Records Audits

Wellcare will conduct random medical record audits as part of its QAPI Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of services, as well as the outcome of such services, is also subject to review and assessment during a medical record audit. Wellcare will provide written notice prior to conducting a medical record review.

Access to Records and Audits from Wellcare

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

Electronic Medical Record (EMR) Access

Providers will grant Wellcare access to providers Electronic Medical Record (EMR) system in order to effectively case manage members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to Wellcare for this access.

Federal and State Laws Governing the Release of Information

The release of certain information is governed by a myriad of Federal and/or State laws.

These laws often place restrictions on how specific types of information may be disclosed, including, but not limited to, mental health, alcohol /substance abuse treatment and communicable disease records.

For example, the federal Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities, such as health plans and providers, release protected health information only when permitted under the law, such as for treatment, payment and operations activities, including care management and coordination.

However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance abuse treatment records (42 CFR Part 2 or "Part 2"). These records generally may not be released without consent from the individual whose information is subject to the release.

Still other laws at the State level place further restrictions on the release of certain information, such as mental health, communicable disease, etc.

For more information about any of these laws, refer to the following:

- HIPAA - please visit the Centers for Medicare & Medicaid Services (CMS) website at: www.cms.hhs.gov and then select "Regulations and Guidance" and "HIPAA – General Information"
- Part 2 regulations - please visit the Substance Abuse and Mental Health Services Administration (within the U.S. Department of Health and Human Services) at: www.samhsa.gov
- State laws - consult applicable statutes to determine how they may impact the release of information on patients whose care you provide.

Contracted providers within the Wellcare network are independently obligated to know, understand and comply with these laws.

Wellcare takes privacy and confidentiality seriously. We have established processes, policies and procedures to comply with HIPAA and other applicable federal and/or State confidentiality and privacy laws.

Please contact the Wellcare Compliance Officer by phone at 1-866-595-8133 or in writing (refer to address below) with any questions about our privacy practices.

Wellcare
Attn: Compliance Officer
7700 Forsyth Boulevard
Clayton, MO 63105

Section 1557 of the Patient Protection and Affordable Care Act

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in:

- Any health program or activity any part of which received funding from HHS
- Any health program or activity that HHS itself administers
- Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces.

For more information, please visit www.hhs.gov/civil-rights/section-1557.

Health Insurance Portability and Accountability Act

To improve the efficiency and effectiveness of the healthcare system, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, includes administrative simplification provisions that require national standards for electronic healthcare transactions and code sets, unique health identifiers and security, as well as federal privacy protections for individually identifiable health information. The Office for Civil Rights administers and enforces the Privacy Rule and the Security Rule.

Other HIPAA Administrative Simplification Rules are administered and enforced by the Centers for Medicare and Medicaid Services (CMS), and include:

- Transactions and code sets standards
- Employer identifier standard
- National Provider Identifier standard

The Enforcement Rule provides standards for the enforcement of all the Administrative Simplification Rules. A summary of the HIPAA Administrative Simplification Rules can be found at www.CMS.gov/Regulations-and-Guidance.

Privacy Regulations

The Privacy rules regulate who has access to a member's personally identifiable health information (PHI) whether in written, verbal or electronic form. In addition, this regulation affords individuals the right to keep their PHI confidential, and in some instances, from being disclosed.

In compliance with the privacy regulations, Wellcare has provided each Wellcare member with a privacy notice, which describes how Wellcare can use or share a member's health records and how the member can get access to the information. In addition, the Member Privacy Notice informs the member of their healthcare privacy rights and explains how these rights can be exercised. Copies of Wellcare's Member Privacy Notices can be found at www.wellcareok.com.

1. As a provider, if you have any questions about Wellcare's privacy practices, contact the Wellcare Compliance Officer at 1-833-853-0865.
2. Members should be directed to Wellcare's Member Services department with any questions about the privacy regulations. Member Services can be reached at Wellcare Medicare HMO Phone: 1-833-853-0865 or Wellcare Dual Medicare (HMO DSNP) & Wellcare Dual Medicare Essentials (HMO DSNP): 1-833-853-0866

The Security Rule

The HIPAA Security Rule establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by Wellcare. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity and security of

electronic protected health information. The Security Rule is located at 45 CFR Part 160, and Subparts A and C of Part 164.

The Breach Notification Rule

On January 25, 2013, the Office for Civil Rights (OCR) of the United States Department of Health and Human Services (HHS) published in the Federal Register a final omnibus rule that revises certain rules promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These revised rules were issued pursuant to changes enacted by Congress in the Health Information Technology for Economic and Clinical Health (HITECH) Act and the Genetic Information Nondiscrimination (GINA) Act of 2008. Effective March 23, 2013, the Final Rule implements section 13402 of the HITECH Act by requiring various notifications following a breach of unsecured protected health information.

The Final Rule eliminates the significant risk of harm standard from the Interim Rule for determining whether a breach has occurred. Covered entities and business associates must ensure compliance with regulatory definitions relating to breach notifications.

Transactions and Code Sets Regulations

Transactions are activities involving the transfer of healthcare information for specific purposes. Under HIPAA, if Wellcare or a healthcare provider engages in one of the identified transactions, they must comply with the standard for it, which includes using a standard code set to identify diagnoses and procedures. The Standards for Electronic Transactions and Code Sets published August 17, 2000, and since modified, adopted standards for several transactions, including claims and encounter information, payment and claims status. Any healthcare provider that conducts a standard transaction also must comply with the Privacy Rule.

Version 5010 refers to the revised set of HIPAA electronic transaction standards adopted to replace the current standards. Every standard has been updated, including claims, eligibility and referral authorizations.

All HIPAA covered entities must be using version 5010 as of January 1, 2012. Any electronic transaction for which a standard has been adopted must have been submitted using version 5010 on or after January 1, 2012.

HIPAA Required Code Sets

The HIPAA Code Sets regulation requires that all codes utilized in electronic transactions are standardized, utilizing national standard coding. Only national standard codes can be used for electronic claims and/or authorization of services.

Nationally recognized code sets include:

1. Health Care Common Procedure Coding System (HCPCS) - This code set, established by the CMS, primarily represents items and supplies and non-physician services not covered by the American Medical Association CPT-4 codes, which can be purchased from the American Medical Association (AMA) at 1-800-621-8335.

2. Current Procedure Terminology (CPT) codes- The CPT codes are used to describe medical procedures, and this code set is maintained by the American Medical Association. For more information on the CPT codes, please contact the AMA.

3. International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volumes 1 and 2 (diagnosis codes) - These are maintained by the National Center for Health Statistics and Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

4. International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volume 3 (procedures) - Those are maintained by CMS.

5. International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM- This is the new diagnosis coding system that was developed as a replacement for ICD-9-CM, Volume 1 and 2. International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS is the new procedure coding system that was developed as a replacement for ICD-9-CM, Volume 3, and two parts:

    - Part 1: ICD-10-CM for diagnosis coding. ICD-10-CM is for use in all U.S. Health care settings. Diagnosis coding under ICD-10-CM uses three (3) to seven (7) digits instead of the three (3) to five (5) digits used with ICD-9-CM, but the format of the code sets is similar.

    - Part 2: ICD-10-PCS for inpatient procedure coding. ICD-10-PCS is for use in U.S. Inpatient hospital settings only. ICD-10-PCS uses seven (7) alphanumeric digits instead of the three (3) or four (4) numeric digits used under ICD-9-CM procedure coding. National Drug Code (NDC) - The NDC is a code that identifies the vendor (manufacturer), product and package size of all medications recognized by the Federal Drug Administration (FDA). To access the complete NDC code set, see www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm.

HIPAA Regulated Transactions

Below are the 10 electronic standardized transactions that are mandated by the HIPAA legislation.

1. Transaction name
2. HIPAA transaction number
3. Claims and encounters
4. Enrollment and disenrollment
5. Health plan eligibility solicitations and response
6. Payment and remittance advice
7. Premium payment
8. Claim status solicitation and response
9. Coordination of benefits

10. Referral and authorization

Though it is standard operating process, Wellcare does not currently utilize all standard transaction sets. Functionality equivalent to that which is offered by these transaction sets is made is available to Wellcare's members and providers via various alternative capabilities such as online tools. Wellcare currently offers an alternative through the Secure Provider Portal, for the following transactions:

- ASC X12 270 Eligibility Status Inquiry
- ASC X12 271 Eligibility Status Response
- ASC X12 276 Claim Status Inquiry
- ASC X12 277 Claim Status Response
- ASC X12 278 Referral Certification and Response

For more information on conducting these transactions electronically, contact the EDI Department at 1-800-225-2573, ext. 6075525 or by email at EDIBA@centene.com.

National Provider Identifier

The National Provider Identifier (NPI) is a HIPAA Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare Clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in all electronic HIPAA standards transactions. However, some LTSS providers are considered "Atypical Providers" because they render non-health or non-medical services to Wellcare members. These providers bill using their Atypical ID (LTSS #) in the Non-NPI Provider ID field of the claim form.

As outlined in the Federal regulation, covered providers must also share their NPI with other providers, health plans, clearinghouses and any entity that may need it for billing purposes.

Please contact the Wellcare Compliance Officer by phone at 1-866-595-8133 or in writing (refer to address below) with any questions about our privacy practices.

Wellcare
Attn: Compliance Officer
7700 Forsyth Boulevard
Clayton, MO 63105

FRAUD, WASTE AND ABUSE

Wellcare takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a Fraud, Waste and Abuse (FWA) program that complies with the federal and state laws. Wellcare, in conjunction with its parent company, Centene, operates a Fraud, Waste and Abuse unit. Wellcare routinely conducts audits to ensure compliance with billing regulations. To better understand this system, please review the Claims section and Billing the Member section of this manual. The Centene Special Investigation Unit (SIU) performs retrospective audits which, in some cases, may result in taking actions against providers who commit Fraud, Waste and/or Abuse. These actions include but are not limited to:

- Remedial education and training to prevent the billing irregularity;
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify

Some of the most common FWA practices include:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT
- Diagnosis and/or procedure code not consistent with the member's age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of benefits
- Claims for services not rendered

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential FWA hotline at 1-866-685-8664. Wellcare takes all reports of potential Fraud, Waste and Abuse very seriously and investigates all reported issues.

OIG/GSA Exclusion and CMS Preclusion List – As a provider in our Medicare network, you are required to check the exclusion lists prior to hiring or contracting and monthly thereafter as outlined below for all your staff, volunteers, temporary employees, consultants, Board of 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

Providers' implementation of Fraud, Waste, and Abuse safeguards to identify excluded providers and entities.

Medicare payment may not be made for items or services furnished or prescribed by a precluded or excluded provider or entity. Plans shall not use federal funds to pay for services, equipment or drugs prescribed or provided by a provider, supplier, employee or First Tier, Downstream or Related entities (FDR) precluded by CMS and/or excluded by the Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) or the General Services Administration (GSA). Wellcare will review the CMS Preclusion List, the DHHS OIG List of Excluded Individuals and Entities (LEIE list) and the GSA Excluded Parties List (EPLS) prior to hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member, or FDR, and monthly thereafter. If anyone is identified, providers are required to notify Wellcare immediately so that if needed Wellcare can take appropriate action. Providers may contact the Wellcare Compliance Officer at 1-833-853-0865 FWA Program Compliance Authority and Responsibility

The Wellcare Vice President of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the compliance program. Wellcare is committed to identifying, investigating, sanctioning and prosecuting suspected Fraud, Waste and Abuse.

The Wellcare provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

To report suspected Fraud, Waste and Abuse call, 1-866-685-8664.

Post-Processing Claims Audit

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. To start the audit, Wellcare's auditors request medical records for a defined review period. Providers have 30 days to respond to the request; if no response is received, a second and final request for medical records is forwarded to the provider. If the provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, Wellcare will recover all amounts paid for the services in question.

Wellcare auditors review cases for common FWA practices including:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT
- Diagnosis and/or procedure code not consistent with the member's age/gender
- Use of exclusion codes

- Excessive use of units
- Misuse of benefits
- Claims for services not rendered

Wellcare's auditors consider state and federal laws and regulations, provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician of like specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report identifying all records reviewed during the audit. If the auditor determines that clinical documentation does not support the claims payment in some or all circumstances, Wellcare will seek recovery of all overpayments. Depending on the number of services provided during the review period, Wellcare may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998).

False Claims Act

The False Claims Act establishes liability when any person or entity improperly receives from or avoids payment to the Federal government. The Act prohibits:

- Knowingly presenting, or causing to be presented a false claim for payment or approval
- Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim
- Conspiring to commit any violation of the False Claims Act
- Falsely certifying the type or amount of property to be used by the Government
- Certifying receipt of property on a document without completely knowing that the information is true
- Knowingly buying Government property from an unauthorized officer of the Government
- Knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the Government

For more information regarding the False Claims act, please visit www.cms.hhs.gov.

Physician Incentive Programs

On an annual basis and in accordance with Federal Regulations, Wellcare must disclose to the Centers for Medicare and Medicaid Services, any Physician Incentive Programs that could potentially influence a physician's care decisions. The information that must be disclosed includes the following:

- Effective date of the Physician Incentive Program
- Whether services not covered by Wellcare are covered under Physician Incentive Program
- Type of Incentive Arrangement i.e., withhold, bonus, capitation
- If Incentive Arrangement involves withhold or bonus, what percentage of withhold or bonus
- Amount and type of stop-loss protection
- Patient panel size
- Description of the pooling method, if applicable
- For capitation arrangements, provide the amount of the capitation payment that is broken down by percentage for primary care, referral and other services
- The calculation of substantial financial risk (SFR)
- Whether Wellcare does or does not have a Physician Incentive Program
- The name, address and other contact information of the person at Wellcare who may be contacted with questions regarding Physician Incentive Programs

Physician Incentive Programs may not include any direct or indirect payments to providers and/or provider groups who create inducements to limit or reduce the provision of necessary services. In addition, Physician Incentive Programs that place providers and/or provider groups at significant financial risk may not operate unless there is adequate stop-loss protection, member satisfaction surveys and satisfaction of disclosure requirements satisfying the Physician Incentive Program regulations.

Substantial financial risk (SFR) occurs when the incentive arrangement places the provider and/or provider group at risk beyond the risk threshold which is the maximum risk if the risk is based upon the use or cost of referral services. The risk threshold is set at 25% and does not include amounts based solely on factors other than a provider and/or provider group's referral levels. Bonuses, capitation, and referrals may be considered incentive arrangements that result in SFR.

If you have questions regarding the Physician Incentive Program Regulations, please contact your Provider Partnership Manager.

First-Tier and Downstream Providers

Through written agreement, Wellcare may delegate certain functions or responsibilities in accordance with CMS regulations 42 CFR § 422.504 to First-Tier, downstream, and delegated entities. These functions and responsibilities include but are not limited to contract administration and management, claims submission, claims payment, credentialing and re-credentialing, network management, and provider training. Wellcare

oversees and is accountable for these responsibilities specified in the written agreement and will impose sanctions or revoke delegation if the entities' performance is inadequate. Wellcare will ensure written agreements which specify these responsibilities by Wellcare, and the delegated entity are clear and concise. Agreements will be kept on file by Wellcare for reference.

Member Notifications

Medicare providers are required in certain circumstances to provide notifications to their patients about various aspects of their care. This section outlines some of the most common member notifications required by Medicare providers. For a comprehensive list of notification requirements, please review Chapter 30 (Financial Liability Protections) of the Medicare Claims Processing Manual, available on www.cms.gov.

Notice of Medicare Non-Coverage (NOMNC)

Scope

The expedited determination process is available to beneficiaries in Original Medicare whose Medicare covered services are being terminated in the following settings. All beneficiaries receiving services in these settings must receive a Notice of Medicare Non-Coverage (NOMNC) before their services end:

- Home Health Agencies (HHAs)
- Comprehensive Outpatient Rehabilitation Services (CORFs)
- Hospice
- Skilled Nursing Facilities (SNFs)-- Includes services covered under a Part A stay, as well as Part B services provided under consolidated billing (i.e., physical therapy, occupational therapy, and speech therapy). A NOMNC must be delivered by the SNF at the end of a Part A stay or when all of Part B therapies are ending.

Provider Delivery of the NOMNC

Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per §260.2. A NOMNC must be delivered even if the beneficiary agrees with the termination of services. Medicare providers are responsible for the delivery of the NOMNC.

Required Delivery Timeframes

The NOMNC should be delivered to the beneficiary at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.

Detailed Explanation of Non-Coverage

The Detailed Explanation of Non-Coverage (DENC)

Medicare providers are responsible for the delivery of the DENC to beneficiaries who request an expedited determination by the QIO. The DENC must contain the following information:

- The facts specific to the beneficiary's discharge and provider's determination that coverage should end.

- A specific and detailed explanation of why services are both no longer reasonable and necessary or no longer covered.
- A description of, and citations to, the Medicare coverage rule, instruction, or other policies applicable to the review.

The delivery must occur in person by close of business of the day the QIO notifies the provider that the beneficiary has requested an expedited determination. A provider may also choose to deliver the DENC with the NOMNC.

Required Notification to Members for Observation Services

Scope

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 if sooner upon release. The OMB approved Medicare Outpatient Observation Notice and accompanying form instructions can be found at www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html

Notice of Hospital Discharge Appeal Rights

Hospitals must issue the ***Important Message*** within two calendar days of admission, obtain signature of the patient or the signature of their authorized representative, and provide a signed follow-up copy to the patient as far in advance of discharge as possible, but not more than two calendar days before discharge.

Provider-Preventable Conditions

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

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 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 or hospitalizations and other services related to these non-covered procedures.

APPENDIX

Appendix I: Common Causes for Upfront Claim Rejections

Common causes for upfront rejections include but are not limited to:

- Unreadable Information - The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), or the font is too small
- Member Date of Birth is missing.
- Member Name or Identification Number is missing.
- Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) Number is missing.
- Attending Provider information missing from Loop 2310A on Institutional claims when CLM05-1 (Bill Type) is 11, 12, 21, 22, or 72 or missing from box 48 on the paper UB claim form.
- Date of Service is not prior to the received date of the claim (future date of service).
- Date of Service or Date Span is missing from required fields. Example: "Statement From" or “Service From" dates.
- Type of Bill is invalid.
- Diagnosis Code is missing, invalid, or incomplete.
- Service Line Detail is missing.
- Date of Service is prior to member’s effective date.
- Admission Type is missing (Inpatient Facility Claims – UB-04, field 14).
- Patient Status is missing (Inpatient Facility Claims – UB-04, field 17).
- Occurrence Code/Date is missing or invalid.
- Revenue Code is missing or invalid.
- CPT/Procedure Code is missing or invalid.
- A missing CLIA Number in Box 23 or a CMS 1500 for CLIA or CLIA waived service
- Incorrect Form Type used.

Appendix II: Common Cause of Claims Processing Delays and Denials

- Procedure or Modifier Codes entered are invalid or missing.
- This includes GN, GO, or GP modifier for therapy services.
- Diagnosis Code is missing the 4th or 5th digit.
- DRG code is missing or invalid.
- Explanation of Benefits (EOB) from the primary insurer is missing or incomplete.
- Third Party Liability (TPL) information is missing or incomplete.
- Member ID is invalid.
- Place of Service Code is invalid.
- Provider TIN and NPI do not match.
- Revenue Code is invalid.
- Dates of Service span do not match the listed days/units.
- Tax Identification Number (TIN) is invalid.

Appendix III: Common EOP Denial Codes and Descriptions

See the bottom of your paper EOP for the updated and complete description of all explanation codes associated with your claims. Electronic Explanations of Payment will use standard HIPAA denial codes.

EX Code	Definition
0B	ADJUST: CLAIM TO BE REPROCESSED CORRECTED UNDER NEW CLAIM NUMBER
0I	ADJUSTMENT: ADJUSTED PER CORRECTED BILLING FROM PROVIDER
1D	DENY: DISCHARGE STATUS INVALID FOR TYPE OF BILL
52	DENY - PAYMENT INCLUDED IN ALLOWANCE FOR ANOTHER PROCEDURE
57	DENY - AUTHORIZATION LIMITATION EXCEEDED
64	DENY - PROCEDURE INCONSISTENT WITH DIAGNOSIS
65	DENY-MISSING OR INVALID INFORMATION
71	DENY-MEMBER NOT ELIGIBLE ON DATE OF SERVICE
76	DENY - MAXIMUM BENEFIT HAS BEEN PAID
78	DENY: INVALID OR MISSING PLACE OF SERVICE LOCATION
82	DENY-NON-COVERED SERVICES
83	DENY - DUPLICATE OF PREVIOUS SUBMITTED CLAIM
A1	APC - OCE LINE-ITEM REJECTION
A2	APC - OCE LINE-ITEM DENIAL
A4	APC - OCE CLAIM LEVEL RETURN TO PROVIDER (RTP)
A5	APC - OCE CLAIM LEVEL REJECTION
AN	DENY - SERVICE DENIED FOR NO AUTHORIZATION ON FILE
BT	DENY: TYPE OF BILL INVALID
C5	DENY: CODE REPLACED BASED ON CODE AUDITING
dh	DENY - NON-EMERGENCY OUT OF AREA SERVICES ARE NOT COVERED

DZ	DENY: RESUBMIT WITH CORRECTED COUNT
EB	DENIED BY MEDICAL SERVICES
EC	DENY: DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT
Es	INVALID OR MISSING REQUIRED ESRD OR HHA \CLAIMS DATA
FT	INVALID FORM TYPE FOR PROCEDURE(S) SUBMITTED
Hn	HHA GROUPER INVALID OR NO TREATMENT AUTHORIZATION CODE PROVIDED
Jq	ORIGINAL CHECK NOT CASHED-PAY TO/ADDRESS VERIFICATION NEEDED
MR	MODIFIER REQUIRED FOR PROCEDURE
NN	MODIFIER NOT REQUIRED FOR THIS PROCEDURE
NV	DENY: PLEASE RESUBMIT WITH INVOICE FOR SERVICES RENDERED
PM	DENY - INVALID PROCEDURE MODIFIER COMBINATION SUBMITTED
QR	DENY: ADJUSTMENT WAS NOT RECEIVED WITHIN TIMELY FILING LIMIT
S9	DENY - CODE BILLED IS NOT COVERED FOR PROVIDER TYPE
TF	DENY - FILING LIMIT EXCEEDED
x2	SERVICE(S) OR SUPPLIES DURING GLOBAL SURGICAL PERIOD
x3	PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE
x8	MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED
ya	DENY: DENIED AFTER REVIEW OF PATIENT S CLAIM HISTORY
ye	CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS
YO	DENY: ADD ON CODE BILLED WITHOUT PRIMARY PROCEDURE
ZW	AFTER REVIEW, PREV DECISION UPHELD, SEE PROV HANDBOOK FOR APPEAL PROCESS

Appendix IV: Instructions for Supplemental Information

(CMS- 1500 02/12) FORM, SHADED FIELD 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (02/12) Claim Form field 24-A-G:

- National Drug Code (NDC)
- Narrative description of unspecified/miscellaneous/unlisted codes
- Contract Rate

The following qualifiers are to be used when reporting these services:

- ZZ Narrative description of unspecified/miscellaneous/unlisted codes
- N4 National Drug Code (NDC)
- CTR Contract Rate

If required to report other supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

More than one supplemental item can be reported in the shaded lines of item number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

For reporting dollar amounts in the shaded area, always enter the dollar amount, a decimal point, and the cents. Use 00 for cents if the amount is a whole number. Do not use commas. Do not enter dollars signs (ex. 1000.00; 123.45).

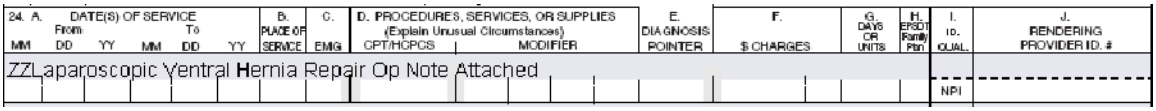
Additional Information for Reporting NDC:

When adding supplemental information for NDC, enter the information in the following order:

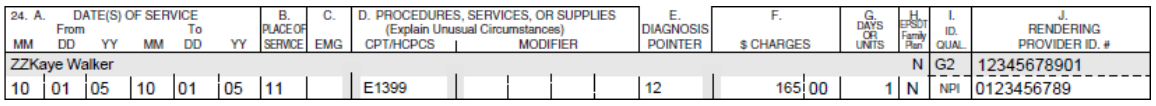
- Qualifier
- NDC Code
- One space

- Unit/basis of measurement qualifier
- F2- International Unit
- ME – Milligram
- UN – Unit
- GR – Gram
- ML - Milliliter
- Quantity
- The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal (ex. 99999999.999).
- When entering a whole number, do not use a decimal (ex. 2).
- Do not use commas.

Unspecified/Miscellaneous/Unlisted Codes

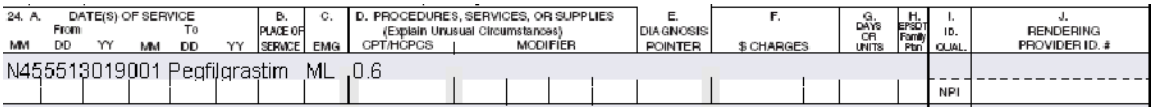


24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZLaparoscopic Ventral Hernia Repair Op Note Attached														NPI	

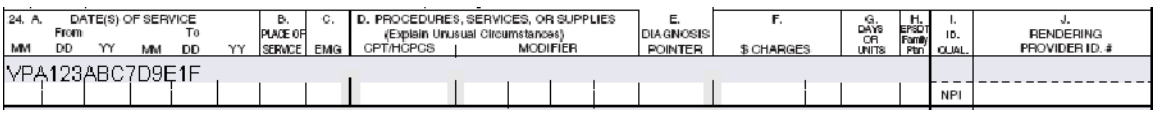


24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZKaye Walker													N	G2	12345678901
10	01	05	10	01	05	11		E1399		12	165 00	1	N	NPI	0123456789

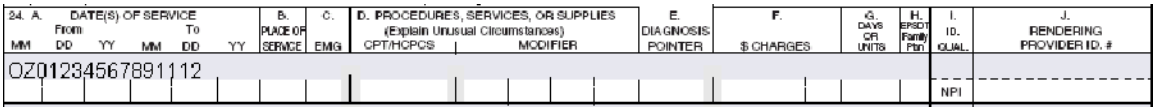
NDC Codes



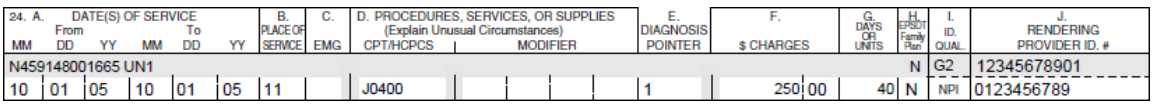
24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N455513019001 Pegfilgrastim ML 0.6														NPI	



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
VPA123ABC7D9E1F														NPI	



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
OZ01234567891112														NPI	



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N459148001665 UN1													N	G2	12345678901
10	01	05	10	01	05	11		J0400		1	250 00	40	N	NPI	0123456789

Appendix V: Common HIPAA Compliant EDI Rejection Codes

These codes on the follow page are the Standard National Rejection Codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted.

ERROR ID	ERROR_DESC
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Prv
07	Invalid Mbr DOB & Prv
08	Invalid Mbr & Prv
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Prv not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17	Invalid Diag
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS; Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS
23	Invalid Prv; Invalid Diag
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag
25	Invalid Mbr; Invalid Prv; Invalid Diag
26	Mbr not valid at DOS; Invalid Diag
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag

29	Prv not valid at DOS; Invalid Diag
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag
32	Mbr not valid at DOS; Prv not valid; Invalid Diag
33	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid; Invalid Diag
34	Invalid Proc
35	Invalid DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
37	Invalid or future date
37	Invalid or future date
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Prv; Invalid Proc; Invalid Mbr DOB
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS, Invalid Proc
49	Invalid Proc; Invalid Prv; Mbr not valid at DOS
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc

55	Mbr not valid at DOS; Prv not valid at DOS, Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS; Invalid Diag; Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
74	Reject. DOS prior to 6/1/2006; OR Invalid DOS
75	Invalid Unit
76	Original claim number required
77	INVALID CLAIM TYPE
81	Invalid Unit; Invalid Prv
83	Invalid Unit; Invalid Mbr & Prv
89	Invalid Prv; Mbr not valid at DOS; Invalid DOS
A2	DIAGNOSIS POINTER INVALID
A3	CLAIM EXCEEDED THE MAXIMUM 97 SERVICE LINE LIMIT
B1	Rendering and Billing NPI are not tied on state file

B2	Not enrolled with MHS and/or State with rendering NPI/TIN on DOS. Enroll with MHS and resubmit claim
B5	Missing/incomplete/invalid CLIA certification number
H1	ICD9 is mandated for this date of service.
H2	Incorrect use of the ICD9/ICD10 codes.
HP	ICD10 is mandated for this date of service.
ZZ	Claim not processed

Appendix VI: Claim Form Instructions

Billing Guide for a CMS 1500 and CMS 1450 (UB-04) Claim Form.

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided

Note: Claims with missing or invalid Required (R) field information will be rejected or denied

Completing A CMS 1500 Claim Form

Updated format (Form 1500 (02-12)) can be accepted as of Jan. 1, 2014 and is required after October 1, 2014.

Please see the following example of a CMS 1500 form.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY | QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM | MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? For govt. claims, see back YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Field #	Field Description	Instruction or Comments	Required or Conditional
1	INSURANCE PROGRAM IDENTIFICATION	Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being field. Enter "X" in the box noted "Other"	R
1a	INSURED'S I.D. NUMBER	The 9-digit identification number on the member's I.D. Card	R
2	PATIENTS NAME (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's I.D. card. Do not use nicknames.	R
3	PATIENT'S BIRTH DATE/SEX	Enter the patient's 8-digit date of (MM/DD/YYYY) and mark the appropriate box to indicate the patient's sex/gender. M= Male F= Female	R
4	INSURED'S NAME	Enter the patient's name as it appears on the member's I.D. Card	C
5	PATIENT'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414).	C
6	PATIENT'S RELATION TO INSURED	Always mark to indicate self.	C

Field #	Field Description	Instruction or Comments	Required or Conditional
7	INSURED'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	C
8	RESERVED FOR NUCC USE		Not Required
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.	C
9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	RESERVED FOR NUCC USE		Not Required
9c	RESERVED FOR NUCC USE		Not Required
9d	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.	

			C
Field #	**Field Description**	**Instructions or Comments**	**Required or Conditional**
10a, b, c	IS PATIENT'S CONDITION RELATED TO	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.	R
10d	CLAIM CODES (Designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code.	C
11	INSURED POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If Item Number 10abc is marked Y, this field should be populated.	C
11a	INSURED'S DATE OF BIRTH / SEX	Enter the 8-digit date of birth (MM | DD | YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.	C
11b	OTHER CLAIM ID (Designated by NUCC)	The following qualifier and accompanying identifier have been designated for use: Y4 Property Casualty Claim Number **FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY:** Required if known. Enter the claim number assigned by the payer.	C
11c	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance health plan or program.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete field's 9a-d and 11c.	R
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File", "SOF", or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	C
13	INSURED'S OR AUTHORIZED PERSONS SIGNATURE	Obtain signature if appropriate.	Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)	Enter the 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	C
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) format.	C
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		C
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials).	C
17a	ID NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. Use ZZ qualifier for Taxonomy code	C
17b	NPI NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		C
19	RESERVED FOR LOCAL USE – NEW FORM:		C

	ADDITIONAL CLAIM INFORMATION		
Field #	**Field Description**	**Instruction or Comments**	**Required or Conditional**
20	OUTSIDE LAB / CHARGES		C
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS A-L to ITEM 24E BY LINE). NEW FORM ALLOWS UP TO 12 DIAGNOSES, AND ICD INDICATOR	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. **Note:** Claims missing or with invalid diagnosis codes will be rejected or denied for payment.	R
22	RESUBMISSION CODE / ORIGINAL REF.NO.	For re-submissions or adjustments, enter the original claim number of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim	C
23	PRIOR AUTHORIZATION NUMBER or CLIA NUMBER	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services	If auth = C If CLIA = R (If both, always submit the CLIA number)
24a-j General Information	Box 24 contains six claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are four individual fields labeled 24A-24G, 24H, 24J, and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields. The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Number. Shaded boxes 24 a-g is for line-item supplemental information and provides a continuous line that		

	accepts up to 61 characters. Refer to the instructions listed below for information on how to complete. The un-shaded area of a claim line is for the entry of claim line-item detail.

Field #	Field Description	Instruction or Comments	Required or Conditional
24 A-G Shaded	SUPPLEMENTAL INFORMATION	The shaded top portion of each service claim line is used to report supplemental information for: NDC Narrative description of unspecified codes Contract Rate For detailed instructions and qualifiers refer to Appendix IV of this guide.	C
24A Unshaded	DATE(S) OF SERVICE	Enter the date the service listed in field 24D was performed (MM⊠DD⊠YYYY). If there is only one date, enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. If identical services (identical CPT/HCPC code(s)) were performed each date must be entered on a separate line.	R
24B Unshaded	PLACE OF SERVICE	Enter the appropriate 2-digit CMS Standard Place of Service (POS) Code. A list of current POS Codes may be found on the CMS website.	R
24C Unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	Not Required
24D Unshaded	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Enter the 5-digit CPT or HCPC code and 2-character modifier, if applicable. Only one CPT or HCPC and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the Procedure Code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
24 E Unshaded	DIAGNOSIS CODE	In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM (or ICD-10-CM, once mandated) diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-9/10 Codes for the date of service, or the claim will be rejected/denied.	R
24 F Unshaded	CHARGES	Enter the charge amount for the claim line-item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	R
24 G Unshaded	DAYS OR UNITS	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one.	R
24 H Shaded	EPSDT (Family Planning)	Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral.	C
24 H Unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit.	C
24 I Shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy Use 1D qualifier for ID, if an Atypical Provider.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
24 J Shaded	NON-NPI PROVIDER ID#	Typical Providers: Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code. Atypical Providers: Enter the Provider ID number.	R
24 J Unshaded	NPI PROVIDER ID	Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g., DME, Independent Lab, Home Health, RHC/FQHC General Medical Exam, etc.).	R
25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number and mark the box labeled EIN	R
26	PATIENT'S ACCOUNT NO.	Enter the provider's billing account number	C
27	ACCEPT ASSIGNMENT?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a member using state funds indicates the provider accepts assignment. Refer to the back of the CMS 1500 (02-12) Claim Form for the section pertaining to Payments	C
28	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e.,	R

		10.00), enter 00 in the area to the right of the vertical line.	

Field #	Field Description	Instructions or Comments	Required or Conditional
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing when Wellcare is listed as secondary or tertiary. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	C
30	BALANCE DUE	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid the claim will be returned unprocessed. **Note:** Does not exist in the electronic 837P.	R

Field #	Field Description	Instructions or Comments	Required or Conditional
32	SERVICE FACILITY LOCATION INFORMATION	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box numbers are not acceptable here.) First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen.	C
32a	NPI – SERVICES RENDERED	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	c

Field #	Field Description	Instructions or Comments	Required or Conditional
32b	OTHER PROVIDER ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical Providers Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces). Atypical Providers Enter the 2-character qualifier 1D (no spaces).	C
33	BILLING PROVIDER INFO & PH#	Enter the billing provider's complete name, address (include the zip + 4 code), and phone number. First line -Enter the business/facility/practice name. Second line -Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line -In the designated block, enter the city and state. Fourth line- Enter the zip code and phone number. When entering a 9-digit zip code (zip+ 4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (555)555-5555). NOTE: The 9-digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission	R

Field #	Field Description	Instructions or Comments	Required or Conditional
33a	GROUP BILLING NPI	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID.	R
33b	GROUP BILLING OTHERS ID	Enter as designated below the Billing Group taxonomy code. Typical Providers: Enter the Provider Taxonomy Code. Use ZZ qualifier. Atypical Providers: Enter the Provider ID number.	R

Completing a UB-04 Claim Form

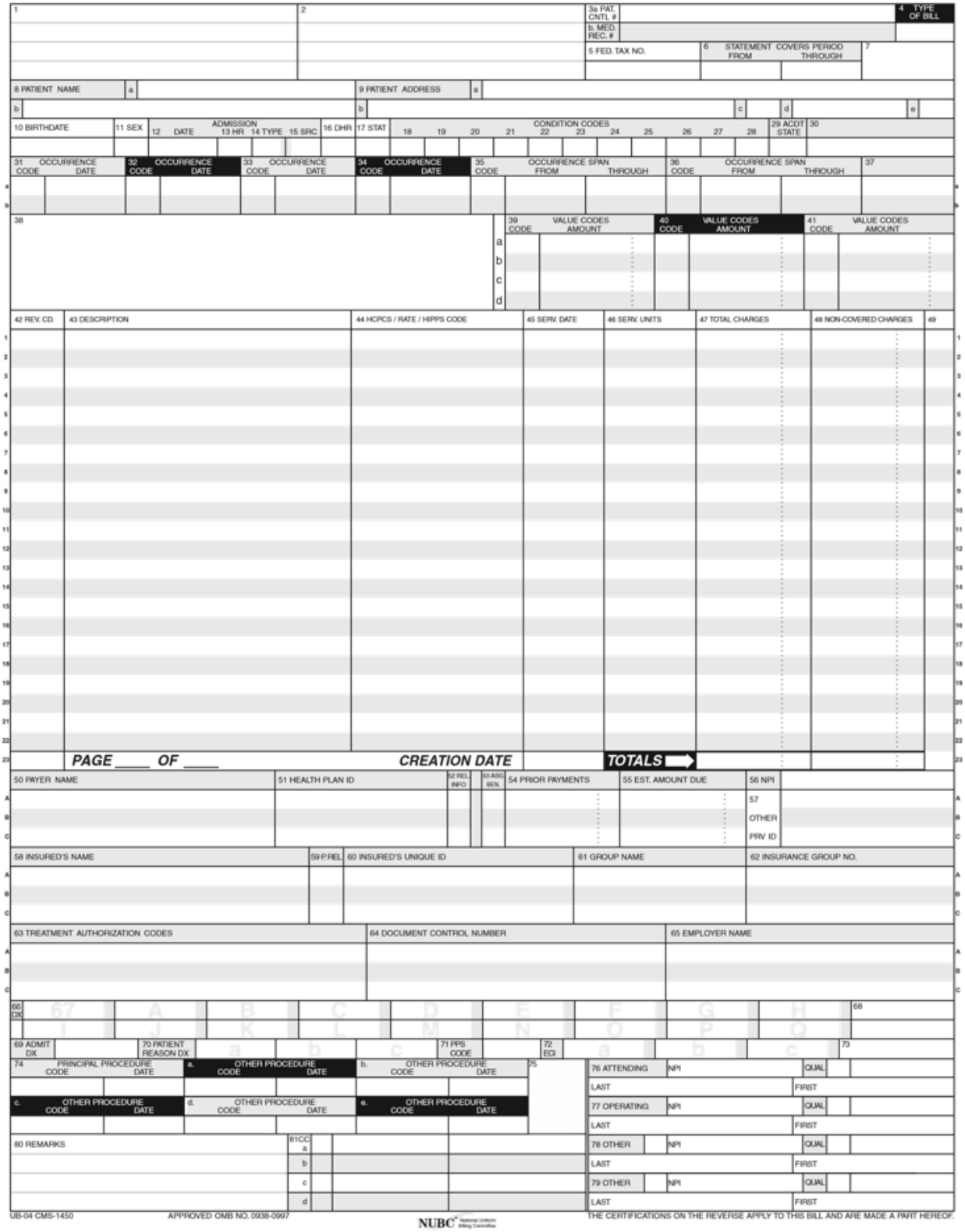
A UB-04 is the only acceptable claim form for submitting inpatient or outpatient Hospital claim charges for reimbursement by Wellcare. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation Facilities (CORF), Home Health Agencies, nursing home admissions, inpatient hospice services, and dialysis services. Incomplete or inaccurate information will result in the claim/encounter being rejected for correction.

UB-04 Hospital Outpatient Claims/Ambulatory Surgery

The following information applies to outpatient and ambulatory surgery claims:

- Professional fees must be billed on a CMS 1500 claim form.
- Include the appropriate CPT code next to each revenue code.
- Please refer to your provider contract with Wellcare or research the Uniform Billing Editor for Revenue Codes that do not require a CPT Code.

Below is an example of a UB-04 form



FIELD #	Field Description	Instruction or Comments	Required or Conditional
1	UNLABELED FIELD	LINE 1: Enter the complete provider's name. LINE 2: Enter the complete mailing address. LINE 3: Enter the City, State, and Zip +4 codes (include hyphen). NOTE: The 9-digit zip (zip +4 codes) is a requirement for paper and EDI claims. LINE 4: Enter the area code and phone number.	R
2	UNLABELED FIELD	Enter the Pay- to Name and Address	Not Required
3a	PATIENT CONTROL NO.	Enter the facility patient account/control number.	Not Required
3b	MEDICAL RECORD NUMBER	Enter the facility patient medical or health record number.	R

Field #	Field Description	Instructions or Comments	Required or Conditional
4	TYPE OF BILL	Enter the appropriate Type of Bill (TOB) Code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows: 1st Digit – Indicating the type of facility. 2nd Digit – Indicating the type of care. 3rd Digit- Indicating the bill sequence (Frequency code).	R
5	FED. TAX NO	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	STATEMENT COVERS PERIOD FROM/THROUGH	Enter begin and end, or admission and discharge dates, for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	R
7	UNLABELED FIELD	Not used	Not Required

FIELD #	Field Description	Instruction or Comments	Required or Conditional
8a-8b	PATIENT NAME	8a – Enter the first 9 digits of the identification number on the member's I.D. card	Not Required
		8b – enter the patient's last name, first name, and middle initial as it appears on the ID card. Use a comma or space to separate the last and first names. Titles: (Mr., Mrs., etc.) should not be reported in this field. Prefix: No space should be left after the prefix of a name (e.g., McKendrick. H) Hyphenated names: Both names should be capitalized and separated by a hyphen (no space) Suffix: a space should separate a last name and suffix. Enter the patient's complete mailing address of the patient.	R
9	PATIENT ADDRESS	Enter the patient's complete mailing address of the patient. Line a: Street address Line b: City Line c: State Line d: Zip code Line e: country Code (NOT REQUIRED)	R (except line 9e)
10	BIRTHDATE	Enter the patient's date of birth (MMDDYYYY)	R
11	SEX	Enter the patient's sex. Only M or F is accepted.	R
12	ADMISSION DATE	Enter the date of admission for inpatient claims and date of service for outpatient claims. Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.	R

Field #	Field Description	Instructions or Comments	Required or Conditional
13	ADMISSION HOUR	0012:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02-02:00 to 02:59 14-02:00 to 02:59 03-03:00 to 03:39 15-03:00 to 03:59 04-04:00 to 04:59 16-04:00 to 04:59 05-05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	R
14	ADMISSION TYPE	Require for inpatient and outpatient admissions (Enter the 1-digit code indicating the of the admission using the appropriate following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn	R

		5 Trauma	

Field #	Field Description	Instructions or Comments	Required or Conditional
15	ADMISSION SOURCE	Required for inpatient and outpatient admissions. Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes. For Type of admission 1,2,3, or 5: 1 Physician Referral 2 Clinic Referral 3 Health Maintenance Referral (HMO) 4 Transfer from a hospital 5 Transfer from Skilled Nursing Facility 6 Transfer from another health care facility 7 Emergency Room 8 Court/Law Enforcement 9 Information not available For Type of admission 4 (newborn): 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth 5 Information not available	R

Field #	Field Description	Instructions or Comments	Required or Conditional
16	DISCHARGE HOUR	Enter the time using 2-digit military times (00-23) for the time of the inpatient or outpatient discharge. 0012:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02-02:00 to 02:59 14-02:00 to 02:59 03-03:00 to 03:39 15-03:00 to 03:59 04-04:00 to 04:59 16-04:00 to 04:59 05-05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	C

Field #	Field Description	Instructions or Comments	Required or Conditional
17	PATIENT STATUS	REQUIRED for inpatient and outpatient claims. Enter the 2-digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service Organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired—place unknown (hospice use only) 43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) 50 Hospice—Home	R

Field 17 continued		51 Hospice—Medical Facility 61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed 62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH) 64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH)	
18-28	CONDITION CODES	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	C
29	ACCIDENT STATE		Not Required
30	UNLABELED FIELD	NOT USED	Not required
31-34 a-b	OCCURRENCE CODE and OCCURENCE DATE	Occurrence Code: **REQUIRED** when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Date: **REQUIRED** when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the	C

		date for the associated Occurrence Code in MMDDYYYY format.	

Field #	Field Description	Instructions or Comments	Require or Conditional
35-36 a-b	OCCURRENCE SPAN CODE and OCCURRENCE DATE	Occurrence Span Code: **REQUIRED** when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Span Date: **REQUIRED** when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	C
37	(UNLABELED FIELD)	**REQUIRED** for re-submissions or adjustments. Enter the DCN (Document Control Number) of the original claim.	C
38	RESPONSIBLE PARTY NAME AND ADDRESS		Not Required
39-41 a-d	VALUE CODES CODES and AMOUNTS	Code: **REQUIRED** when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All "a" fields must be completed before using "b" fields, all "b" fields before using "c" fields, and all "c" fields before using "d" fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: **REQUIRED** when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	C

Field #	Field Description	Instructions or Comments	Required or Conditional

General Information Fields 42-47	SERVICE LINE DETAIL	The following UB-04 fields – 42-47: Have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.	
42 Line 1-22	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 Line 23	Rev CD	Enter 0001 for total charges.	R
43 Line 1-22	DESCRIPTION	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R
43 Line 23	PAGE ___ OF ___	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted, enter a "1" in both fields (i.e., PAGE "1" OF "1"). (Limited to 4 pages per claim)	C

Field #	Field Description	Instructions or Comments	Required or Conditional
44	HCPCS/RATES	REQUIRED for outpatient claims when an appropriate CPT/HCPCS Code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s) do not use spaces, commas, dashes, or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract.	C
45 Line 1-22	SERVICE DATE	REQUIRED on all outpatient claims. Enter the date of service for each service line billed. (MMDDYY) Multiple dates of service may not be combined for outpatient claims	C
45 Line 23	CREATION DATE	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	R
46	SERVICE UNITS	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed.	R
47 Line 1-22	TOTAL CHARGES	Enter the total charge for each service line.	R
47 Line 23	TOTALS	Enter the total charges for all service lines.	R
48 Line 1-22	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the Revenue Code listed in field 42 of the service line. Do not list negative amounts.	C

48 Line 23	TOTALS	Enter the total non-covered charges for all service lines.	C
Field #	**Field Description**	**Instruction or Comments**	**Required or Conditional**
49	(UNLABELED FIELD)	Not Used	Not Required
50 A-C	PAYER	Enter the name of each Payer from which reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary	R
51 A-C	HEALTH PLAN IDENTIFCATION NUMBER		Not Required
52 A-C	REL INFO	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter “Y” (yes) or “N” (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y”.	R
53	ASG. BEN.	Enter “Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R
54	PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when	C

		Wellcare is listed as secondary or tertiary.	
55	EST. AMOUNT DUE		Not Required
56	NATIONAL PROVIDER IDENTIFIER OR PROVIDER ID	Required: Enter providers 10- character NPI ID.	R
57	OTHER PROVIDER ID	a. Enter the numeric provider identification number. Enter the TPI number (non -NPI number) of the billing provider.	R
58	INSURED'S NAME	b. For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	PATIENT RELATIONSHIP		Not Required

Field #	Field Description	Instructions or Comments	Required or Conditional
60	INSURED'S UNIQUE ID	REQUIRED: Enter the patient's Insurance ID exactly as it appears on the patient's ID card. Enter the Insurance ID in the order of liability listed in field 50.	R
61	GROUP NAME		Not Required
62	INSURANCE GROUP NO.		Not Required
63	TREATMENT AUTHORIZATION CODES	Enter the Prior Authorization or referral when services require pre-certification.	C
64	DOCUMENT CONTROL NUMBER	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting Wellcare Health Plan from field 50. Applies to claim submitted with a Type of Bill (field 4) Frequency of "7" (Replacement of Prior Claim) or Type of Bill Frequency of "8" (Void/Cancel of Prior Claim). * Please refer to reconsider/corrected claims section.	C
65	EMPLOYER NAME		Not Required
66	DX VERSION QUALIFIER		Not Required
67	PRINCIPAL DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service.	R

Field #	Field Description	Instructions or Comments	Required or Conditional
67 A-Q	OTHER DIAGNOSIS CODE	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or "5" digit. "E" and most "V" codes are **NOT** acceptable as a primary diagnosis. **Note:** Claims with incomplete or invalid diagnosis codes will be denied.	C
68	PRESENT ON ADMISSION INDICATOR		R
69	ADMITTING DIAGNOSIS CODE	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or "5" digit. "E" codes and most "V" are **NOT** acceptable as a primary diagnosis. **Note:** Claims with missing or invalid diagnosis codes will be denied.	R

Field #	Field Description	Instructions or Comments	Required or Conditional
70	PATIENT REASON CODE	Enter the ICD-9/10-CM Code that reflects the patient's reason for visit at the time of outpatient registration. Field 70a requires entry, fields 70b-70c are conditional. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest digit – 4th or "5". "E" codes and most "V" codes are NOT acceptable as a primary diagnosis. NOTE: Claims with missing or invalid diagnosis codes will be denied.	R
71	PPS/DRG CODE		Not Required
72 a, b, c	EXTERNAL CAUSE CODE		Not Required
73	UNLABLED		Not Required
74	PRINCIPAL PROCEDURE CODE/DATE	CODE: Enter the ICD-9/10 Procedure Code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code, it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C

Field #	Field Description	Instructions or Comments	Required or Conditional
74 a-e	OTHER PROCEDURE CODE DATE	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9 procedure code(s) that identify significant a procedure(s) performed other than the principal/primary procedure. Up to five ICD-9 Procedure Codes may be entered. Do not enter the decimal between the 2nd or 3rd digits of code, it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
75	UNLABLED		Not Required
76	ATTENDING PHYSICIAN	Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifiers and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code.	R

		LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	

Field #	Field Description	Instructions or Comments	Required or Conditional
77	OPERATING PHYSICIAN	REQUIRED when a surgical procedure is performed. Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifiers and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code. LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	C
78 & 79	OTHER PHYSICIAN	Enter the Provider Type qualifier, NPI, and name of the physician in charge of the patient care. (Blank Field): Enter one of the following Provider Type Qualifiers: DN – Referring Provider ZZ – Other Operating MD 82 – Rendering Provider NPI: Enter the other physician 10-character NPI ID.	C

		QUAL: Enter one of the following qualifiers and ID number: 0B - State license number 1G - Provider UPIN number G2 - Provider commercial number	
80	REMARKS		Not Required
Field #	Field Description	Instructions or Comments	Required or Conditional
81	CC	A: Taxonomy of billing provider. Use B3 qualifier.	R
82	Attending Physician	Enter name or 7-digit Provider number of ordering physician	R

Appendix VII: Billing Tips and Reminders

Adult Day Health Care

- Must be billed on a CMS 1500 Claim Form
- Must be billed in location 99

Ambulance

- Must be billed on a CMS 1500 Claim Form.
- Appropriate modifiers must be billed with the Transportation Codes

Ambulatory Surgery Center (ASC)

- Ambulatory surgery centers must submit charges using the CMS 1500 Claim Form
- Must be billed in place of service 24
- Invoice must be billed with Corneal Transplants
- Most surgical extractions are billable only under the ASC

Anesthesia

- Bill total number of minutes in field 24G of the CMS 1500 Claim Form and must be submitted with the appropriate modifier.
- Failure to bill total number of minutes may result in incorrect reimbursement or claim denial
- Appropriate modifiers must be utilized

APC Billing Rules

- Critical Access Hospitals (CAHs) are required to bill with 13x-14x codes.
- The bill type for APC claims is limited to 13xs-14x range.
- Late charge claims are not allowed. Only replacement claims. Claims with late charges will be denied and must be resubmitted.
- Claims spanning two calendar years will be required to be submitted by the provider as one claim.
- CMS Maximum Unit Edits (MUEs) will be applied per line, per claim.
    - Claim lines exceeding the MUE value will be denied.
- Observation: Providers are required to bill HCPCS G0378 along with the revenue code. The Observation G code will allow the case rate.
- Ambulance Claims: Need to be submitted on a CMS 1500 form. Any Ambulance claim submitted on a UB will be denied.
- Revenue codes and HCPCs codes are required for APC claims.

Comprehensive Day Rehab

- Must be billed on a CMS 1500 Claim Form
- Must be billed in location 61
- Acceptable modifiers

Deliveries

- Use appropriate value codes as well as birth weight when billing for delivery services.

DME/Supplies/Prosthetics and Orthotics

- Must be billed with an appropriate modifier
- Purchase only services must be billed with modifier NU
- Rental services must be billed with modifier RR

Hearing Aids

- Must be billed with the appropriate modifier LT or RT

Home Health

- Must be billed on a UB 04

- Bill type must be 3XX
- Must be billed in location 12
- Both Rev and CPT codes are required
- Each visit must be billed individually on separate service line

Long Term Acute Care Facilities (LTACs)

- Long Term Acute Care Facilities (LTACs) must submit Functional Status Indicators on claim submissions.

Maternity Services

- Providers must utilize correct coding for Maternity Services.
- Services provided to members prior to their Wellcare effective date should be correctly coded and submitted to the payer responsible.
- Services provided to the member on or after their Wellcare effective date should be correctly coded and submitted to Wellcare.

Modifiers

- Appropriate Use of – 25, 26, TC, 50, GN, GO, GP
- **25 Modifier -** should be used when a significant and separately identifiable E&M service is performed by the same physician on the same day of another procedure (e.g., 99381 and 99211-25. Modifier 25 is subject to the code edit and audit process. Appending a modifier 25 is not a guarantee of automatic payment and may require the submission of medical records. Well-Child and sick visit performed on the same day by the same physician). *NOTE: 25 modifiers are not appended to non-E&M procedure codes, e.g., lab.
- **26 Modifier** – should never be appended to an office visit CPT code.

Use 26 modifier to indicate that the professional component of a test or study is performed using the 70000 (radiology) or 80000 (pathology) series of CPT codes. Inappropriate use may result in a claim denial/rejection.

- **TC Modifier** – used to indicate the technical component of a test or study is performed
- **50 Modifier** – indicates a procedure performed on a bilateral anatomical site
    - Procedure must be billed on a single claim line with the 50 modifier and quantity of one.
    - RT and LT modifiers or quantities greater than one should not be billed when using modifier 50

- **GN, GO, GP Modifiers** – therapy modifiers required for speech, occupational, and physical therapy

Supplies

- Physicians may bill for supplies and materials in addition to an office visit if these supplies are over and above those usually included with the office visit.

- Supplies such as gowns, drapes, gloves, specula, pelvic supplies, urine cups, swabs, jelly, etc., are included in the office visit and may not be billed separately. Providers may not bill for any reusable supplies.

Outpatient Hospital Laboratory Services

- Bill Type 141 – Must be utilized when a non-inpatient or non-outpatient hospital member's specimen is submitted for analysis to the Hospital Outpatient Laboratory. The Member is not physically present at the hospital.

- Bill Type 131 and Modifier L1 – Must be utilized when the hospital only provides laboratory tests to the Member and the Member does not also receive other hospital outpatient services during the same encounter. Must also be utilized when a hospital provides a laboratory test during the same encounter as other hospital outpatient services that are clinically unrelated to the other hospital outpatient services, and the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services provided in the hospital outpatient setting.

- Services not billed following the above guidelines will be denied as EX code AT.

POA

- Present on Admission (POA) Indicator is required on all inpatient facility claims
    - Failure to include the POA may result in a claim denial/rejection

Rehabilitation Services – Inpatient Services

- Functional status indicators must be submitted for inpatient Rehabilitation Services.

Telemedicine

- Physicians at the distant site may bill for telemedicine services and MUST utilize the appropriate modifier to identify the service was provided via telemedicine.
    - E&M CPT plus the appropriate modifier
    - Via interactive audio and video tele-communication systems.

Appendix VIII: Reimbursement Policies

As a general rule, Wellcare follows Medicare reimbursement policies. Instances that vary from Medicare include:

Calculating Anesthesia

Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service.

Certified Nurse Midwife (CNM) Rules

Payment for CNM services is made at 100% of the contracted rate.

EKG Payment

EKG Interpretation is separately billable and payable from the actual test. However, the first provider to bill receives payment for services.

Physician Site of Service

Physicians will be paid at Physician rate only at the following Sites of Service: Office, Home, Assisted Living Facility, Mobile unit, walk in retail health clinic, urgent care facility, birthing center, nursing facility, SNFs, independent clinic, FQHC, Intermediate HC Facility, Resident Substance Abuse Facility, Nonresident Substance Abuse Facility, Comprehensive OP Rehab facility, ESRD Facility, State or Local Health Clinic, RHC, Indy lab, Other POS.

Endoscopic Multiple Procedure Rules

When you have two sets of unrelated endoscopies (e.g., 43202 and 43217; 46606 and 46608) - identify the primary code within the family, and then apply multiple procedure discounts to the two primary codes. Secondary codes are not paid because you consider the total payment for each set of endoscopies as one service.

When you have two related endoscopies and a third, unrelated procedure - identify the primary code in the related endoscopies. Then apply multiple procedure discounts to the unrelated code and the identified primary code. The secondary code is not paid because you consider the total payment for each set of endoscopies as one service.

Diagnostic Testing of Implants

Charges and payments for diagnostic testing of implants following surgery is not included in the global fee for surgery and is reimbursable if the testing is outside the global timeframe. If it is inside the global timeframe, it is not reimbursable.

Lesser of Language

Pay Provider lesser of the Providers allowable charges or the negotiated rate

Multiple Procedure Rules for Surgery

Payment should be paid at 100%/50%/50%, starting with procedure ranked highest. Max of 3 procedures.

Procedures 4+ are subject to manual review and payment if appropriate.

Multiple Procedure Ranking Rules

If two or more multiple surgeries are of equal payment value and bill charges do not exceed the payment rate, rank them in descending dollar order billed pay based on multiple procedure discounts.

Multiple Procedure Rules for Radiology

Multiple procedure radiology codes follow Multiple Procedure discount rules: 100%/50%/50%, max three radiology codes.

Physician Assistant (PA) Payment Rules

Physician assistant services are paid at 85% of what a physician is paid under the Wellcare Physician Fee Schedule.

- PA services furnished during a global surgical period shall be paid 85% of what a physician is paid under the Wellcare Physician Fee Schedule.

- PA assistant-at-surgery services at 85 percent of what a physician is paid under the Medicare Physician Fee Schedule. Since physicians are paid at 16% of the surgical payment amount under the Medicare Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that PAs receive for assistant-at-surgery services is 13.6% of the amount paid to physicians. The AS modifier must be used.

Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) Payment Rules

In general, NPs and CNSs are paid for covered services at 85% of what a physician is paid under the Wellcare Physician Fee Schedule.

- NP or CNS assistant-at-surgery services at 85% of what a physician is paid under the Wellcare Physician Fee Schedule. Since physicians are paid at 16% of the surgical payment amount under the Wellcare Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that PAs receive for assistant-at-surgery services is 13.6% of the amount paid to physicians. The AS modifier must be used.

Surgical Physician Payment Rules

For surgeries billed with either modifier 54, 55, 56, or 78 pay the appropriate percentage of the fee schedule payment as identified by the modifier and procedure code used.

Incomplete Colonoscopy Rule

Incomplete colonoscopies should be billed with CPT 45378 and MOD 53. This will pay 25% of the FS rate for the incomplete procedures. The rest of the claim pays according to the FS.

Injection Services

Injection service codes must pay separately if no other physician service is paid and when not billed with office visit. If an office visit is billed, then no injection is payable because it is covered in the office charge.

Unpriced Codes

In the event that the CMS/Medicare RBRVS does not contain a published fee amount, an alternate "gap fill" source is utilized to determine the fee amount. If there is no fee available on the alternate "gap fill" source, Wellcare will reimburse 40% of billed charges less any applicable copay, coinsurance or deductible, unless contracted differently. Unlisted codes are subject to the code edit and audit process and will require the submission of medical records.

Rental or Purchase Decisions

Rental or purchase decisions are made at the discretion of Medical Management.

Payment for Capped Rental Items during Period of Continuous Use

When no purchase options have been exercised, rental payments may not exceed a period of continuous use of longer than 15 months. For the month of death or discontinuance of use, contractors pay the full month rental. After 15 months of rental have been paid, the supplier must continue to provide the item without any charge, other than for the maintenance and servicing fees until medical necessity ends or Wellcare coverage ceases. For this purpose, unless there is a break in need for at least 60 days, medical necessity is presumed to continue. Any lapse greater than 60 days triggers new medical necessity.

If the beneficiary changes suppliers during or after the 15-month rental period, this does not result in a new rental episode. The supplier that provides the item in the 15th month of the rental period is responsible for supplying the equipment and for maintenance and servicing after the 15-month period. If the supplier changes after the 10th month, there is no purchase option.

Percutaneous Electrical Nerve Stimulator (PENS) Rent Status While Hospitalized

An entire month's rent may not be paid when a patient is hospitalized during the month. The rent will be prorated to allow for the time not hospitalized.

Transcutaneous Electrical Nerve Stimulator (TENS)

In order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, contractors pay 10 percent of the purchase price of the item for each of 2 months. The purchase price and payment for maintenance and servicing are

determined under the same rules as any other frequently purchased item. There is a reduction in the allowed amount for purchase due to the two months rental.

Appendix IX: EDI Companion Guide Overview

The Companion Guide provides Wellcare trading partners with guidelines for submitting the ASC X12N/005010x222 Health Care Claim: Professional (837P) and ASC X12N/005010x223 Health Care Claim: Institutional (837I). The Wellcare Companion Guide documents any assumptions, conventions, or data issues that may be specific to Wellcare business processes when implementing the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3). As such, this Companion Guide is unique to Wellcare and its affiliates.

This document does NOT replace the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) for electronic transactions, nor does it attempt to amend any of the rules therein or impose any mandates on any trading partners of Wellcare. This document provides information on Wellcare - specific code handling and situation handling that is within the parameters of the HIPAA administrative Simplification rules. Readers of this Companion Guide should be acquainted with the HIPAA Technical Reports Type 3, their structure and content. Information contained within the HIPAA TR3s has not been repeated here although the TR3s have been referenced when necessary. The HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) can be purchased at http://*store.x12.org*.

The Companion Guide provides supplemental information to the Trading Partner Agreement (TPA) that exists between Wellcare and its trading partners. Refer to the TPA for guidelines pertaining to Wellcare legal conditions surrounding the implementations of EDI transactions and code sets. Refer to the Companion Guide for information on Wellcare business rules or technical requirements regarding the implementation of HIPAA compliant EDI transactions and code sets.

Nothing contained in this guide is intended to amend, revoke, contradict, or otherwise alter the terms and conditions of the Trading Partner Agreement. **If there is an inconsistency with the terms of this guide and the terms of the Trading Partner Agreement, the terms of the Trading Partner Agreement shall govern.**

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Rules of Exchange

The Rules of Exchange section details the responsibilities of trading partners in submitting or receiving electronic transactions with Wellcare.

Transmission Confirmation

Transmission confirmation may be received through one of two possible transactions: the ASC X12C/005010X231 Implementation Acknowledgment for Health Care Insurance (TA1, 999). A TA1 Acknowledgement is used at the ISA level of the transmission envelope structure, to confirm a positive transmission or indicate an error at the ISA level of the transmission. The 999 Acknowledgement may be used to verify a successful transmission or to indicate various types of errors.

Transmission Confirmation cont.

Confirmations of transmissions, in the form of TA1 or 999 transactions, should be received within 24 hours of batch submissions, and usually sooner. Senders of transmissions should check for confirmations within this time frame.

Batch Matching

Senders of batch transmissions should note that transactions are unbundled during processing, and rebundled so that the original bundle is not replicated. Trace numbers or patient account numbers should be used for batch matching or batch balancing.

TA1 Interchange Acknowledgement

The TA1 Interchange Acknowledgement provides senders a positive or negative confirmation of the transmission of the ISA/IEA Interchange Control.

999 Functional Acknowledgement

The 999 Functional Acknowledgement reports on all Implementation Guide edits from the Functional Group and transaction Sets.

277CA Health Care Claim Acknowledgement

The X12N005010X214 Health Care Claim Acknowledgment (277CA) provides a more detailed explanation of the transaction set. Wellcare also provides the Pre-Adjudication rejection reason of the claim within the STC12 segment of the 2220D loop. ***NOTE: The STC03 – Action Code will only be a "U" if the claim failed on HIPAA validation errors, NOT Pre-Adjudication errors.***

Duplicate Batch Check

To ensure that duplicate transmissions have not been sent, Wellcare checks five values within the ISA for redundancy:

- ISA06, ISA08, ISA09, ISA10, ISA13

Collectively, these numbers should be unique for each transmission. A duplicate ISA/IEA receives a TA1 response of "025" (Duplicate Interchange Control Number).

Duplicate Batch Check cont.

To ensure that Transaction Sets (ST/SE) have not been duplicated within a transmission, Wellcare checks the ST02 value (Transaction Set Control Number), which should be a unique ST02 within the Functional Group transmitted.

Note: ISA08 & GS03 could also be the Single Payer ID

New Trading Partners

New trading partners should access https://sites.edifecs.com, register for access, and perform the steps in the Wellcare trading partner program. The EDI Support Desk (EDIBA@Centene.com) will contact you with additional steps necessary upon completing your registration.

Claims Processing

Acknowledgements

Senders receive four types of acknowledgement transactions: the TA1 transaction to acknowledge the Interchange Control Envelope (ISA/IEA) of a transaction, the 999 transaction to acknowledge the Functional Group (GS/GE) and Transaction Set (ST/SE), the 277CA transaction to acknowledge health care claims, and the Wellcare Audit Report. At the claim level of a transaction, the only acknowledgement of receipt is the return of the Claim Audit Report and/or a 277CA.

Coordination of Benefits (COB) Processing

To ensure the proper processing of claims requiring coordination of benefits, Wellcare recommends that providers validate the patient's Membership Number and supplementary or primary carrier information for every claim.

Code Sets

Only standard codes, valid at the time of the date(s) of service, should be used.

Corrections and Reversals

The 837 defines what values submitters must use to signal payers that the Inbound 837 contains a reversal or correction to a claim that has previously been submitted for processing. For both Professional and Institutional 837 claims, 2300 CLM05-3 (Claim Frequency Code) must contain a value for the National UB Data Element Specification Type List Type of Bill Position 3.

Data Format/Content

Wellcare accepts all compliant data elements on the 837 Professional Claim. The following points outline consistent data format and content issues that should be followed for submission.

Dates

The following statements apply to any dates within an 837 transaction:

- All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD.
- The only values acceptable for "CC" (century) within birthdates are 18, 19, or 20.
- Dates that include hours should use the following format: CCYYMMDDHHMM.
- Use Military format, or numbers from 0 to 23, to indicate hours. For example, an admission date of 201006262115 defines the date and time of June 26, 2010 at 9:15 PM.
- No spaces or character delimiters should be used in presenting dates or times.
- Dates that are logically invalid (e.g., 20011301) are rejected.

- Dates must be valid within the context of the transaction. For example, a patient's birth date cannot be after the patient's service date.

Decimals

All percentages should be presented in decimal format. For example, a 12.5% value should be presented as .125.

Dollar amounts should be presented with decimals to indicate portions of a dollar; however, no more than two positions should follow the decimal point. Dollar amounts containing more than two positions after the decimal point are rejected.

Monetary and Unit Amount Values

Wellcare accepts all compliant data elements on the 837 Professional Claim; however, monetary or unit amount values that are in negative numbers are rejected.

Delimiters

Delimiters are characters used to separate data elements within a data string. Delimiters suggested for use by Wellcare are specified in the Interchange Header segment (the ISA level) of a transmission; these include the tilde (~) for segment separation, the asterisk (*) for element separation, and the colon (:) for component separation.

Phone Numbers

Phone numbers should be presented as contiguous number strings, without dashes or parenthesis markers. For example, the phone number (336) 555-1212 should be presented as 3365551212. Area codes should always be included. Wellcare requires the phone number to be AAABBBCCCC where AAA is the Area code, BBB is the telephone number prefix, and CCCC is the telephone number.

Additional Items

- Wellcare will not accept more than 97 service lines per UB-04 claim.
- Wellcare will not accept more than 50 service lines per CMS 1500 claim.
- Wellcare will only accept single digit diagnosis pointers in the SV107 of the 837P.
- The Value Added Network Trace Number (2300-REF02) is limited to 30 characters.

Identification Codes and Numbers

General Identifiers

Federal Tax Identifiers

Any Federal Tax Identifier (Employer ID or Social Security Number) used in a transmission should omit dashes or hyphens. Wellcare sends and receives only numeric values for all tax identifiers.

Sender Identifier

The Sender Identifier is presented at the Interchange Control (ISA06) of a transmission. Wellcare expects to see the sender's Federal Tax Identifier (ISA05, qualifier 30) for this value. In special circumstances, Wellcare will accept a "Mutually Defined" (ZZ) value. Senders wishing to submit a ZZ value must confirm this identifier with Wellcare EDI.

Provider Identifiers

National Provider Identifiers (NPI)

HIPAA regulation mandates that providers use their NPI for electronic claims submission. The NPI is used at the record level of HIPAA transactions; for 837 claims, it is placed in the 2010AA loop. See the 837 Professional Data Element table for specific instructions about where to place the NPI within the 837 Professional file. The table also clarifies what other elements must be submitted when the NPI is used.

Billing provider

The Billing Provider Primary Identifier should be the group/organization ID of the billing entity, filed only at 2010AA. This will be a Type 2 (Group) NPI unless the Billing provider is a sole proprietor and processes all claims and remittances with a Type 1 (Individual) NPI.

Rendering Provider

When providers perform services for a member, the service will need to be reported in the Rendering Provider Loop (2310B or 2420A). You should only use 2420A when it is different than Loop 2310B/NM1*82.

Referring Provider

Wellcare has no specific requirements for Referring Provider information.

Atypical Provider

Atypical providers are not always assigned an NPI number, however, if an atypical provider has been assigned an NPI, then they need to follow the same requirements as a medical provider. An Atypical provider which provides non-medical services is not required to have an NPI number (i.e., carpenters, transportation, etc.). Existing Atypical providers need only send the Provider Tax ID in the REF segment of the billing provider loop.
NOTE: If an NPI is billed in any part of the claim, it will not follow the Atypical Provider Logic.

Subscriber Identifiers

Submitters must use the entire identification code as it appears on the **subscriber's card** in the 2010BA element.

Claim Identifiers

Wellcare issues a claim identification number upon receipt of any submitted claim. The ASC X12 Technical Reports (Type 3) may refer to this number as the Internal Control Number (ICN), Document Control Number (DCN), or the Claim Control Number (CCN). It is provided to senders in the Claim Audit Report and in the CLP segment of an 835 transaction. Wellcare returns the submitter's Patient Account Number (2300, CLM01) on the Claims Audit Report and the 835 Claim Payment/Advice (CLP01).

Connectivity Media for Batch Transactions

Secure File Transfer

Wellcare encourages trading partners to consider a secure File Transfer Protocol (FTP) transmission option. Wellcare offers two options for connectivity via FTP.

- Method A – the trading partner will push transactions to the Wellcare FTP server and Wellcare will push outbound transactions to the Wellcare FTP server.
- Method B – the trading partner will push transactions to the Wellcare FTP server and Wellcare will push outbound transactions to the trading partner's FTP server.

Encryption

Wellcare offers the following methods of encryption SSH/SFTP, FTPS (Auth TLS), FTP w/PGP, HTTPS (Note this method only applies with connecting to Wellcare's Secure FTP. Wellcare does not support retrieve files automatically via HTTPS from an external source at this time.) If PGP or SSH keys are used, they will be shared with the trading partner. These are not required for those connecting via SFTP or HTTPS.

Direct Submission

Wellcare also offers posting an 837 batch file directly on the Provider Portal website for processing.

Edits and Reports

Incoming claims are reviewed first for HIPAA compliance and then for Wellcare business rules requirements. The business rules that define these requirements are identified in the 837 Professional Data Element Table below and are also available as a comprehensive list in the 837 Professional Claims – Wellcare Business Edits Table. HIPAA TR3 implementation guide errors may be returned on either the TA1 or 999 while Wellcare business edit errors are returned on the Wellcare Claims Audit Report.

Reporting

The following table indicates which transaction or report to review for problem data found within the 837 Professional Claim Transaction.

Transaction Structure Level	Type of Error or Problem	Transaction or Report Returned
ISA/IEA Interchange Control		TA1
GS/GE Functional Group ST/SE Segment Detail Segments	HIPAA Implementation Guide violations	999 Wellcare Claims Audit Report (a proprietary confirmation and error report)

Detail Segments	Wellcare Business Edits (see audit report rejection reason codes and explanation.)	Wellcare Claims Audit Report (a proprietary confirmation and error report)
Detail Segments	HIPAA Implementation Guide violations and Wellcare Business Edits.	277CA

277CA/Audit Report Rejection Codes

Error Code	Rejection Reason
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Provider
07	Invalid Mbr DOB & Provider
08	Invalid Mbr & Provider
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Provider not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17	Invalid Diag Code
18	Invalid Mbr DOB; Invalid Diag

Error Code	Rejection Reason
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS; Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS
23	Invalid Prv; Invalid Diagnosis Code
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag Code
25	Invalid Mbr; Invalid Prv; Invalid Diag Code
26	Mbr not valid at DOS; Invalid Diag Code
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag Code
29	Provider not valid at DOS; Invalid Diag Code
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag
32	Mbr not valid at DOS; Prv not valid; Invalid Diag
33	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag
34	Invalid Proc
35	Invalid Mbr DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
37	Invalid Future Service Date
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Mbr DOB, Invalid Prv; Invalid Proc

Error Code	Rejection Reason
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS; Invalid Proc
49	Mbr not valid at DOS; Invalid Prv; Invalid Proc
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc
55	Mbr not valid at DOS; Prv not valid at DOS; Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS; Invalid Diag; Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc

Error Code	Rejection Reason
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
74	Services performed prior to Contract Effective Date
75	Invalid units of service
76	Original Claim Number Required
77	Invalid Claim Type
78	Diagnosis Pointer- Not in sequence or incorrect length
81	Invalid units of service, Invalid Prv
83	Invalid units of service, Invalid Prv, Invalid Mbr
89	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
91	Invalid Missing Taxonomy or NPI/Invalid Prov
92	Invalid Referring/Ordering NPI
93	Mbr not valid at DOS; Invalid Proc
96	GA OPR NPI Registration-State
A2	Diagnosis Pointer Invalid
A3	Service Lines- Greater than 97 Service lines submitted- Invalid
B1	Rendering and Billing NPI are not tied on State File- IN rejection
B2	Not enrolled with MHS IN and/or State with rendering NPI/TIN on DOS. Enroll with MHS and Resubmit claim
B5	Invalid CLIA
C7	NPI Registration- State GA OPR
C9	Invalid/Missing Attending NPI

Error Code	Rejection Reason
HP/H1/H2	ICD9 after end date/ICD10 sent before Eff Date/Mixed ICD versions

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