



— 2019 NEBRASKA —
**MEDICAID
PROVIDER MANUAL**



Partners in Quality Care

Dear Provider Partner:

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

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

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

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

Thank you again for being a trusted WellCare provider partner!



Sincerely,

Dr. Martin Wetzel
Interim Chief Medical Officer,
WellCare of Nebraska

Quality Highlights

Section 2

- Responsibilities of all Providers
- Access Standards
- Cultural Competency Program and Plan
- Member Rights and Responsibilities

Section 3

- Quality Improvement

Section 4

- Prior Authorization
- Criteria for Utilization Management Decisions
- Disease Management Programs

Section 7

- Appeals and Grievances

Section 10

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

Section 12

- Preferred Drug List

Quality care is a team effort.
Thank you for playing a starring role!

 **WellCare**[®]
Beyond Healthcare. A Better You.

Table of Contents

Table of Contents	1
2019 WellCare of Nebraska Provider Handbook Table of Revisions	5
Section 1: Welcome to WellCare of Nebraska	7
Purpose of this Provider Handbook	7
WellCare’s Managed Care Plan	8
Core Benefits and Services	9
Value-Added (Expanded) Services.....	18
Excluded Services	22
Provider Services.....	23
Section 2: Provider and Member Administrative Guidelines	26
Provider Administrative Overview	26
Prohibited Services.....	27
Mainstreaming of Members	28
Identification and Reporting of Abuse, Neglect and Exploitation of Children and Vulnerable Adults.....	28
Access Standards.....	29
Responsibilities of All Providers.....	30
Responsibilities of Primary Care Provider (PCPs).....	33
Cost Sharing	33
Vaccines for Children Program.....	33
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	34
Domestic Violence and Substance Abuse Screening.....	36
Adult Health Screening.....	36
Cultural Competency Program and Plan	36
Overview	36
Cultural Competency Survey	38
Member Administrative Guidelines.....	38
Overview	38
Member Handbook	39
Enrollment.....	39
Effective Date of Payment for New Members.....	39
Member Identification Cards.....	39
Eligibility Verification	40
Member Engagement	40
Assessments for Members	40
Member Rights and Responsibilities	41
Assignment of Primary Care Provider	42
Changing Primary Care Providers	42
Women’s Health Specialists	42
Hard of hearing, Interpreter and Sign Language Services	42
Section 3: Quality Improvement	44
Overview	44
Medical Records	44
Provider Participation in the Quality Improvement Program.....	46
Member Satisfaction	46
Patient Safety to Include Quality of Care (QOC) and Quality of Service (QOS).....	46
Web Resources	49

Section 4: Utilization Management (UM), Case Management (CM) and Disease Management (DM)	50
Utilization Management.....	50
Overview.....	50
Medically Necessary Services.....	50
Criteria for UM Decisions.....	51
Utilization Management Process.....	52
Peer-to-Peer Reconsideration of Adverse Determination.....	55
Services Requiring No Authorization.....	55
WellCare Proposed Actions.....	55
Second Medical Opinion.....	56
Individuals with Special Healthcare Needs.....	56
Service Authorization Decisions.....	56
Emergency/Urgent Care and Post-Stabilization Services.....	57
Continuity of Care.....	57
Transition of Care.....	58
Authorization Request Forms.....	58
Special Requirements for Payment of Services.....	59
Care Management Program.....	61
Disease Management Program.....	63
Delegated Entities.....	64
Section 5: Claims	65
Overview.....	65
Updated Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Process.....	65
Timely Claims Submission.....	65
Claims Submission Requirements.....	67
Claims Processing.....	69
Patient Liability/Cost-Sharing.....	70
Encounters Data.....	70
Balance Billing.....	72
Provider-Preventable Conditions.....	72
Hold Harmless Dual-Eligible Members.....	72
Claims Disputes.....	73
Corrected or Voided Claims.....	73
Reimbursement.....	74
Non-Participating Provider Reimbursement.....	74
Overpayment Recovery	76
Benefits During Disaster and Catastrophic Events.....	77
Section 6: Credentialing	78
Overview.....	78
Practitioner Rights.....	79
Baseline Criteria.....	80
Liability Insurance.....	80
Site Inspection Evaluation (SIE).....	81
Covering Physician/Providers.....	81
Allied Health Professionals.....	81
Ancillary Healthcare Delivery Organizations.....	82
Re-Credentialing.....	82
Updated Documentation.....	82

Office of Inspector General Medicare/Medicaid Sanctions Report	82
Eligibility in the Medicaid Program	82
Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials	82
Provider Dispute Process	82
Participating Provider Appeal through Dispute Resolution Peer Review Process...	83
Delegated Entities.....	84
Section 7: Complaints, Appeals and Grievances	85
Provider and Member Appeals Process	85
Provider Appeal Process for Administrative and Medical Necessity Reviews	85
Member Appeal Process	86
Expedited Appeals Process	88
Standard Appeals Process	89
Continuation of Benefits while the Appeal and State Fair Hearing are pending	90
Grievance Process	91
Provider Complaint Grievance Process	91
Member.....	91
Section 8: Compliance	94
WellCare's Compliance Program	94
Overview	94
Provider Education and Outreach.....	95
Code of Conduct and Business Ethics	97
Overview	97
Fraud, Waste and Abuse	97
Confidentiality of Member Information and Release of Records	99
Disclosure of WellCare Information to WellCare Members	99
Section 9: Delegated Entities.....	101
Overview	101
Delegation Oversight Process	101
Section 10: Behavioral Health	103
Overview	103
Behavioral Health Program.....	103
Continuity and Coordination of Care between Medical Care and Behavioral Health Care	103
Responsibilities of Behavioral Health Providers	104
Section 11: Pharmacy.....	106
Overview	106
Preferred Drug List	106
Generic Medications	107
Step Therapy	107
Age Limits	107
Injectable and Infusion Services	107
Coverage Limitations	108
Smoking Cessation therapy — Oral	108
Over-the-Counter (OTC) Medications.....	108
Compounded Prescriptions	109
Member Co-Payments.....	109
Pharmacy Reimbursement	109
Coverage Determination Review Process (Requesting Prior Authorization).....	109
Restricted Services.....	110

Medication Appeals	110
Payer Sheets	110
Prospective DUR Response Requirements.....	110
Pharmacy Management – Provider Education Program (PEP)	111
Member Pharmacy Access.....	111
Specialty Pharmacy	111
Section 12: Definitions	112
Section 13: WellCare Resources	117

2019 WellCare of Nebraska Provider Handbook Table of Revisions

Date	Section	Comments	Page	Change
03/27/2019	Section 1: Welcome to WellCare of Nebraska	Value-Added (Expanded) Services	19-21	Updated: Community Welcome Room Added: Community Connections Line, Behavioral Health Incentive, College Scholarship, BH Provider consultation, College Bound Dorm items, JumpSTART, Free Cell Phone, Bus Passes, Swimming Lessons, Summer Camp, Caregiver Pertussis Vaccine, Zoo Passes
		XtraSavings Program	20	Replaced Discount Card with XtraSavings Program
03/27/2019	Section 4: UM/CM/DM	UM Process	52	Description updated to reflect requirement for facilities to notify the health plan within 24 hours of the admission

		Retrospective Review	54	Updated description
		Emergency/Urgent Care and Post-Stabilization Services	57	Updated description
03/27/2019	Section 5: Claims	Disclosure of Coding Edits	69	Added Section
		Multiple Claims Errors	72	Added Section
03/27/2019	Section 6: Credentialing	Provider Dispute Process	82	Added Section
03/27/2019	Section 7: Complaints, Appeals and Grievances	Provider Complaint Grievance Process	91	Updated description
03/27/2019	Section 10: Behavioral Health	Overview	103	Updated section
		Responsibilities of BH Providers	104	Updated Appointment Access Standards
03/27/2019	Section 11: Pharmacy	Injectable and Infusion Services	107	Updated section, changed retail pharmacy to specialty pharmacy
03/27/2019	Section 12: Definitions		112	Updated Adverse Benefit Determination, Provider and Provider Agreement

Section 1: Welcome to WellCare of Nebraska

Overview

WellCare of Nebraska, Inc., provides managed care services targeted exclusively to government-sponsored Medicaid and Medicare healthcare programs, including prescription drug plans and health plans for families and children. WellCare's corporate office is located in Tampa, Florida. WellCare serves approximately 4.4 million Members. WellCare's experience and commitment to government-sponsored healthcare programs lets us serve our Members and Providers, as well as effectively and efficiently manage our operations.

WellCare of Nebraska Contact Information:

**10040 Regency Circle, Suite 100
Omaha, NE 68114
1-855-599-3811 (Toll Free)**

For specific contact information, refer to the *Quick Reference Guide* at www.wellcare.com/Nebraska/Providers/Medicaid.

Mission

Our Members are our reason for being. WellCare helps those eligible for government-sponsored healthcare plans live better, healthier lives.

Vision

To be a leader in government-sponsored healthcare programs in collaboration with our Members, Providers and government partners. WellCare fosters a rewarding and enriching culture to inspire our associates to do well for others and themselves.

Core Values

- *Partnership* – WellCare delivers excellent service to our Member, Provider and government partners. Members are the reason we are in business; Providers are our partners in serving our Members; and government partners are the stewards of the public's resources and trust.
- *Integrity* – WellCare does the right thing to keep the trust of those we serve and with whom we work.
- *Accountability* – WellCare is responsible for the commitments we make and the results we deliver both internally and externally.
- *One Team* – WellCare demonstrates a collaborative "One Team" approach across all areas and puts Members first in all we do.

Purpose of this Provider Handbook

This Handbook is intended for Nebraska-contracted (participating) Medicaid Providers who offer healthcare service(s) to individuals enrolled in WellCare Managed Care Plans. This Handbook serves as a guide to the policies and procedures governing the administration of WellCare's Medicaid plan and is an extension of and supplements the Provider Contract between WellCare and healthcare Providers, who include, without limitation: Primary Care Providers, hospitals and ancillary Providers (collectively, Providers).

This Handbook replaces and supersedes any previous versions dated prior to March 27, 2019 and is available at www.wellcare.com/Nebraska/Providers/Medicaid.

A paper copy may be obtained at no charge by contacting a Provider Relations representative.

In accordance with the policies and procedures clause of the Provider Agreement, contracted WellCare Providers must abide by all applicable provisions in this Handbook. Revisions to this Handbook reflect changes made to WellCare's policies and procedures. Revisions shall become binding 30 days after notice is provided by mail or electronic means, or such other period of time as necessary for WellCare to comply with any statutory, regulatory, contractual and/or accreditation requirements. As policies and procedures change, updates will be issued by WellCare in the form of Provider Bulletins and will be incorporated into subsequent versions of this Handbook.

WellCare's Managed Care Plan

Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most healthcare costs are covered if you qualify for both Medicare and Medicaid.

WellCare is contracted with the Nebraska Department of Medicaid and Long-Term Care (MLTC) to provide Medicaid managed care services.

Nebraska Department of Medicaid and Long-Term Care (MLTC) Contact Information:

Nebraska Department of Health and Human Services
Finance and Support
301 Centennial Mall S., Fifth Floor
P.O. Box 95026
Lincoln, NE 68509

1-402-471-3121

dhhs.ne.gov/Pages/Heritage-Health-Contacts.aspx

Co-payment Exceptions: WellCare ensures that co-payments are not imposed on any of the following populations:

- Individuals age 18 or younger
- Pregnant women through the immediate postpartum period (the immediate postpartum period begins on the last day of pregnancy and continues through the end of the month in which the 60-day period following termination of pregnancy ends)
- Any individual who is an inpatient in a hospital, long-term care (LTC) facility (nursing facility (NF) or ICF/MR)), or other medical institution if the individual is required, as a condition of receiving services in the institution, to spend all but a minimal amount of his/her income required for person needs for medical care costs
- Individuals residing in alternate care, which is defined as domiciliaries, residential care facilities, centers for the developmentally disabled, and adult family homes
- Indians who receive items and/or services furnished directly by an Indian Health Care Provider or through referral from an Indian Health Care Provider under contract health services

- Individuals who are receiving waiver services provided under a 1915(c) waiver, such as the Community-Based Waiver for Adults with Intellectual Disabilities or Related Conditions; The Home and Community-Based Model Waiver for Children with Intellectual Disabilities and their Families; or the Home and Community-Based Wavier for Aged Persons or Adults or Children with Disabilities or the Early Intervention Waiver
- Individuals with excess income (over the course of the excess income cycle, both before and after the obligation is met)
- Individuals who receive assistance under the State Disability Program (SDP)

Core Benefits and Services

Covered Services	Co-payments	Coverage/Limits
Ambulance Services	\$0 co-pay	<ul style="list-style-type: none"> • Covered when Medically Necessary and reasonable to transport a Member to obtain or after receiving covered medical services • Basic Life Support (BLS) Ambulance – A BLS ambulance provides transportation plus the equipment and staff needed for basic services such as control of bleeding, splinting fractures, treatment for shock, delivery of babies, treatment of heart attacks and similar situations • Advanced Life Support (ALS) Services – An ALS ambulance provides transportation and has special life-saving equipment and trained staff • Air Ambulance – Medically Necessary air ambulance services only when transportation by ground ambulance would not be appropriate and: <ul style="list-style-type: none"> • Great distances or other obstacles are involved in getting a Member to the destination • Transportation is needed right away because of severe trauma • The point of pickup can't be reached by a land vehicle
Ambulatory Surgical Center (ASC) services	\$0 co-pay	<ul style="list-style-type: none"> • Covered when Medically Necessary
Chiropractic Services	\$0 co-pay	<ul style="list-style-type: none"> • Covered when services are provided in the office or the Member's home • Limited to X-rays and manual manipulation of the spine

Covered Services	Co-payments	Coverage/Limits
		<ul style="list-style-type: none"> For Members 21 and older: Manual manipulation of the spine is limited to 12 treatments per calendar year For Members 20 and younger: Manual manipulation of the spine is limited to 18 treatments during the initial five-month period from the date of initiation of treatment for the reported diagnosis. A maximum of one treatment per month is covered thereafter if needed for stabilization care. Only one treatment per Member per day is covered
Durable Medical Equipment, Orthotics, Prosthetics and Medical Supplies	\$3 per specified service	<ul style="list-style-type: none"> Certain medical equipment and supplies are covered when they are Medically Necessary and prescribed by a Provider Limitations may apply
Family Planning Services	\$0 co-pay	<ul style="list-style-type: none"> Covered Services include consultation and treatment This may include initial physical examinations and health history, annual and follow-up visits, laboratory services, prescribing and supplying contraceptives, counseling and medications
Free Standing Birth Center Services	\$0 co-pay	<ul style="list-style-type: none"> Covered when Medically Necessary
HEALTH CHECK Services (EPSDT)	\$0 co-pay	<ul style="list-style-type: none"> Available to all individuals age 20 or younger HEALTH CHECK provides checkups, provides diagnosis and treatment for any health problems found at a checkup Some treatment services provided as a result of a HEALTH CHECK exam require prior approval HEALTH CHECK services include: <ul style="list-style-type: none"> Health and developmental history Complete physical exams Immunizations (shots) Necessary lab tests Health education Hearing checkup Eye exams Dental exams Treatment for identified problems Well-baby, well-child, Head Start, school and sport physicals
Hearing Services (Adult)	\$0 co-pay	<ul style="list-style-type: none"> Covered when Medically Necessary and prescribed by a physician: Hearing aids, hearing aid repairs,

Covered Services	Co-payments	Coverage/Limits
		hearing aid rental, assistive listening devices, and other hearing aid services. Limitations may apply
Home Health Agency Services	\$0 co-pay	<ul style="list-style-type: none"> • Home health agency services when prescribed by a doctor and provided in the Member's home (this does not include a hospital or nursing facility) • Covered services include nursing services, aide services, necessary medical supplies and equipment, and physical, speech, and occupational therapies if there is no other way to receive these services • There are limitations on some services
Hospice Services	\$0 co-pay	<ul style="list-style-type: none"> • Hospice services are designed to ease the pain of a terminal illness • Hospice services include nursing services, Provider services, medical social services, counseling services, home health aide/homemaker, medical equipment, medical supplies, drugs and biologicals, physical therapy, occupational therapy, speech language pathology, volunteer services, and pastoral care services offered on the Member's needs • Hospice services require approval before they can be received • Hospice services are not covered if provided in a nursing facility. While hospice in a nursing facility is not covered by WellCare, it is covered by fee-for-service Medicaid.
Hospital Services (Outpatient)	\$0 co-pay	<ul style="list-style-type: none"> • Diagnostic services such as X-rays and laboratory services provided on an outpatient basis at a hospital are covered when Medically Necessary and ordered by a physician. Treatment services such as physical therapy, dialysis and radiation may also be covered when coverage criteria are met, when Medically Necessary, ordered by a physician, and meeting prior authorization requirements (when applicable). • Not covered are items such as: private rooms, private-duty nursing, any services not Medically Necessary and emergency room services for routine treatment.

Covered Services	Co-payments	Coverage/Limits
Inpatient Hospital Services (includes transitional hospital services and transplant services)	\$0 co-pay	<ul style="list-style-type: none"> • Inpatient and emergency room services, as long as they are Medically Necessary • Limitations may be placed on the amount of care that will be paid for as long as the care received is Medically Necessary (required) through prior authorizations and concurrent review. • Not covered are items such as: private rooms, private-duty nursing, any services not Medically Necessary and emergency room services for routine treatment
Laboratory and Radiology (X-ray) Services	\$0 co-pay	<ul style="list-style-type: none"> • Payment may be made for Medically Necessary diagnostic tests, X-rays and other procedures that are part of the Member's diagnosis or treatment • Clinical and anatomical laboratory services, including the administration of blood draws completed in the physician's office or an outpatient clinic for a behavioral health diagnosis. • For Members unable to leave their homes, a portable X-ray device is available.
Mental Health and Substance Use Disorder Services for Children and Adolescents (ages 0-20)	\$0 co-pay	<p>Mental health and substance use disorder services for children and adolescents in the following categories:</p> <ul style="list-style-type: none"> • Crisis stabilization services (includes treatment crisis intervention) • Inpatient psychiatric hospital (acute and sub-acute) • Psychiatric residential treatment facility (age 19 and under) • Outpatient assessment and treatment: <ul style="list-style-type: none"> ▪ Partial hospitalization ▪ Day treatment ▪ Intensive outpatient ▪ Medication management ▪ Outpatient therapy (individual, family, or group) ▪ Injectable psychotropic medications ▪ Substance use disorder treatment ▪ Psychological evaluation and testing when performed by a psychiatrist, psychologist, or licensed independent mental health professional (LIMHP) ▪ Initial diagnostic interviews when performed by a psychiatrist, psychologist, or LIMHP ▪ Sex offender risk assessment ▪ Community treatment aide (CTA) services ▪ Comprehensive child and adolescent assessment (CCAA) ▪ CCAA addendum

Covered Services	Co-payments	Coverage/Limits
		<ul style="list-style-type: none"> ▪ Hospital observation room services (up to 23 hours and 59 minutes in duration) ▪ Parent-child interaction therapy ▪ Child-parent psychotherapy ▪ Applied behavioral analysis ▪ Multi-systemic therapy ▪ Functional family therapy ▪ Peer support • Rehabilitation Services <ul style="list-style-type: none"> ▪ Day treatment/intensive outpatient ▪ CTA services ▪ Professional resource family care ▪ Therapeutic group home

Covered Services	Co-payments	Coverage/Limits
<p>Mental Health and Substance Use Disorder Services for Individuals Age 21 and Over</p>	<p>\$0 co-pay</p>	<ul style="list-style-type: none"> • Mental health and substance use disorder services for individuals ages 21 and older in the following categories: <ul style="list-style-type: none"> • Crisis stabilization services (includes treatment crisis intervention) • Inpatient psychiatric hospital (acute and sub-acute) • Outpatient assessment and treatment: <ul style="list-style-type: none"> ▪ Partial hospitalization ▪ Social detoxification ▪ Day treatment ▪ Intensive outpatient ▪ Medication management ▪ Outpatient therapy (individual, family, or group) ▪ Injectable psychotropic medications ▪ Substance use disorder treatment ▪ Psychological evaluation and testing when performed by a psychiatrist, psychologist, or licensed independent mental health professional (LIMHP) ▪ Electroconvulsive therapy ▪ Initial diagnostic interviews when performed by a psychiatrist, psychologist, or LIMHP ▪ In-home psychiatric nursing ▪ Peer support • Rehabilitation Services <ul style="list-style-type: none"> ▪ Dual-disorder residential ▪ Intermediate residential (SUD) ▪ Short-term residential ▪ Halfway house ▪ Therapeutic community (SUD only) ▪ Community support ▪ Psychiatric residential rehabilitation ▪ Secure residential rehabilitation ▪ Assertive community treatment (ACT) and Alternative (Alt) ACT ▪ Community support ▪ Day rehabilitation
<p>Nurse Midwife Services</p>	<p>\$0 co-pay</p>	<p>Covered when:</p> <ul style="list-style-type: none"> • Attending cases of normal childbirth • Providing prenatal, intrapartum, and postpartum care • Providing normal obstetrical and gynecological services for women

Covered Services	Co-payments	Coverage/Limits
		<ul style="list-style-type: none"> • Providing care for the newborn immediately following birth
Nurse Practitioner Services	\$0 co-pay	<ul style="list-style-type: none"> • Nursing assessments as nurse practitioner services • The services must be Medically Necessary • The initial medical diagnosis and therapy plan or referral may also be covered • Services of certified pediatric nurse practitioners and certified family nurse practitioners also covered, as required by federal law
Nursing Facility Services	\$0 co-pay	<ul style="list-style-type: none"> • Services provided in skilled/rehabilitative and transitional nursing facilities • Services that a nursing facility must provide include: <ul style="list-style-type: none"> • Regular room • Dietary • Nursing services • Social services when required • Most medical supplies and equipment • Oxygen • Other routine services
Nutrition Services	\$0 co-pay	Covered when Medically Necessary, provided by a nutrition therapist, and prescribed by a physician.
Physician Services	\$0 co-pay	<ul style="list-style-type: none"> • Covered Services include medical and surgical services performed at the physician's office, a Member's home, clinic, hospital, or other locations. • Payment may also be made for diagnostic tests, X-rays, and other procedures that are part of a Member's diagnosis or treatment. • Some services have special requirements, limitations, and/or require the Provider to obtain approval from WellCare of Nebraska. • Wellness Exams are covered at 100% (annual exams, well-child visits).
Podiatry Services	\$0 per visit	<ul style="list-style-type: none"> • Medical and surgical services provided by a podiatrist • May also cover diagnostic tests, X-rays and other procedures that are part of the treatment

Covered Services	Co-payments	Coverage/Limits
Prescribed Drugs	Generic \$0 per prescription; Brand name \$3 per prescription	<ul style="list-style-type: none"> • Covered when Medically Necessary and prescribed by a physician or Provider practicing within the scope of their practice • Some over-the counter drugs may be covered if prescribed by the provider and approved by the health plan • Limitations may apply. • Medications covered under Medicare Part D may be subject to Medicare Part D copays for dual members.
Private-Duty Nursing Services	\$0 co-pay	<ul style="list-style-type: none"> • Private-duty nursing services when ordered by the Member's doctor and when Medically Necessary and prescribed by a physician or provider practicing within the scope of their practice. • Private duty nursing services may be provided in the Member's home or some other living arrangement.
Screening Services (Mammograms)	\$0 co-pay	<ul style="list-style-type: none"> • Mammograms when provided based on a Medically Necessary diagnosis • Without a diagnosis, WellCare of Nebraska covers mammograms according to the American Cancer Society's periodicity schedule
Services Provided by Clinics	\$0 co-pay	<ul style="list-style-type: none"> • Services provided by clinics, including rural health clinics (RHCs), federally qualified health centers (FQHCs), community mental health centers, and Indian Health Services (IHS) clinics if they participate in Nebraska Medicaid. • Covered Services may include Provider services, nurse practitioner services, and other services that are usually covered by the health plan
Physical Therapy	\$0 co-pay	<ul style="list-style-type: none"> • Physical therapy covered in the office, in the Member's home, hospital, nursing facilities, or other facilities • The services must be prescribed by a physician • Therapy is limited to restoration of lost function due to illness or injury if the Member is age 21 and older • For Members age 20 and younger, services must be reasonable and Medically Necessary for the treatment of the Member's illness or injury; or restorative therapy with a medically appropriate expectation that the Member's condition will improve significantly within a reasonable period of time.

Covered Services	Co-payments	Coverage/Limits
Occupational Therapy	\$0 co-pay	<ul style="list-style-type: none"> Occupational therapy covered in the office, in the Member's home, hospital, nursing facilities, or other facilities The services must be prescribed by a physician Therapy is limited to restoration of lost function due to illness or injury if the Member is age 21 and older For Members age 20 and younger, services must be reasonable and Medically Necessary for the treatment of the Member's illness or injury; or restorative therapy with a medically appropriate expectation that the Member's condition will improve significantly within a reasonable period of time
Speech Therapy & Audiology	\$0 co-pay	<ul style="list-style-type: none"> Speech therapy covered in the office, in the Member's home, hospital, nursing facilities or other facilities The services must be prescribed by a Provider Therapy is limited to restoration of lost function due to illness or injury if the Member is age 21 and older For Members age 20 and younger, services must be reasonable and Medically Necessary for the treatment of the Member's illness or injury; or restorative therapy with a medically appropriate expectation that the Member's condition will improve significantly within a reasonable period of time
Vision Services	\$2 per eyeglasses; \$2 per visit office visit or eye exam	<ul style="list-style-type: none"> Eye examinations to determine the need for glasses, the purchase of glasses and necessary repairs Eye exams for adults 21 years and older are limited to one every 24 months, for clients 20 years of age and younger annual exams are covered Covers eyeglasses including lenses and frames when needed for the following medical reasons: the Member's first pair of prescription eyeglasses; size change needed due to growth; or a prescribed lens change only if new lenses cannot be accommodated by the current frame. A pair of eyeglasses is covered for Members 21 years and older when one of the above conditions is met within a 24-month period.

Value-Added (Expanded) Services

Benefits	Description
Mail Order Pharmacy	<p>Members can have their medications shipped right to their home. This is an important consideration for Members who live in rural areas or have difficulty leaving their homes.</p> <p>Using this option doesn't mean Members won't still be able to use a local pharmacy. It's just another way to make sure they can get the medications they need.</p>
No Co-pays	\$0 co-pays for all benefits except brand name pharmacy drugs, durable medical equipment (DME) and vision services.
Boy Scouts	Free Boy Scouts annual membership and subscription to <i>Boys Life Magazine</i> for all Members ages 5-18.
Girl Scouts	Free Girl Scouts annual membership for Members ages 5-18 and includes supply fee. Includes free annual membership for all participating adults.
Steps2Success	<p>WellCare wants to help Members take steps to successfully reach their employment, financial and/or educational goals.</p> <ul style="list-style-type: none"> • Training: FREE job training and financial education classes. • Reading Scholarships: FREE reading scholarships for qualified Members who are in pre-kindergarten to fifth grade who want to improve their reading skills. • General Educational Development® (GED) Exam: We understand the importance of education, which is why we're offering this program <p>Members can take the GED® test for FREE if age 16 or older and don't have their high school diploma</p> <ul style="list-style-type: none"> • Visit our website to: <ul style="list-style-type: none"> - Read Frequently Asked Questions (FAQ) - Get the registration form - Find help preparing for the test
Non-Medical Transportation	Free non-medical transportation to WIC appointments, childbirth classes, and breastfeeding classes.
Telcare Diabetic Management System	Connects diabetes patients to the health plan, Providers and family through a device that works like a cell phone. It lets Members measure their blood glucose and sends data to a WellCare Nurse, their Provider or caregiver. This makes managing diabetes easier.
COBALT	WellCare of Nebraska provides free, confidential online behavioral therapy through the Web-based COBALT Program. This program has helped people with depression, anxiety, insomnia and substance use.

Benefits	Description
OTC Benefits	With our OTC benefit, Member households get \$10 a month for over-the-counter (OTC) items such as diapers, pain relievers and vitamins.
Tobacco Cessation Programs	Educational materials, gum, patches, lozenges and counseling for qualified Members
Healthy Rewards Program	<p>Members can earn rewards for taking steps that help them live a healthy life (completing annual wellness visits). Rewards include:</p> <ul style="list-style-type: none"> • Reloadable prepaid visa card or gift card for completing healthy behaviors. • Choice of diapers, portable playard, or stroller or car seat for pregnant mothers who complete prenatal and postpartum visits. • Members may also receive a discount card after completing their first healthcare activity. The discount card can be used to buy everyday items such as over-the-counter items.
Prenatal Care Management Program	For moms-to-be, this program can help Members get care for a healthy pregnancy – both before and after delivery.
Breast Pump	Free electric breast pumps for Members who have delivered a baby in the past 30 days or a NICU baby in the last 90 days. Prior authorization is required.
Hypoallergenic Bedding	Qualified Members can get up to \$100 in free hypoallergenic bedding to avoid asthma triggers.
Weight Watchers	<p>Free Weight Watchers® membership for qualified Members age 13 and older, including:</p> <ul style="list-style-type: none"> • Simple ways to make healthier food choices • A weight-loss plan based on the latest nutritional science • This program is offered at no cost for six months • To be successful, Members must attend weekly Weight Watchers meetings and reach the goals given to them by their WellCare of Nebraska Health Coach
Community Welcome Room	<p>Provides support for medical and non-medical needs, including:</p> <ul style="list-style-type: none"> • Member Services • Transportation assistance • Community support • Rooms located in Kearney, Norfolk, Omaha and Scottsbluff Nebraska
Community Connections Line	<p>Provides referrals to non-medical community support.</p> <ul style="list-style-type: none"> • Food Services • Housing Services • Transportation • Utilities <p>To contact an Advocate, Members may call 1-866-775-2192. The hours of operation are from Monday-Friday 8 a.m to 5 p.m Central time.</p>

Benefits	Description
24-Hour Behavioral Crisis Hotline	In a behavioral health emergency, Members can call the crisis line 24 hours a day, 7 days a week — 1-800-378-8013
Community Baby Showers	Free community baby showers for new and expectant mothers that focus on providing mothers with critical health information for themselves and their babies, and successful parenting techniques. A gift basket and opportunity to participate in a raffle is also provided.
MyWellCare Mobile App	Provides Members with easy access to the Member ID card, find-a-Provider tool, quick care (urgent care and hospital services locator), contact WellCare, and wellness services which includes care gaps.
XtraSavings Program	<p>Members can get discounts with the following programs:</p> <p>CVS™ Discount Program: Members can get a 20% savings on CVS health-related items. Members will receive their CVS discount card in the mail. Use the discount card by shopping at a CVS store or online at CVS.com.</p> <p>OTC4ME: Members can get discounts on more than 500 over-the-counter items they use every day from our OTC vendor. Save on vitamins, toothpaste, diapers and much more. Enjoy a 20% discount on the first order. Then get a 10% discount on each order after that. Shipping is free on orders of \$25 or more.</p> <p>Swipe and Save: This is part of the Healthy Rewards program. Members who complete their first healthy activity in the program will receive a discount card. Visit myotcoffers.com to see the discounts for each month. Participating stores include CVS, Dollar General, Family Dollar, Fred's Pharmacy and Meijer.</p>
Behavioral Health Incentive	Behavioral Health Members that follow up for a post-ER or hospital visit, and/or their medication check will be incented with a \$5 gift card.
College/Trade School Scholarship	Scholarship award for members; for members age 18 and up who are entering college. Awarding 10 scholarships for eligible members @ \$1,000 per winner.
Behavioral Health Provider Consultation	WellCare will cover any consultation your doctor has with a mental health provider.
College Bound Dorm Room Items – Foster Care	Provides dorm room items to former foster care children who are college bound.
JumpSTART	<p>Free program that provides health tips and tools to kid's ages 4–11 to encourage immunizations and checkups.</p> <ul style="list-style-type: none"> • Rewards Program for well-child visits • Cool and fun rewards for healthy habits • Kids newsletters about fitness and nutrition • Raffle to win a bicycle (four times a year)
Free Cell Phone	Free cell phone to enrollees engaged in a care management program who do not have a telephone (High Risk Pregnancies and other Chronic Conditions).

Benefits	Description
Getting Around/Bus Passes	Additional transportation Bus passes and information on how to access public transportation. Limited to Foster Care members ages 16-17, Members with Refugee status and ABD members.
Swimming Lessons	WellCare to offer up to 20 swimming lessons total per year for qualified members.
Summer Camp	WellCare offers a scholarship for qualified members to attend one summer camp session (one week) for members (ages 4-12)
Caregiver Pertussis Vaccine	Provides pertussis vaccine (whooping cough) for households of pregnant members who would be caregivers for newborns.
Zoo Passes	Annual individual or Family Membership to the zoo for qualified members

Special Programs

Benefits	Description
Foster Care	WellCare of Nebraska's child welfare coordinators help Members in foster care get the most from their benefits with services like these: <ul style="list-style-type: none"> • Help understanding basic health information • Doula services for pregnant teens • Wellness plans, including preventive care services
Health Fairs	Members attend and participate in health-focused events to receive information, resources and education concerning health topics such as diabetes management, back-to-school health, physical activity, and general overall health and well-being.
WellCare Days	On-site events called WellCare Days to promote and educate Members on health plan resources and health information. Conducted in key locations and agencies across the state to conveniently provide Members with health education, information and benefit assistance on site.
HealthConnections Activities	<ul style="list-style-type: none"> • Community-based health and wellness events leveraging existing programs. • HealthConnections Councils focusing on identifying creative and innovative ways to sustain the social safety network. • CommUnity Assistance Line to connect Members to social services.
Family Support Specialists	A partnership with Nebraska Family Support Network where families receive counseling on the side effects of the Member's condition, depression, anxiety, and behavior modification/coaching.

Smoking Cessation

Primary Care Providers (PCPs) should direct Members who smoke and want to quit smoking to call WellCare's Member Services Department and ask to be directed to the Smoking Cessation program. A health coach will work with Members through tailored interactions based on their individual needs and health objectives associated with smoking cessation. To reach the quit line call **1-800-QUIT-NOW (1-800-784-8669)**.

PCPs can also reference the Agency for Health Care and Research & Quality's Smoking Cessation *Quick Reference Guide* at [www.wellcare.com/ Nebraska/Providers/Medicaid](http://www.wellcare.com/Nebraska/Providers/Medicaid) or by contacting a Provider Relations representative.

Weight Loss

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

For more information on Covered Services, refer to the Provider Handbook on the Nebraska MLTC website at dhhs.ne.gov/Pages/medicaid-and-long-term-care.aspx

Medical Transportation Services

Non-emergency transportation services are covered by Nebraska Medicaid. IntelliRide is the transportation vendor. Members may contact IntelliRide at **1-844-531-3783** to arrange medical transportation services.

Baby's First

Baby's First is an innovative, thoughtful approach to postpartum education and outreach. Offered in both English and Spanish, this program is designed to support the 21st century working mother who relies on quick, effective and easy forms of communication. Baby's First takes the guesswork out of parenting by delivering evidence based education straight to the Member's phone. Topics include: two reminders for each well-visit and immunization appointment, breastfeeding, the postpartum visit and postpartum depression screening (and referrals for help), preventing Shaken Baby Syndrome, safe sleep, and much more.

Baby's First is not an app, there is nothing to download. Members sign up and messages are sent straight to their phone via text. In addition to text messages, this program also offers web-based topic deep dives and videos.

To utilize the Baby's First program, Members can text BABY1 to **52046** (for Spanish, text **BEBE1**). From this point, Members will receive communication from the Baby's First program via text.

Excluded Services

Excluded services are those services that a Member may obtain under the Nebraska State Medicaid (Fee-For-Service) Plan, which WellCare of Nebraska does not cover. WellCare of Nebraska will educate the Member how to access these services, help with referrals as required and also in the scheduling of these services, which will be paid for by Medicaid and Long Term Services (MLTC).

The following are excluded services that will not be covered by WellCare of Nebraska:

- Dental services.
- Intermediate care facility services for individuals with developmental disabilities.
- Any institutional long-term care/nursing facility (LTC/NF) services at a custodial level of care.
- School-based services.
- All Home and Community Based Services (HCBS) waiver services.

- Targeted Case Management services.
- Medicaid State Plan Personal Assistance Services
- Non-Emergency Transportation (NEMT). Please note that WellCare will cover NEMT beginning July 1, 2019. Intelliride will be the WellCare transportation vendor.

For the most up-to-date information on Covered Services, refer to the Nebraska MLTC website at dhhs.ne.gov/Pages/medicaid-and-long-term-care.aspx

Provider Services

WellCare has implemented the following enhanced Provider Services technology to better serve Providers:

Interactive Voice Response (IVR) System

- a. Technology to expedite Provider verification and authentication within the IVR
- b. Provider/Member account information is sent directly to the Member or Provider Service agent's desktop from the IVR validation process, so Providers do not have to re-enter information
- c. Full speech capability, allowing Providers to speak their information or use the touch-tone keypad

Self-Service Features

- d. Ability to receive Member co-pay information
- e. Ability to receive Member eligibility information
- f. Ability to request authorization and/or status information
- g. Unlimited claims information on full or partial payments
- h. Receive status for multiple lines of claim denials
- i. Automatic routing to the PCS claims adjustment team to dispute a denied claim
- j. Rejected claims information is now available through self-service

Tips for using IVR

Providers should have the following information available with each call:

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

Benefits of using Self-Service

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

For more information, please refer to the *Phone Access Guide* at www.wellcare.com/Nebraska under the Providers section, "Overview & Resources".

Providers may contact the appropriate departments at WellCare by referring to the *Quick Reference Guide* at www.wellcare.com/Nebraska/Providers/Medicaid.

Provider Relations representatives are available to help participating WellCare Providers.

Provider Services (Call Center) Phone Number and Hours of Operation

1-855-599-3811

Monday-Friday 7 a.m. to 8 p.m. Central time

Website Resources

WellCare's website, www.wellcare.com/Nebraska, offers tools to help Providers and their staff.

Available resources include:

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

Secure Provider Portal — Benefits of Registering

WellCare's secure online provider portal offers immediate access to an assortment of useful tools. All Providers who create an account and are assigned the appropriate role/permission can use the following features:

- **Claims Submission, Status, Appeal, Dispute:** Submit a claim, check the status of an existing claim, appeal or dispute claims, and download reports.
- **Member Eligibility, Co-Pay Information and More:** Verify Member eligibility and view co-pays, benefit information, demographic information, care gaps, health conditions, visit history and more.
- **Authorization Requests:** Submit authorization requests, attach clinical documentation, check authorization status and submit appeals. Providers can also print and/or save copies of the authorization.
- **Pharmacy Services and Utilization:** View and download a copy of WellCare of Nebraska's Preferred Drug List (PDL), access pharmacy utilization reports and obtain information about WellCare pharmacy services.
- **Visit Checklist/Appointment Agenda:** Download and print a checklist for Member appointments, then submit online to get credit for Partnership for Quality (P4Q).
- **Secure Inbox:** View the latest announcements for Providers and receive important messages from WellCare.

Provider Registration Advantage

The secure provider portal allows Providers to have one username and password, and be affiliated with multiple Providers/offices. Administrators can easily manage users and permissions. Once registered for WellCare's portal, Providers should retain their username and password information for future reference.

How to Register

To create an account, please refer to the Provider Resource Guide on WellCare of Nebraska's website at www.wellcare.com/Nebraska/Providers. For more information about web capabilities, please call Provider Services or contact Provider Relations to schedule a website in-service.

Section 2: Provider and Member Administrative Guidelines

Provider Administrative Overview

This section is an overview of guidelines for which all participating WellCare Medicaid Managed Care Providers are accountable. Please refer to the Participating Provider Agreement (Provider Agreement) or contact a Provider Relations representative for clarification of any of the following.

Contracted WellCare Providers must, in accordance with generally accepted professional standards:

- Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973
- Not discriminate in any manner between WellCare Members and non-WellCare Members
- Ensure that the hours of operation offered to WellCare Members is no less than those offered to commercial Members or comparable Medicaid Fee-for-Service recipients if Provider serves only Medicaid recipients
- Not deny, limit or condition the furnishing of treatment to any WellCare Member on the basis of any factor that is related to health status, including, but not limited to, the following:
 - Inability to pay co-payment
 - Medical condition, including mental as well as physical illness
 - Claims experience
 - Receipt of healthcare
 - Medical history
 - Genetic information
 - Evidence of insurability
 - Including conditions arising out of acts of domestic violence, or disability
- Agree to cooperate with WellCare in its efforts to monitor compliance with its Medicaid contract approved MLTC rules and regulations, and assist us in complying with corrective action plans necessary for us to comply with such rules and regulations
- Retain all agreements, books, documents, papers and medical records related to the provision of services to WellCare Members as required by state and federal laws
- Provide Covered Services in a manner consistent with professionally recognized standards of healthcare, as defined in the Nebraska Contract
- Use physician extenders appropriately. Provider assistants (PAs) and advanced registered nurse practitioners (APRNs) should provide direct Member care within the scope or practice established by the rules and regulations of the approved MLTC and WellCare guidelines
- Assume full responsibility to the extent of the law when supervising PAs and APRNs whose scope of practice should not extend beyond statutory limitations
- Clearly identify physician extender titles (examples: MD, DO, APRN, PA) to Members and to other healthcare professionals

- Honor at all times any Member request to be seen by a Provider rather than a Provider extender
- Administer, within the scope of practice, treatment for any Member in need of healthcare services
- Maintain the confidentiality of Member information and records
- Allow WellCare to use Provider performance data for quality improvement activities
- Respond promptly to WellCare's request(s) for medical records to comply with regulatory requirements
- Maintain accurate medical records and adhere to all WellCare's policies governing content and confidentiality of medical records as outlined in *Section 3: Quality Improvement* and *Section 8: Compliance*
- Ensure that:
 - All employed Providers and other healthcare practitioners and Providers comply with the terms and conditions of the Provider Agreement between Provider and WellCare
 - To the extent Provider maintains written agreements with employed physicians and other healthcare practitioners and Providers, such agreements contain similar provisions to the Provider Agreement
 - Provider maintains written agreements with all contracted physicians or other healthcare practitioners and Providers, whose agreements contain similar provisions to the Provider Agreement
- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene
- Communicate timely clinical information between Providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to WellCare, the Member or the requesting party at no charge, unless otherwise agreed
- Preserve Member dignity and observe the rights of Members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen
- Freely communicate with and advise Members regarding the diagnosis of the Member's condition and advocate on Member's behalf for Member's health status, medical care and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services
- Identify Members who need of services related to children's health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation, substance abuse or other behavioral health issues. If indicated, Providers must refer Members to WellCare-sponsored or community-based programs
- Must document the referral to WellCare-sponsored or community-based programs in the Member's medical record and provide the appropriate follow-up to ensure the Member accessed the services

Prohibited Services

Prohibited services are those required to treat complications or conditions resulting from non-Covered Services, services not reasonable and necessary, and services that are experimental and investigational unless approved by the MLTC Director.

The MCO is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) described in Section 1903(i) of the Social Security Act.

Mainstreaming of Members

To ensure mainstreaming of Nebraska Medicaid Members, WellCare takes affirmative action so that Members are provided Covered Services without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual-orientation, genetic information, or physical or mental illnesses. WellCare takes into account a Member's literacy and culture when addressing Members and their concerns, and must take reasonable steps to ensure subcontractors do the same.

Examples of prohibited practices include the following, in accordance with 42 CFR 438.6(f):

- Denying or not providing a Member any Covered Service or access to an available facility
- Providing to a Member any Medically Necessary Covered Service that is different, or is provided in a different manner or at a different time from that provided to other Members, other public or private patients or the public at large, except where Medically Necessary
- Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; or restricting a Member in any way in his/her enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service
- Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual orientation, income status, Medicaid Membership, or physical or mental illnesses of the participants to be served

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

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

Suspected cases of abuse, neglect and/or exploitation must be reported to the state's Adult Protective Services Unit. Adult Protective Services (APS) are services designed to protect elders and vulnerable adults from abuse, neglect or exploitation. The Nebraska Department of Aging and the Nebraska Department of Health and Human Services have defined processes for ensuring elderly victims of abuse, neglect or exploitation in need of home- and community-based services are referred to the aging network, tracked and served in a timely manner. Requirements for serving elderly victims of abuse, neglect and exploitation can be found in Nebraska Code Ch. 28 Section 710 and Ch. 28 Section 372 respectively.

Providers may be asked to cooperate with WellCare to provide services or arrange for the Member to change locations. Training regarding abuse, neglect and exploitation is at www.wellcare.com/Nebraska/Providers/Medicaid/Training.

To report suspected abuse, neglect or exploitation of children or vulnerable adults, Providers should call the Nebraska Abuse Hotline at **1-800-652-1999**. The toll-free number is available 24 hours a day. If a Provider sees a child or vulnerable adult in immediate danger, they should call **911**.

Access Standards

All Providers must adhere to standards of timeliness for appointments and in-office waiting times. These standards take into consideration the immediacy of the Member's needs.

WellCare shall monitor Providers against these standards to ensure Members can obtain needed health services within the acceptable appointment time frames, in-office waiting times and after-hours standards. Hours of operation offered for Medicaid beneficiaries must be no less than those offered to commercial Members or comparable Medicaid Fee-For-Service recipients if the Provider serves only Medicaid recipients. Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare.

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

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

Appointment Availability Access Standards

- Emergency services must be available immediately upon presentation at the service delivery site, 24 hours a day, seven days a week. Members with emergent behavioral health needs must be referred to services within one hour generally and within two hours in designated rural areas.
- Urgent care must be available the same day and be provided by the Primary Care Provider (PCP) or as arranged by the MCO. Non-urgent sick care must be available within 72 hours, or sooner if the Member's medical condition(s) deteriorate into an urgent or emergent situation.
- Family planning services must be available within seven calendar days.
- Non-urgent, preventive care must be available within four weeks.
- PCPs who have a one-Provider practice must have office hours of at least 20 hours per week. Practices with two or more Providers must have office hours of at least 30 hours per week.
- For high-volume specialty care, routine appointments must be available within 30 calendar days of referral. High volume specialists include cardiologists, neurologists, hematologists/oncologists, OB/GYNs, and orthopedic Providers. For other specialty care, consultation must be available within one month of referral or as clinically indicated.
- Laboratory and X-ray services must be available within three weeks for routine appointments and 48 hours (or as clinically indicated) for urgent care.
- Maternity care must be available within 14 calendar days of request during the first trimester, within seven calendar days of request during the second trimester, and within three calendar days of request during the third trimester. For high-risk pregnancies, the Member must be seen within three calendar days of identification of high risk by the MCO or maternity care Provider, or immediately if an emergency exists.

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

Geographic Access Standards

- WellCare must, at a minimum, contract with two PCPs within 30 miles of the personal residences of Members in urban counties; one PCP within 45 miles of the personal residences of Members in rural counties; and one PCP within 60 miles of the personal residences of Members in frontier counties.
- WellCare must, at a minimum, contract with one high volume specialist within 90 miles of personal residences of Members. High volume specialties include cardiology, neurology, hematology/oncology, obstetrics/gynecology, and orthopedics.
- WellCare must secure participation in its pharmacy network of a sufficient number of pharmacies that dispense drugs directly to Members (other than by mail order) to ensure convenient access to covered drugs.
 - In urban counties, a network retail pharmacy must be available within 5 miles of 90% of Members' personal residences
 - In rural counties, a network retail pharmacy must be available within 15 miles of 70% of Members' personal residences
 - In frontier counties, a network retail pharmacy must be available within 60 miles of 70% of Members' personal residences
- WellCare must, at a minimum, contract with behavioral health inpatient and residential service Providers with sufficient locations to allow Members to travel by car or other transit Provider and return home within a single day in rural and frontier areas. If it is determined by MLTC that no inpatient Providers are available within the access requirements, the MCO must develop alternative plans for accessing comparable levels of care, instead of these services, subject to approval by MLTC
- WellCare must, at a minimum, contract with an adequate number of behavioral health outpatient assessment and treatment Providers to meet the needs of its Members and offer a choice of Providers. The MCO must provide adequate choice within 30 miles of Members' personal residences in urban areas; a minimum of two Providers within 45 miles of Members' personal residences in rural counties, and a minimum of two Providers within 60 miles of Members' personal residences in frontier counties. If the rural or frontier requirements cannot be met because of a lack of behavioral health Providers in those counties, the MCO must utilize telehealth options.
- The classification of counties according to urban, rural and frontier status are based upon data from the most recent U.S. Census.
- WellCare must contract with a sufficient number of hospitals to ensure that transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the state on the basis of community standards.

Responsibilities of All Providers

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

Provider Identifiers

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

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

Advance Directives

Members have the right to control decisions relating to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life. Living will and advance directive rights may differ between states.

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

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

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

Provider Billing and Address Changes

Providers are required to give prior notice (30-day advance notice is recommended) for any of the following changes by calling **1-855-599-3811**. Please also contact Provider Enrollment as well via the State's current contractor Maximus to keep your information current.

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

Provider Termination

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

- Any contracted Provider must give at least 90 days prior written notice to WellCare before terminating their relationship with WellCare "without cause," unless otherwise agreed to in writing. This ensures that adequate notice may be given to WellCare Members regarding the Provider's participation status with WellCare. Please refer to the Provider Agreement for the details regarding the specific required days for providing termination notice, as the Provider may be required by contract to give more notice than listed above
- Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month
Members in active treatment may continue care when such care is Medically Necessary, through the completion of treatment of a condition for which the Member was receiving

treatment at the time of the termination or until the Member selects another treating Provider, not to exceed six months after the Provider termination. For pregnant Members who have initiated a course of general care, regardless of the trimester in which care was initiated, continuation shall be provided until the completion of postpartum care

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

Please note that WellCare will notify in writing all appropriate agencies and/or Members prior to the termination effective date of a participating Primary Care Provider (PCP), hospital, specialist or significant ancillary Provider within the service area as required by Nebraska Medicaid program requirements and/or regulations and statutes.

Out-of-Area Member Transfers

Providers should assist WellCare in arranging and accepting the transfer of Members receiving care out of the service area if the transfer is considered medically acceptable by the WellCare Provider and the out-of-network attending provider/Provider.

Members with Special Healthcare Needs

Members with special healthcare needs include Members with the following conditions:

- Intellectually disabled or related conditions
- Serious chronic illnesses such as schizophrenia or degenerative neurological disorders
- Disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes
- Children and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care
- Related populations eligible for Supplemental Security Income (SSI)

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

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

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

Responsibilities of Primary Care Provider (PCPs)

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

- Coordinate, monitor and supervise the delivery of primary care services to each Member
- See Members for an initial office visit and assessment within the first 90 days of enrollment in WellCare
- Coordinate, monitor and supervise the delivery of Medically Necessary primary and preventive care services to each Member, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT®) services for Members younger than 21
- Provide appropriate referrals of potentially eligible women, infants and children to the Women, Infants, and Children (WIC) program for nutritional assistance
- Ensure Members are aware of the availability of public transportation where available
- Provide access to WellCare or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity. A related organization or entity is defined as having influence, ownership or control and either a financial relationship or a relationship for rendering services to the primary care office
- Submit an encounter for each visit where the Provider sees the Member or the Member receives a Healthcare Effectiveness Data and Information Set (HEDIS®) service
- Submit encounters. For more information on encounters, refer to *Section 5: Claims*
- Ensure Members utilize network Providers. If unable to locate a participating WellCare Medicaid Provider for services required, contact Clinical Services for assistance. Refer to the *Quick Reference Guide* on WellCare's website
- Comply with and participate in corrective action and performance improvement plan(s)

Cost Sharing

Providers may not deny care or services to any Member because of his or her inability to pay the co-payment. WellCare shall not hold Members liable for debt due to insolvency of WellCare or non-payment by the state to WellCare. Further, WellCare and all Providers and subcontractors shall not charge Members for missed appointments.

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

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

Vaccines for Children Program

Providers must participate in the Vaccines for Children Program (VFC). The VFC is a federally funded and state operated vaccine supply program that supplies vaccines at no cost to children from birth through age 18. The program is administered by the Nebraska Department of Health and Human Services, Immunization Program.

Who is eligible for Vaccines for Children (VFC) vaccine?

- Children — birth through 18 years of age AND one of the following:
- American Indian or Alaska Native
- Medicaid enrolled
- Uninsured (have no health insurance)
- Underinsured*

The VFC Program provides vaccines at no charge to Providers and encourages providing healthcare services within the Member's medical home. WellCare covers and reimburses participating Providers for immunizations covered by Medicaid, but not provided through VFC. Providers who are directly enrolled in the VFC program must maintain adequate vaccine supplies. Providers must submit immunization data to the Nebraska State Immunization Information System at dhhs.ne.gov/Pages/public-health.aspx

*Children whose insurance has a very high deductible (catastrophic insurance) are NOT considered underinsured.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

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

1. Providing all needed initial, periodic and inter-periodic EPSDT health assessments, diagnosis and treatment to all eligible Members in accordance with the Agency's approved Medicaid administrative regulation 471 NAC 33-000 and the periodicity schedule provided by the American Academy of Pediatrics (AAP)
2. Referring the Member to an out-of-network provider for treatment if the service is not available within WellCare's network
3. Providing vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines at dhhs.ne.gov/publichealth/Immunization and www.aap.org/immunization/IZSchedule.html
4. Providing vaccinations in conjunction with EPSDT/Well-child visits. Providers are required to use vaccines available without charge under the Vaccines for Children (VFC) Program for Medicaid children 18-years-old and younger;
5. Addressing unresolved problems, referrals and results from diagnostic tests including results from previous EPSDT visits
6. Requesting prior authorization for Medically Necessary EPSDT special services in the event other healthcare, diagnostic, preventive or rehabilitative services, treatment or other measures required under 471 NAC 33-001.03 that are not otherwise covered under the Nebraska Medicaid Program
7. Monitoring, tracking and following up with Members:
 - a. Who have not had a health assessment screening
 - b. Who miss EPSDT services, to assist them in obtaining an appointment
8. Ensuring Members receive the proper referrals to treat any conditions or problems identified during the health assessment including tracking, monitoring and following up with Members to ensure they receive the necessary medical services
9. Helping Members with transition to other appropriate care for children who age-out of EPSDT services

Providers will be sent a monthly membership list which specifies the health assessment eligible children who have not had an encounter within 90 days of joining WellCare or are not in compliance with the EPSDT Program.

Provider compliance with Member monitoring, tracking and follow-up will be assessed through random medical record review audits conducted by the WellCare Quality Improvement Department, and corrective action plans will be required for Providers who are below 80% compliance with all elements of the review.

For more information on EPSDT Covered Services, refer to *Section 1: Welcome to WellCare*. To learn more about the Nebraska Medicaid EPSDT periodicity schedule, refer to the Agency's website at dhhs.ne.gov/Pages/Heritage-Health-Resources.aspx. To learn more about the periodicity schedule based on the American Academy of Pediatrics guidelines, refer to the AAP website at www.aap.org/en-us/Documents/periodicity_schedule.pdf.

Primary Care Offices

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

- Support of the Provider Relations, Provider Services and Clinical Services Departments, as well as the tools and resources available on our website at www.wellcare.com/Nebraska
- Information on WellCare network Providers for the purposes of referral management and discharge planning

Closing of Provider Panel

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

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

Covering Physicians/Providers

If participating Providers are temporarily unavailable to provide care or referral services to WellCare Members, Providers shall make arrangements with another WellCare-contracted (participating) and credentialed Provider to provide services on their behalf, unless there is an emergency.

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

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

Termination of a Member

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

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

If a participating Provider desires to terminate his/her relationship with a WellCare Member, the Provider should submit adequate documentation to support that although they have tried to maintain a satisfactory Provider and Member relationship, the Member's noncompliance with treatment or uncooperative behavior is impairing the ability to care for and treat the Member effectively.

Request for Transfer of Members should be submitted via WellCare's secure provider portal by users who have Administrator rights for their contract or sub-group. After logging in, providers should access the My Patients area, search for the member, select Request Member Transfer from the Select Action menu, then complete and submit the form.

Domestic Violence and Substance Abuse Screening

PCPs should identify indicators of substance abuse or domestic violence and offer referral services to applicable community agencies.

Adult Health Screening

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

Cultural Competency Program and Plan

Overview

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

The objectives of the Cultural Competency program are to:

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

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

The components of WellCare's Cultural Competency program include:

- Data Analysis – WellCare analyzes data on the populations in each region it serves for the purpose of learning about that region's cultural and linguistic needs, as well as any health disparities specific to that region. Such analyses are performed at the time WellCare enters a new market and regularly thereafter, depending on the frequency with which new data become available. Data sources and analysis methods include the following:
 - State-supplied data for Medicaid population
 - Demographic data available from the U.S. Census and any special studies done locally
 - Claims and encounter data to identify the healthcare needs of the population by identifying the diagnostic categories that are the most prevalent
 - Member requests for assistance, or Member grievances, to identify areas of opportunity to improve service to Members from a cultural and linguistic angle
 - Data on race, ethnicity and language spoken for Members can be collected both electronically from the state data received and through voluntary self-identification by the Member during enrollment/intake or during encounters with network Providers
- Community-Based Support – WellCare's success requires linking with other groups that share the same goals.
 - WellCare reaches out to community-based organizations that support racial and ethnic minorities, and the disabled, to ensure that existing community resources for Members who have special needs are used to their full potential. The goal is to coordinate the deployment of both community and WellCare resources, as well as to take full advantage of the bonds that may exist between the community-based entities and the covered population.
 - WellCare develops and maintains grassroots sponsorships that enhance its effort to reach low-income communities. WellCare also provides opportunities for building meaningful relationships that benefit all Members of the communities. These sponsorships are coordinated with Providers, community health fairs and public events.
- Diversity and Language Abilities of WellCare – WellCare recruits diverse talented staff to work in all levels of the organization. WellCare does not discriminate with regard to race, religion or ethnic background when hiring staff.
 - WellCare ensures that bilingual staff Members are hired for functional units that have direct contact with Members to meet the needs identified. Today, one-third of WellCare's Member Services representatives are bilingual. Spanish is the most common translation required. Whenever possible, WellCare will also distinguish place of origin of its Spanish-speaking staff to ensure sensitivity to differences in cultural backgrounds, language idioms and accents. For example, in Georgia, about two-thirds of the Hispanic population is of Mexican origin. In New York City, the Puerto Rican population is predominant.

- Where WellCare enrolls significant numbers of Members who speak languages other than English or Spanish, WellCare seeks to recruit staff Members who are bilingual in English plus one of those other languages. WellCare does this even if the particular population is not a size that triggers state agency mandates.
- Diversity of Provider Network
 - Providers are inventoried for their language abilities. This information is available in the Provider Directory so Members can choose a Provider who speaks their primary language.
 - Providers are recruited to ensure a diverse selection of Providers to care for the population served.
- Linguistic Services
 - Providers will identify Members who have potential linguistic barriers for which alternative communication methods are needed and will contact WellCare to arrange appropriate assistance.
 - Members may receive interpreter services at no cost when needed to access Covered Services through a vendor, as arranged by the Member Services Department.
 - Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency, and sign language for the hard of hearing. These services are provided by vendors with such expertise and coordinated by WellCare's Member Services Department. Interpreter services are provided via phone when possible.
 - Written materials are available for Members in large-print format, and certain non-English languages prevalent in WellCare's service areas.
- Electronic Media
 - Telephone system adaptations – Members have access to the TTY line for hard of hearing services. WellCare's Member Services Department is responsible for any necessary follow-up calls to the Member. The toll-free TTY number can be found on the Member identification card.
- Provider Education
 - WellCare's Cultural Competency Program provides a checklist to assess the cultural competency of Providers' offices

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

Cultural Competency Survey

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

Member Administrative Guidelines

Overview

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

Eligibility

For eligibility criteria, please refer to the Nebraska Medicaid Agency website at dhhs.ne.gov/Pages/Heritage-Health-Resources.aspx. An individual must meet specific eligibility requirements in order to be eligible for Medicaid. Each program has specific income and asset limits that must be met. Membership enrollment in WellCare's Medicaid managed care plan is solely determined by the Nebraska Division of Medicaid and Long-term Care (MLTC).

The Agency requires designated Medicaid recipients to enroll with a managed care plan. Eligible recipients will be sent an enrollment letter that indicates the Managed Care Organization (MCO) choice deadline. Beginning January 1, 2017, Members will be automatically assigned to an MCO once they are determined mandatory to enroll. Annually Members will receive information from Nebraska Medicaid regarding the open enrollment period. There is one open enrollment period each year during which Members may switch their plan.

Member Handbook

In the Welcome Packet, new Members can find information about how to find a Member Handbook online. New Members also can call Member Services to ask for a Member Handbook.

Enrollment

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

Upon enrollment in WellCare, Members are provided with the following:

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

Effective Date of Payment for New Members

WellCare is responsible for benefits and services in the core benefits package from and including the effective date of a Member's Medicaid eligibility. WellCare must reimburse a Provider and that Provider must reimburse a Member for payments already made by a Member for Medicaid Covered Services during the retroactive eligibility period.

Member Identification Cards

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

Note: If a Member is a dual eligible individual, WellCare does not require him/her to choose a new PCP through WellCare, and will not prevent the Member from receiving primary care services from the Member's existing Medicare PCP.

Eligibility Verification

Members will be issued at least two separate ID cards relating to their Medicaid eligibility and their enrollment in the Nebraska Medicaid managed care delivery system. MLTC issues an ID card to all Medicaid eligible individuals, including WellCare Members. This card is not proof of eligibility, but can be used by Providers to access the state's electronic eligibility verification systems. These systems contain the most current information available on Members, including WellCare enrollment. No WellCare-specific information is printed on the card. The WellCare Member may need to show this card to access Medicaid services not included in the WellCare benefits and services, such as dental services.

A Member's eligibility status can change at any time. Therefore, all Providers should consider requesting and copying a Member's WellCare-issued identification card, along with additional proof of identification such as a photo ID, and file them in the Member's medical record. If services being rendered are not covered by WellCare, Providers should request the Member's MLTC-issued identification card.

Providers may do one of the following to verify eligibility using the WellCare-issued identification card:

- Access to secure, online provider portal of the WellCare website at www.wellcare.com/Nebraska
- Access to WellCare's Interactive Voice Response (IVR) system
- Contact Provider Services

Providers may also verify eligibility by calling the Nebraska Medicaid Eligibility system (NMES) line at **1-800-642-6092**.

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

Member Engagement

WellCare utilizes a number of engagement strategies to establish a relationship with its Members. Engagement begins with notification of Member enrollment. Notice of enrollment triggers an attempt to reach the Member by phone to complete the Health Risk Assessment (HRA) and to familiarize the Member with his or her plan benefits. A total of three attempts are made to contact the Member.

Assessments for Members

A Health Risk Assessment is completed with the Member within the first 90 days of enrollment. Members have several options for completing the HRA. A paper version is mailed to the Member with his or her enrollment materials. The Member can alternatively choose to take the HRA online via the Member Portal. In addition, WellCare makes three attempts to contact the Member telephonically to complete an HRA.

In the event that the HRA identifies a Member who requires a more comprehensive assessment, the Member is electronically referred to WellCare's Care Management Program for completion of a more comprehensive assessment. Care Managers are either licensed registered nurses or social workers. Upon completion of the more comprehensive assessment, a care plan is developed with input from the Member, the Provider and the Care Manager. The care plan is available for Providers to view via the provider portal. Care Managers collaborate with the Provider to ensure the most successful care plan is developed and implemented to effect positive outcomes for the Member.

Member Rights and Responsibilities

Members have the right:

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

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

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

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

Members have the responsibility:

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

Assignment of Primary Care Provider

Members enrolled in a WellCare plan must choose a PCP at the point of enrollment or they will be assigned to a PCP within WellCare's network. Members have 10 calendar days from the date of enrollment to select another participating PCP. To ensure quality and continuity of care, the PCP is responsible for arranging all of the Member's healthcare needs from providing primary care services to coordinating referrals to specialists and Providers of ancillary or hospital services.

Changing Primary Care Providers

Members may change their PCP selection at any time by calling Member Services.

Women's Health Specialists

PCPs may also provide routine and preventive healthcare services that are specific to female Members. If a female Member selects a PCP who does not provide these services, she has the right to direct in-network access to a women's health specialist for Covered Services related to this type of routine and preventive care.

Hard of hearing, Interpreter and Sign Language Services

Hard of hearing, interpreter and sign language services are available to WellCare Members through WellCare's Member Services Department. Interpreter services are provided via phone when possible. PCPs should coordinate these services for WellCare Members and contact Member Services if help is needed. For Provider Services telephone numbers, please refer to the *Quick Reference Guide* at www.wellcare.com/Nebraska/Providers/Medicaid.

CommUnity Assistance Line

A no-cost CommUnity Assistance Line (CAL) is available in Nebraska for all WellCare Members. This service is offered to anyone, not just Members of our plans. This includes those who are deaf or hearing impaired. By calling the CAL, people can learn about programs in their community and social services in their area. The CAL will connect you to services that include:

- Utility assistance
- Food banks
- Transportation
- Rental assistance
- Free and reduced-cost child care

Members can call the CAL toll-free at **1-866-775-2192 (TTY 711)** Monday-Friday, from 9 a.m. to 5 p.m. Central time.

Section 3: Quality Improvement

Overview

WellCare's Quality Assessment and Performance Improvement (QAPI) Program is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral healthcare and services.

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

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

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

Medical Records

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

Confidentiality of Member information must be maintained at all times. Records are to be stored securely with access granted to authorized personnel only. Access to records should be granted to WellCare or its representatives without a fee to the extent permitted by state and federal law. Providers should have procedures in place to permit the timely access and submission of medical records to WellCare upon request. WellCare follows state and federal law regarding the retention of records remaining under the care, custody and control of the healthcare Provider. Information from the medical records review may be used in the re-credentialing process as well as quality activities.

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

The Member's medical record is the property of the Provider who generates the record. However, each Member or his or her representative is entitled to copies of his or her medical record at no cost.

Medical Record Standards

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

- Member/patient identification information on each page
- Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers of emergency contacts (if no phone, contact name), consent forms, identify language spoken, and guardianship information
- Date of data entry and date of encounter
- Late entries should include date and time of occurrence and date and time of documentation
- Provider identification by name and profession of the rendering Provider (e.g., M.D., D.O., O.D.)
- Allergies and/or adverse reactions to drugs shall be noted in a prominent location
- Past medical history, including serious accidents, operations and illnesses. For children, past medical history includes prenatal care and birth information, operations and childhood illnesses (i.e., documentation of chicken pox)
- Identification of current problems
- The consultation, laboratory and radiology reports filed in the medical record shall contain the ordering Provider's initials or other documentation indicating review
- A current list of immunizations pursuant to NAC 33-002.02C
- Identification and history of nicotine, alcohol use or substance abuse
- Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department of Public Health pursuant to Title 173 (173 NAC 1)
- Follow-up visits provided secondary to reports of emergency room care
- Hospital discharge summaries
- Advanced medical directives, for adults 18 and older
- Documentation that Member has received the Provider's office policy regarding office practices compliant to HIPAA
- Record is legible to at least a peer of the writer and written in standard English. Any record judged illegible by one reviewer shall be evaluated by another reviewer

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

- History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health and substance abuse status

- Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening (EPSDT) services are addressed from previous visits
- Plan of treatment including:
 - Medication history, current medications prescribed, including the strength, amount and directions for use and refills
 - Therapies and other prescribed regimen
- Follow-up plans including consultation and referrals and directions, including time to return
- Education and instructions whether verbal, written or via telephone

Provider Participation in the Quality Improvement Program

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

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

Member Satisfaction

On an annual basis, WellCare conducts a Member satisfaction survey of a representative sample of Members. Satisfaction with services, quality, and access is evaluated. The results are compared to WellCare's performance goals, and improvement action plans are developed to address any areas not meeting the standard.

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

Programs promoting patient safety are a public expectation, a legal and professional standard and an effective risk-management tool. As an integral component of healthcare delivery by all inpatient and outpatient Providers, WellCare supports identification and implementation of a complete range of patient safety activities. These activities include medical record legibility and documentation standards, communication and coordination of care across the healthcare network, medication allergy awareness/documentation, drug interactions, utilization of evidence-based clinical guidelines to reduce practice variations, tracking and trending adverse events/quality of care issues/quality of service issues, and grievances related to safety.

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

- Death or serious disability

- Delay or omission of care
- Medication issue
- Patient safety
- Post-op complications
- Procedural issue

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

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

EPSDT is a comprehensive and preventive child health program for Members under the age of 21. The EPSDT statute and Federal Medicaid regulations require that WellCare cover all services within the scope of the federal Medicaid program, including services not included in Nebraska's Medicaid State Plan, if necessary, to correct or ameliorate a known medical condition (42 U.S.C. 1396d(r)(5) and the CMS Medicaid State Manual, Part 5 EPSDT). The program consists of two mutually supportive, operational components: (1) ensuring the availability and accessibility of required healthcare services; and (2) helping Members and their parents or guardians effectively use these services. The intent of the EPSDT program is to direct attention to the importance of preventive health services and early detection and treatment of identified problems.

Members should have EPSDT visits on or before the following:

- Initial visit, pre-natal, newborn, within 3-5 days, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months and 30 months
- Annually from 3 years to age 21
- A complete history and physical examination within the first 90 days of joining WellCare

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

- **Comprehensive health and developmental history** including assessment of physical health, mental health (social, emotional and behavioral issues), development and nutrition.
- **Comprehensive unclothed physical exam** including height, weight, head circumference (newborn to age 30 months) and blood pressure risk assessment (annually starting at age 3).
- **Developmental Milestones** and, when needed, developmental screening and assessment using a recognized standardized developmental screening tool.
- **Appropriate immunizations** for age and health history, or documentation of immunizations when received elsewhere.
- **Laboratory tests** to be performed at the Provider's discretion, including newborn blood screening, congenital heart screening, tuberculosis screening, dyslipidemia screening, urinalysis, cervical cancer screening and sickle cell testing. Tests that are required or recommended are listed below:
 - **Lead test** (prior to age 12 months and 24 months)
 - **Hemoglobin and Hematocrit** testing is recommended at 12 months, and when a medical need is identified.
 - **Newborn blood screening**; newborn up to 2 months
 - **Congenital heart defect screening** is recommended at birth

- **Health education** including anticipatory guidance
- **Vision and hearing Screening** includes an age appropriate assessments; Medically Necessary and reasonable diagnosis and treatment for defects are covered
- **Oral Screening** is part of the physical examination. Children should be referred to a dentist for routine and periodic examination at least annually. For children age 1 and older, services are furnished by a dentist.
- **Referral** to WIC, family care management and other community agencies (as appropriate).
- **Diagnosis** to determine the nature or cause of a physical or mental disease or abnormality. A diagnosis enables a Provider to make a plan for treatment specific to the EPSDT participant's problems.
- **Treatment** includes health check follow-up services necessary to diagnose or treat a condition identified during an EPSDT health check screening exam.

Preventive Guidelines

Patient safety is also addressed through adherence to clinical guidelines that target preventable conditions. Preventive services include:

- Regular checkups for adults and children
- Prenatal care for pregnant women
- Well-baby care
- Immunizations for children, adolescents and adults
- Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, tests for sexually transmitted diseases, Pap smears and mammograms

Preventive guidelines address prevention and/or early detection interventions, and the recommended frequency and conditions under which interventions are required. Prevention activities are based on reasonable scientific evidence, best practices, and the Member's needs. Prevention activities are reviewed and approved by the Utilization Management Medical Advisory Committee (UMAC) with input from participating Providers and the Quality Assurance and Performance Improvement Committee (QAPIC). Activities include distribution of information, encouragement to utilize Screening tools and ongoing monitoring and measuring of outcomes. While WellCare can and does implement activities to identify interventions, the support and activities of families, friends, Providers and the community have a significant impact on prevention.

Clinical Practice Guidelines

WellCare adopts validated evidence-based Clinical Practice Guidelines and uses the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other Provider may supersede Clinical Practice Guidelines, the guidelines provide clinical staff and Providers with information about medical standards of care to assist in applying evidence from research in the care of both individual Members and populations. The Clinical Practice Guidelines are based on peer-reviewed medical evidence and are relevant to the population served. Approval of the Clinical Practice Guidelines occurs through the Quality Assurance and Performance Improvement Committee . Clinical Practice Guidelines, to include preventive health guidelines, may be found at www.wellcare.com/Nebraska/Providers/Clinical-Guidelines/CPGs.

Healthcare Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. The tool comprises 92 measures across six domains of care:

- Effectiveness of care
- Access/availability of care
- Experience of Care
- Utilization and risk adjusted utilization
- WellCare (health plan) descriptive information
- Measures collected using electronic clinical data systems

HEDIS is a mandatory process that occurs annually. It lets WellCare and Providers demonstrate the quality and consistency of care that is available to Members. Medical records and claims data are reviewed for capture of required data. Compliance with HEDIS standards is reported on an annual basis with results available to Providers upon request. Through compliance with HEDIS standards, Members benefit from the quality and effectiveness of care received and Providers benefit by delivering industry recognized standards of care to achieve optimal outcomes.

Web Resources

WellCare periodically updates clinical, coverage, and preventive guidelines as well as other resource documents posted on the WellCare website. Please check www.wellcare.com/Nebraska frequently for the latest news and updated documents.

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

Utilization Management

Overview

WellCare's Utilization Management (UM) program is designed to meet contractual requirements with federal regulations while providing Members access to high-quality, cost-effective Medically Necessary care. For purposes of this section, terms and definitions may be contained within this section, within *Section 12: Definitions* of this Handbook, or both.

The focus of the UM program is on:

- Evaluating requests for services by determining the Medical Necessity, efficiency, appropriateness and consistency with the Member's diagnosis and level of care required
- Providing access to medically appropriate, cost-effective healthcare services in a culturally sensitive manner and facilitating timely communication of clinical information among Providers
- Reducing overall expenditures by developing and implementing programs that encourage preventive healthcare behaviors and Member partnership
- Facilitating communication and partnerships among Members, families, Providers, delegated entities and WellCare in an effort to enhance cooperation and appropriate utilization of healthcare services
- Reviewing, revising and developing medical coverage policies to ensure Members have appropriate access to new and emerging technology
- Enhancing the coordination and minimizing barriers in the delivery of behavioral and medical healthcare services

Medically Necessary Services

The determination of whether a covered benefit or service is Medically Necessary complies with the requirements established in Nebraska Administrative Code 471 NAC 1-002.02A, as amended, within the Nebraska Contract.

To be Medically Necessary or a Medical Necessity, a covered benefit shall meet the following conditions:

- Be appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the Member; and to meet the needs of the Member
- Be provided for the diagnosis or direct care and treatment of the Member's condition enabling the Member to make reasonable progress in treatment
- Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or healthcare coverage organization or governmental agencies
- Within the standards of professional practice and given at the appropriate time and in the appropriate setting in a cost-efficient manner
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency, and of demonstrated value
- The most appropriate level of Covered Services, which can safely be provided
- Be furnished in a manner not primarily intended for the convenience of the recipient, the

recipient's caretaker or the Provider

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

The fact that a Provider has prescribed, recommended or approved medical or behavioral care, goods or services does not, in itself, make such care, goods or services Medically Necessary or a Medical Necessity or a Covered Service.

In accordance with the Nebraska Contract, each Medically Necessary service must be sufficient in amount, duration and scope to reasonably achieve its purpose.

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

WellCare does not reward its associates or any practitioners, Providers or other individuals or entities performing UM activities for issuing denials of coverage, services or care. WellCare does not provide financial incentives to encourage or promote underutilization.

Criteria for UM Decisions

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

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

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

The clinical reviewer and/or medical director involved in the UM process apply Medical Necessity criteria in context with the Member’s individual circumstance and the capacity of the local Provider delivery system. When the above criteria do not address the individual Member’s

needs or unique circumstance, the medical director will use clinical judgment in making the determination.

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

Utilization Management Process

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

- Notifications
- Referrals
- Prior authorizations
- Concurrent review
- Retrospective review

Decision and notification time frames are determined by either National Committee for Quality Assurance (NCQA®) requirements, contractual requirements or a combination of both.

WellCare forms for the submission of notifications and authorization requests can be found at www.wellcare.com/Nebraska/Providers/Medicaid/Forms.

Notification

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

- Prenatal services. This helps WellCare identify pregnant Members for inclusion into the care coordination program for pregnant Members. OB Providers are required to notify WellCare of pregnancies via fax using the *Prenatal Notification Form* as soon as possible after the initial visit. This process will expedite case management and claims reimbursement.
- A Member's admission to a hospital. This lets WellCare log the hospital admission and follow up with the facility on the next business day to receive clinical information. The notification should be received by via WellCare Portal, fax or telephone and include Member demographics, facility name and admitting diagnosis.
- Failure to notify WellCare of a facility admission within 24 hours may result in an administrative denial. This includes, but is not limited to, Inpatient Admissions (Acute Care Hospital or Critical Access Hospital), Observation Stays, Behavioral Health Facilities, Long Term Acute Care Hospitals, Inpatient Rehabilitation Facilities or Skilled Nursing Facilities.

Referrals

For an initial referral, WellCare does not require authorization as a condition of payment. Certain diagnostic tests and procedures considered by WellCare to be routinely part of an office visit may be conducted as part of the initial visit without an authorization.

Prior Authorization

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

Reasons for requiring prior authorization may include:

- Review for Medical Necessity
- Appropriateness of rendering Provider
- Appropriateness of setting
- Care and disease management considerations

Prior authorization is **required** for select elective or non-emergency services as designated by WellCare, or Nebraska MLTC. Guidelines for prior authorization requirements by service type may be found in the *Quick Reference Guide* at www.wellcare.com/Nebraska/Providers/Medicaid or by calling WellCare Provider Services at the phone number listed on the bottom of this page.

Some prior authorization guidelines to note are:

- The prior authorization request should include the diagnosis to be treated and the CPT® Code describing the anticipated procedure. If the procedure performed and billed is different from that on the request, but within the same family of services, a revised authorization is not required.
- An authorization may be given for a series of visits or services related to an episode of care. The authorization request should outline the plan of care including the frequency and total number of visits requested and the expected duration of care.
- Failure to obtain prior authorization, when indicated, is grounds for an administrative denial.

The attending physician or designee is responsible for obtaining the prior authorization of the elective or nonurgent admission. Refer to the *Quick Reference Guide*, which may be found at www.wellcare.com/Nebraska/Providers/Medicaid for a list of services requiring prior authorization.

Concurrent Review

Concurrent review activities involve the evaluation of a continued hospital, Long-Term Acute Care (LTAC) hospital, skilled nursing or acute rehabilitation stay for medical appropriateness, utilizing appropriate criteria. The concurrent review nurse follows the clinical status of the Member through telephonic or on-site chart review and communication with the attending physician, hospital UM, care management staff or hospital clinical staff involved in the Member's care.

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

- Ensure that services are provided in a timely and efficient manner
- Make certain that established standards of quality care are met
- Implement timely and efficient transfer to lower level of care when clinically indicated and appropriate
- Complete timely and effective discharge planning
- Identify cases appropriate for care management

The concurrent review process incorporates the use of Milliman Clinical Guidelines (MCG) criteria to assess quality and appropriate level of care for continued medical treatment. If at any time Medical Necessity is no longer met for the prior approved level of care, subsequent hospital days may no longer be covered/reimbursed. Reviews are performed by licensed nurses under the direction of the WellCare medical director.

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

Discharge Planning

Discharge planning begins upon admission and is designed for early identification of medical and/or psychosocial issues that will need post-hospital intervention. The concurrent review nurse works with the attending physician, hospital discharge planner, ancillary Providers and/or community resources to coordinate care and post-discharge services to facilitate a smooth transfer of the Member to the appropriate level of care. An inpatient review nurse may refer an inpatient Member with identified complex discharge needs to care management for follow-up needs.

Retrospective Review

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

- Retrospective review initiated by WellCare
 - WellCare requires periodic documentation including, but not limited to, the medical record (UB and/or itemized bill) to complete an audit of the Provider-submitted coding, treatment, clinical outcome and diagnosis relative to a submitted claim. On request, medical records should be submitted to WellCare to support accurate coding and claims submission.
- Retrospective review initiated by Providers

WellCare will review post-service requests for authorization of inpatient admissions or outpatient services only if, at the time of treatment, the Member was not eligible, but became eligible with WellCare retroactively or in cases of emergency treatment and the payer is not known at the time of service. The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions, and taking into account the Member's needs at the time of service. WellCare will also identify quality issues, utilization issues and the rationale behind failure to follow WellCare's Prior Authorization/pre-certification guidelines.

WellCare will give a written notification to the requesting Provider and Member within 30 calendar days of receipt of a request for a UM determination. If WellCare cannot decide because of matters beyond its control, WellCare may extend the decision time frame once, for up to 14 calendar days of the post-service request.

The Member or Provider may request a copy of the criteria used for a specific determination of Medical Necessity by contacting the Utilization Management Department via Provider Services. Refer to the *Quick Reference Guide*, which may be found at www.wellcare.com/Nebraska/Providers/Medicaid.

Peer-to-Peer Reconsideration of Adverse Determination

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

The review determination notification contains instructions on how to use the peer-to-peer reconsideration process.

Services Requiring No Authorization

WellCare has determined that many routine procedures and diagnostic tests are allowable without medical review to facilitate timely and effective treatment of Members including:

- Certain diagnostic tests and procedures considered by WellCare to routinely be part of an office visit, and plain film X-rays
- Clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories and physician offices under a Clinical Laboratory Improvements Amendments (CLIA) waiver do not require prior authorization. There are exceptions to this rule for specialty laboratory tests that require authorization regardless of place of service:
 1. Reproductive laboratory tests
 2. Molecular laboratory tests
 3. Cytogenetic laboratory tests
- Certain tests described as CLIA-waived may be conducted in the physician's office if the Provider is authorized through the appropriate CLIA certificate, a copy of which must be submitted to WellCare.

All services performed without prior authorization are subject to retrospective review by WellCare.

WellCare Proposed Actions

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

- The action WellCare has taken or intends to take
- The reason(s) for the action
- The Member's right to receive, on request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's claim for benefits. Such information includes Medical Necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits.
- The Member's right to appeal, and the process to do so
- The Member's right to request a state hearing or external review
- Procedures for exercising the Member's rights to appeal or file a grievance
- Circumstances under which expedited resolution is available and how to request it
- The Member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services

Second Medical Opinion

A second medical opinion may be requested in any situation where there is a question related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. A second opinion may be requested by any member of the healthcare team, a Member, parent(s) and/or guardian(s) or a social worker exercising a custodial responsibility.

The second opinion must be provided at no cost to the member by a qualified healthcare professional within network, or a non-participating provider if there is not a participating Provider with the expertise required for the condition.

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

Individuals with Special Healthcare Needs

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

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

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

Service Authorization Decisions

Type of Request	Decision	Extension
Standard Pre-Service	14 calendar days	14 calendar days
Expedited Pre-Service	72 hours	14 calendar days

Type of Request	Decision	Extension
Urgent Concurrent	24 hours	48 hours
Post-Service	30 calendar days	14 calendar days

Standard Service Authorization

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

Expedited Service Authorization

In the event the Provider indicates, or WellCare determines, that following the standard time frame could seriously jeopardize the Member's life or health, WellCare will make an expedited authorization determination and provide notice within 72 hours of the request. An extension may be granted for 14 more calendar days if the Member or the Provider asks for an extension, or if WellCare justifies a need for more information and the extension is in the Member's best interest. **Requests for expedited decisions for prior authorization should be requested by telephone**, not fax or WellCare's secure, online provider portal. Please refer to the *Quick Reference Guide* to contact the UM Department via Provider Services, which may be found at www.wellcare.com/Nebraska/Providers/Medicaid.

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

Urgent Concurrent Authorization

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

Emergency/Urgent Care and Post-Stabilization Services

Emergency services are not subject to prior authorization requirements and are available to Members 24 hours a day, 7 days a week. Urgent care services should be provided within one day and are also not subject to prior authorization requirements. See *Section 12: Definitions* for definitions of "emergency" and "urgent".

Post-stabilization services are services related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or improve, or resolve the Member's condition. WellCare requires authorization for services that require a prior authorization for post-stabilization services. Failure to notify WellCare of post-stabilization services within 24 hours is grounds for an administrative denial.

Continuity of Care

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

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

For continued care under this provision, WellCare and the terminated Provider shall continue to abide by the same terms and conditions as existed in the terminated contract.

Transition of Care

Transition Period-Out of Network Care:

During a Member's first 120 days of enrollment with Wellcare, with the exception of residential services and certain services rendered to dual diagnosis populations, WellCare shall allow a Member who is receiving Covered Benefits from a non-network Provider to continue accessing that Provider, even if the network has been closed due to WellCare meeting the network access requirements.

WellCare can establish single-case agreements or otherwise authorize non-network care past the initial 120 days to provide continuity of care for Members receiving active treatment with an out-of network provider.

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

Transitions during Inpatient Stays:

WellCare shall provide care coordination after the Member has disenrolled from WellCare whenever the Member disenrollment occurs during an inpatient stay.

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

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

When Member disenrollment to another program contractor occurs during an inpatient stay, WellCare shall notify the new program contractor of the inpatient status of the Member, if known to WellCare. WellCare shall also notify the inpatient hospital of the change in program contractor enrollment, but advise the hospital that WellCare maintains financial responsibility, and that the receiving plan will be responsible for any discharge planning the Member would need.

Authorization Request Forms

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

- *Inpatient Authorization Request Form* is used for services such as planned elective/non-urgent inpatient, observation, and skilled nursing facility and inpatient rehabilitation authorizations

- *Outpatient Authorization Request Form* is used for services such as follow-up consultations, consultations with treatment, diagnostic testing, office procedures, ambulatory surgery, radiation therapy, out-of-network services, and dialysis
- *DME Authorization Request Form* is used for services such as durable medical equipment (DME).
- *Home Health Services Request Form* is used for home care services, and outpatient therapies including physical therapy (PT), occupational therapy (OT), and speech therapy (ST).

All Authorization Request forms for non-urgent/elective ancillary services should be submitted via fax to the number listed on the form.

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

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

These forms among others can be found at

www.wellcare.com/Nebraska/Providers/Medicaid/Forms.

If prior authorization is not granted, all associated claims will not be paid. See WellCare's *Clinical Coverage Guidelines* at www.wellcare.com/Nebraska/Providers/Clinical-Guidelines/CCGs for more information.

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

All forms can be found at

www.wellcare.com/Nebraska/Providers/Medicaid/Forms. All forms should be submitted via fax to the number on the form.

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

Special Requirements for Payment of Services

The following services have special requirements from the State of Nebraska.

Sterilizations

Prior authorization is not required for sterilization procedures. However, WellCare will deny any Provider claims submitted without the required consent form or with an incomplete or inaccurate consent form. Documentation meant to satisfy informed consent requirements, which has been completed or altered after the service was performed, will not be accepted.

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

- Is under 21 years of age at the time he/she signs the consent

- Is not mentally competent
- Is institutionalized in a correctional facility, mental hospital or other rehabilitation facility

The required *MMS-100 Sterilization Consent Form (Tubal Ligation and Vasectomy)* must be completed and submitted to WellCare.

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

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

An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since s/he signed the informed consent for the sterilization. For a premature delivery, the Member must have signed the informed consent at least 72 hours before the surgery is performed and at least 30 days before the expected date of delivery; the expected delivery date must be entered on Form MMS-100.

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

Hysterectomy

Prior authorization is required for the administration of a hysterectomy to validate Medical Necessity. WellCare reimburses Providers for hysterectomy procedures only when the following requirements are met:

- The Provider ensured that the individual was informed, verbally and in writing, prior to the hysterectomy that she would be permanently incapable of reproducing
- Prior to the hysterectomy, the Member/individual and the attending physician must sign and date MMS-101 "Informed Consent Form"
- In the case of prior sterility or emergency hysterectomy, a Member is not required to sign the consent form if the physician who performs the hysterectomy certifies in writing that the individual was already sterile before the hysterectomy and states the cause of the sterility.
- The informed consent form is not required if the individual requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible, and the physician who performs the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which s/he determined prior acknowledgement was not possible. The physician must also include certification of the emergency.

WellCare will not cover a hysterectomy if

- It was performed solely to make the woman sterile
- If there was more than one purpose for the procedure, it would not have been performed except to make the woman sterile.

WellCare will deny payment on any claim(s) submitted without the required documentation or with incomplete or inaccurate documentation. WellCare does not accept documentation meant

to satisfy informed consent requirements that has been completed or altered after the service was performed.

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

All forms are at www.wellcare.com/Nebraska/Providers/Medicaid/Forms.

Abortions

All requests for abortion services must be approved in writing by both WellCare of Nebraska's medical director and the MLTC medical director before performed to ensure compliance with federal and state regulations.

Abortions will be provided in accordance with 42 CFR 441.202 and Consolidated Appropriations Act of 2008, as amended, which require that abortions are covered only in instances where pregnancy is the result of either:

- Rape or incest
- In cases where the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

For abortion services performed, a physician must certify in his/her writing that, on the basis of his/her professional judgement, the life of the pregnant woman would be endangered if the fetus were carried to term. The Provider must attach the certification statement to the claim form that must be retained by WellCare. This certification statement must contain the diagnosis or medical condition that makes the pregnancy life endangering.

All forms are at www.wellcare.com/Nebraska/Providers/Medicaid/Forms.

Care Management Program

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

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

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

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

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

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

- **Clinical Assessment and Evaluation** – A comprehensive assessment of the Member is completed to determine where he or she is in the health continuum. This assessment gauges the Member's support systems and resources and seeks to align the Member with appropriate clinical needs.
- **Care Planning** – Collaboration with the Member and/or caregiver, the PCP and other Providers involved in the Member's care to identify the best way to fill any identified gaps or barriers to improve access and adherence to the Provider's plan of care.
- **Service Facilitation and Coordination** – Working with community resources to facilitate Member adherence with the plan of care. Activities may be as simple as reviewing the plan with the Member and/or caregiver or as complex as arranging services, transportation and follow-up. Behavioral health services are coordinated with the regional Community Mental Health Center (CMHC).
- **Member Advocacy** – Advocating on behalf of the Member within the complex labyrinth of the healthcare system. Care Managers assist Members with seeking services to optimize their health. Care Management emphasizes continuity of care for Members through the coordination of care among physicians, CMHCs, HCBS Care Managers and other Providers.
- Members commonly identified for WellCare's Care Management program include those with:
 - **Catastrophic Injuries** – Traumatic injuries, i.e., amputations, blunt trauma, spinal cord injuries, head injuries, burns and multiple traumas.
 - **Multiple Chronic Conditions** – Multiple comorbidities such as diabetes, chronic obstructive pulmonary disease (COPD) and hypertension, or multiple intricate barriers to quality healthcare, i.e., Acquired Immune Deficiency Syndrome (AIDS).
 - **Transplantation** – Organ failure, donor matching, post-transplant follow-up.
 - **Complex Discharge Needs** – Members discharged home from acute inpatient or skilled nursing facilities (SNF) with multiple service and coordination needs (i.e., DME, PT/OT, home health); complicated, non-healing wounds, advanced illness, etc.
 - **Special Healthcare Needs** – Children or adults who have serious medical or chronic conditions with severe chronic illnesses, physical, mental and developmental disabilities.

Disease Management Program

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

The Disease Management Program targets the following conditions:

- Asthma – adult and pediatric
- Coronary artery disease (CAD)
- Congestive heart failure (CHF)
- COPD
- Diabetes – adult and pediatric
- Hypertension
- Smoking Cessation

WellCare's Disease Management Program educates Members and their caregivers regarding the standards of care for chronic conditions, triggers to avoid and appropriate medication management. The program also focuses on educating the Provider with regards to the standards of specific disease states and current treatment recommendations. Intervention and education can improve the quality of life of Members, improve health outcomes and decrease medical costs. In addition, WellCare makes available to Providers and Members general information regarding health conditions at www.wellcare.com/Nebraska.

Candidates for Disease Management

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

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

Disease-specific *Clinical Practice Guidelines* adopted by WellCare may be found at www.wellcare.com/Nebraska/Providers/Clinical-Guidelines/CPGs.

Access to Care and Disease Management Programs

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

For more information on the Care Management referral line, refer to the *Quick Reference Guide* at www.wellcare.com/Nebraska/Providers/Medicaid.

Care and Disease Management Referrals

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

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

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

Delegated Entities

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

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

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

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

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

Section 5: Claims

Overview

The focus of WellCare's Claims Department is to process claims in a timely manner. WellCare has toll-free telephone numbers for Providers to access a representative in its Provider Services Department. For more information, refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Nebraska/Providers/Medicaid.

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

The claims submission address, telephone numbers for contacting Provider Services, how to file a claims dispute, and authorization information are located in the *Quick Reference Guide* at www.wellcare.com/Nebraska/Providers/Medicaid.

More information regarding reimbursement policies and *Claims Companion Guides* are at www.wellcare.com/Nebraska/Providers/Medicaid/Claims.

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

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

Once registered, this no-cost secure service offers Providers options for viewing and receiving remittance details. ERAs can be imported directly into practice management or patient accounting system, eliminating the need to rekey remittance data.

Multiple practices and accounts are supported. Providers can reuse enrollment information to connect with multiple payers. Different payers can be assigned to different bank accounts.

Providers will not receive paper Explanation of Payments (EOPs). EOPs can be viewed and/or downloaded and printed from PaySpan's website once registration is completed.

Providers can register using PaySpan's enhanced Provider registration process at payspan.com. Providers can also view PaySpan's webinar anytime at payspan.webex.com. PaySpan Health Support can be reached via email at providersupport@payspanhealth.com, by phone at **1-877-331-7154** or on the Web at payspanhealth.com.

Timely Claims Submission

Unless otherwise stated in the Provider Agreement, Provider must submit claims (initial, corrected and voided) within 180 days from the date of service. For Continuation of Benefit (COB) claims, a claim must be filed within 365 days from the service date even if Third Party Resources (TPR) are outstanding. (Nebraska Provider Information-Provider Bulletin 16-06 and 471 NAC 3.002.01, as amended). Unless prohibited by federal law or the Centers for Medicare & Medicaid Services (CMS), WellCare may deny or reject payment for any claims that fail to meet WellCare's submission requirements for Clean Claims (as defined in the Definition

section) or that are received after the time limit in the Provider Agreement for filing Clean Claims.

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

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

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

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

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

WellCare requires the payer-issued Tax ID number and NPI on all claims submissions.

WellCare will reject claims without the Tax ID number and NPI, with the exception of atypical Providers. Atypical Providers must preregister with WellCare before submitting claims to avoid NPI rejections. More information on NPI requirements, including HIPAA's NPI Final Rule Administrative Simplification, is available at www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html.

Taxonomy

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

ZIP Code

Providers must submit claims with the correct nine-digit ZIP code consistent with Provider's service location, specialty and services being rendered for appropriate adjudication. WellCare may reject the claim if the ZIP code is incomplete or the +4 zip code extension is omitted.

Pre-Authorization number

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

National Drug Codes (NDC)

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

Strategic National Implementation Process (SNIP)

All claims and encounter transactions submitted via paper, direct data entry (DDE) or electronically will be validated for transaction integrity/syntax based on the SNIP level V guidelines. Claims with invalid NDC codes will be rejected. If there are any State-specific front-end edits, WellCare of Nebraska will also incorporate these edit modifications as well, including both removal and/or addition of certain edits.

If a claim is rejected for lack of compliance with WellCare's claim and encounter submission requirements, the rejected claim should be resubmitted within timely filing limits.

Claims Submission Requirements

WellCare requires all participating hospitals to properly code all relevant diagnoses and surgical and obstetrical procedures on all inpatient and outpatient claims submitted. WellCare requires all diagnosis coding to be ICD-10-CM, or its successor, as mandated by CMS. *Refer to Compliance section for additional information.* Also, the CPT-4 coding and/or Healthcare Common Procedure Coding System (HCPCS) is required for all outpatient surgical, obstetrical, injectable drugs, diagnostic laboratory and radiology procedures. When coding, the Provider must select the code(s) that most closely describe(s) the diagnosis (es) and procedure(s) performed. When a single code is available for reporting multiple tests or procedures, that code must be utilized rather than reporting the tests or procedures individually.

WellCare tracks billing codes and Providers who continue to apply incorrect coding rules. Providers will be educated on the proper use of codes as part of the Retrospective Review process. Should a Provider continue to repeat the inappropriate coding practice, the Provider will be subject to an adverse action.

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

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

Providers using electronic submission shall submit all claims to WellCare or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 837 electronic format, or a CMS 1500 and/or CMS-1450 or their successors. Claims shall include the Provider's NPI, Tax ID, the valid Taxonomy code, and nine-digit ZIP code that most accurately describes the services reported on the claim. The Provider acknowledges and agrees that no reimbursement is due for a Covered Service and/or no claim is complete for a Covered Service unless performance of that Covered Service is fully and accurately documented in the Member's medical record before the initial submission of any claim. The Provider also acknowledges and agrees that at no time shall Members be responsible for any payments to the Provider with the exception of Member expenses and/or Non-Covered Services. Providers should be familiar with Nebraska regulations which prohibit billing the Medicaid Member (471 NAC 3-002.11). WellCare does not permit Providers to charge Members administrative fees, such as no-show fees. For more information on paper submission of claims, refer to the *Quick Reference Guide* at www.wellcare.com/Nebraska/Providers/Medicaid.

For more information on Covered Services under WellCare's Medicaid plan, go to www.wellcare.com/Nebraska/Members/Medicaid-Plans/WellCare-of-Nebraska.

For more information on claims submission requirements, refer to the Nebraska Contract.

Electronic Claims Submissions

WellCare accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to WellCare must be in the ANSI ASC X12N format, version 5010A or its successor. For more information on EDI implementation with

WellCare, refer to the *WellCare Companion Guides* at www.wellcare.com/Nebraska/Providers/Medicaid/Claims.

Most clearinghouses can exchange data with one another, so Providers should work with their existing clearinghouse or a WellCare contracted clearinghouse to establish EDI with WellCare. For a list of WellCare-contracted clearinghouse(s), for information on the unique WellCare Payer Identification (Payer ID) numbers used to identify WellCare on electronic claims submissions, or to contact WellCare's EDI team, refer to the *Nebraska Medicaid Provider Resource Guide* at www.wellcare.com/Nebraska/Providers/Medicaid.

HIPAA Electronic Transactions and Code Sets

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

Specific WellCare requirements for claims and encounter transactions, code sets and SNIP validation are described as follows: *To promote consistency and efficiency for all claims and encounter submissions to WellCare, it is WellCare's policy that these requirements also apply to all paper and DDE transactions.*

For more information on EDI implementation with WellCare, refer to the *WellCare Companion Guides* at www.wellcare.com/Nebraska/Providers/Medicaid.

Paper Claims Submissions

For timelier processing of claims, Providers should submit electronically. Claims not submitted electronically may be subject to penalties as specified in the Provider Agreement. For help in creating an EDI process, contact WellCare's EDI team by referring to the *Quick Reference Guide* at www.wellcare.com/Nebraska/Providers/Medicaid.

If permitted under the Provider Agreement and until the Provider has the ability to submit electronically, paper claims (UB-04 and CMS-1500, or their successors) must contain the required elements and formatting described below:

1. Paper claims must only be submitted on an original (red ink on white paper) claim forms
 - Any missing, illegible, incomplete, or invalid information in any field will cause the claim to be rejected or processed incorrectly
2. Per CMS guidelines, the following process should be used for Clean Claims submission:
 - **The information must be aligned within the data fields and must be:**
 - On an original red ink on white paper claim form
 - Typed. Do not print, handwrite, or stamp any extraneous data on the form
 - In black ink
 - In large, dark font such as pica or arial 10-, 11- or 12-point type
 - In capital letters
 - **The typed information must not have:**
 - Broken characters
 - Script, italics or stylized font
 - Red ink
 - Mini font

- Dot matrix font

Claims Processing

Readmission

WellCare follows the State of Nebraska's 30-day readmission policy (471 NAC 10-010.03B11). WellCare may review hospital admissions on a specific Member if it appears that two or more admissions are related based on same or similar conditions. Based upon the claim review (including a review of medical records if requested from the Provider), WellCare will make all necessary adjustments to the claim, including recovery of payments that are not supported by the medical record. Providers who do not submit the requested medical records, or who do not remit the overpayment amount identified by WellCare, may be subject to a recoupment. WellCare may evaluate readmissions during concurrent review, pre-payment, or as part of the post-payment review process. If WellCare determines that the second admission was preventable or related to the index hospitalization, the claim for the second admission may be denied or recoupment may be pursued. For more information, providers should review the Claims Edit Guideline: Inpatient Readmission Policy available on the WellCare website.

Disclosure of Coding Edits

WellCare uses claims editing software programs to assist in determining proper coding for Provider claims payment. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule Database, the American Medical Association (AMA) and Specialty Society correct coding guidelines, and state-specific regulations. These software programs may result in claim edits for specific procedure code combinations. They may also result in adjustments to the Provider's claims payment or a request for review of medical records, prior to or subsequent to payment, that relate to the claim. Providers may request reconsideration of any adjustments produced by these claims editing software programs by submitting a timely request for reconsideration to WellCare. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a Non-Covered Service, and thus Providers must not bill or collect payment from Members for such reductions in payment.

Prompt Payment

WellCare of Nebraska will follow the state guidance on prompt payment of claims and will apply interest in conjunction with the state's corresponding interest rate for clean claims processed beyond 60 days.

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

WellCare shall coordinate payment for Covered Services in accordance with the terms of a Member's benefit plan, applicable state and federal laws, and CMS guidance. Providers shall bill primary insurers for items and services they provide to a Member before they submit claims for the same items or services to WellCare. Medicaid is the payer of last resort. Any balance due after receipt of payment from the primary payer should be submitted to WellCare for consideration and the claim must include information verifying the payment amount received from the primary plan as well as a copy of the primary payer's Explanation of Payment (EOP). The primary carrier's EOP should contain the name of the primary carrier, payment date, payment/denied amount, reason for denial (if applicable), billed charges and any remaining patient liability. WellCare uses the "lesser of" logic when processing COB claims. WellCare will pay the Member's coinsurance, deductibles, co-payments and other cost-sharing expenses up

to the allowed amount or, the difference between the primary payer's amount and WellCare's allowed amount, whichever is less. The Contractor's total liability **shall not exceed** the allowed amount minus the amount paid by the primary payer. WellCare defines the Medicaid allowable amount as the lessor of the contracted rate or the amount allowed by the primary payor. WellCare may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services to the extent permitted by applicable laws. Providers shall follow WellCare policies and procedures regarding subrogation activity.

Patient Liability/Cost-Sharing

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

Encounters Data

Overview

This section is intended to provide delegated vendors and Providers (IPAs) with the needed information to let them submit encounter data to WellCare. If encounter data does not meet the Service Level Agreements (SLAs) for timeliness of submission, completeness or accuracy, the Agency can impose significant financial sanctions on WellCare. WellCare requires all delegated vendors and delegated Providers to submit encounter data, even if they are reimbursed through a capitated arrangement.

Timely and Complete Encounters Submission

Unless otherwise stated in the Provider Agreement, delegated vendors and capitated Providers should submit complete and accurate encounter files to WellCare as follows:

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

Fines/Penalties

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

Accurate Encounters Submission

All encounter transactions submitted via DDE or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines as per the state requirements. SNIP Levels 1 through 5 shall be maintained. Once WellCare receives a delegated vendor or Provider encounter, the encounter is loaded into WellCare's encounters system and processed. The encounter is subjected to a series of SNIP editing to ensure that the encounter has all the required information and that the information is accurate.

For more information on submitting encounters electronically, refer to the *WellCare Companion Guides* at www.wellcare.com/Nebraska/Providers/Medicaid/Claims.

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

Encounters Submission Methods

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

Submitting Encounters Using WellCare's SFTP Process (*Preferred Method*)

WellCare accepts electronic claims submission through EDI as its preferred method of claims submission. Encounters may be submitted using WellCare's SFTP process. Refer to WellCare's ANSI ASC X12 837I, 837P and, 837D Health Care Claim/Encounter Institutional, Professional and Dental Guides for detailed instructions on how to submit encounters electronically using SFTP. For more information on EDI implementation with WellCare, please refer to www.wellcare.com/Nebraska/Providers/Medicaid/Claims/Electronic.

Submitting Encounters Using Direct Data Entry (DDE)

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

Encounters Data Types

There are three encounter types that vendors and Providers must submit encounter records to WellCare. Encounter records should be submitted using the HIPAA standard transactions for the appropriate Service type. The three encounter types are:

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

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

Encounters submitted to WellCare from a delegated vendor or Provider can be a new, voided or a replaced/overlaid encounter. The definitions of the types of encounters are as follows:

- New encounter – An encounter that has never been submitted to WellCare previously

- Voided encounter – An encounter that WellCare deletes from the encounter file and is not submitted to the state
- Replaced or overlaid encounter – An encounter that is updated or corrected within the WellCare system

Balance Billing

Providers shall accept payment from WellCare for Covered Services provided to WellCare Members in accordance with the reimbursement terms outlined in the Provider Agreement. Payment made to Providers constitutes payment in full by WellCare for Covered Benefits, with the exception of Member expenses. For Covered Services, Providers shall not balance bill Members any amount in excess of the contracted amount in the Provider Agreement. An adjustment in payment as a result of WellCare's claims policies and/or procedures does not indicate that the Service provided is a Non-Covered Service, and Members are to be held harmless for Covered Services. For more information on balance billing, refer to the Nebraska Contract. Additionally, Providers shall not charge WellCare Members for missed appointments.

Provider-Preventable Conditions

WellCare follows CMS guidelines regarding Hospital Acquired Conditions, Never Events, and other Provider-Preventable Conditions (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 at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html and include such events as an air embolism, falls and catheter-associated urinary tract infection.

Providers may not bill, try 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.

Hold Harmless Dual-Eligible Members

Those dual-eligible Members whose Medicare Part A and B Member expenses are identified and paid for at the amounts provided for by Nebraska Medicaid shall not be billed for such Medicare Part A and B Member Expenses, regardless of whether the amount a Provider receives is less than the allowed Medicare amount or Provider charges are reduced due to limitations on additional reimbursement provided by Nebraska Medicaid. Providers shall accept WellCare's payment as payment in full.

Multiple Claims Errors

When a claim error is reported, WellCare provider services team looks for multiple impacted claims based on the type of error, or the Provider may inform us they believe multiple claims may be impacted. Provider's services would run an impact report based on the error to identify if other claims were impacted.

- Systematic claim error is identified:
 - Agents review other claims that could be impacted within this same time frame.

- If multiple claims are identified as an impact, these calls/inquiry are escalated to the Provider Escalation (PE) Team for complete resolution.
- Provider Escalation Agent runs an impact report utilizing specific Provider information.
- All impact claims are reviewed for possible adjustment or reviewed to ensure the correction will take place systematically.
- If system issue is already fixed & under 20 Claims were identified.
 - Provider Escalation Agent adjusts all impacted Claims.
- If system issue is not yet fixed & / or 20+ Claims are impacted.
 - Provider Escalation Agent forwards the Claims to appropriate area/department for corrections.
- Provider is contacted throughout the process for updates.
- Resolution is Provided via phone call.

Claims Disputes

The claims dispute process is designed to address claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Claim payment disputes must be submitted to WellCare in writing within 90 days of the date of denial of the Explanation of Payment (EOP).

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

To start the process, Providers may mail to the address listed in the *Quick Reference Guide* at www.wellcare.com/Nebraska/Providers/Medicaid.

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

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

Corrected or Voided Claims

Corrected and/or Voided Claims are subject to Timely Claims Submission (i.e., Timely Filing) guidelines.

How to submit a Corrected or Voided Claim electronically:

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

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

To submit a Corrected or Voided Claim via paper:

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

Example:

Box 4 – Type of Bill: the third character represents the “frequency code”

3a PAT. CNTL. #		4 TYPE OF BILL	
5 MED. REC. #		117	
6 STATEMENT COVERS PERIOD FROM		7 THROUGH	
8 FED. TAX NO.			

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

64 DOCUMENT CONTROL NUMBER
298370064

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

Example:

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
7 OR 8	123456789012A33456

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

Please Note: If the Provider handwrites, stamps or types “Corrected Claim” on the claim form without entering the appropriate Frequency Code (7 or 8) along with the Original Reference Number as indicated above, the claim will be considered a first-time claim submission.

The correction or void process involves two transactions:

- The original claim will be negated – paid or zero payment (zero net amount due to a co-pay, coinsurance or deductible) – and noted “*Payment lost/voided/missed.*” This process will deduct the payment for this claim, or zero net amount if applicable.
- The corrected or voided claim will be processed with the newly submitted information and noted “*adjusted per corrected bill.*” This process will pay out the newly calculated amount on this corrected or voided claim with a new claim number.

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

Reimbursement

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

Non-Participating Provider Reimbursement

All services rendered by non-participating providers and facilities require authorization with the exception of family planning education and counseling, in-office visits for family planning,

childhood immunization administration, and emergency transportation and services. Non-participating providers are reimbursed at not more than 90% of the Medicaid rate in effect on the date of service.

Surgical Payments

Reimbursement to the surgeon for surgical services includes charges for preoperative evaluation and care, surgical procedures, and postoperative care. The following claims payment policies apply to surgical services:

- **Incidental Surgeries/Complications** – A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for extra payment. Any complicated procedure that warrants consideration for extra payment should be identified with an operative report and the appropriate modifier. A determination will be made by a WellCare medical director on whether the proposed complication merits additional compensation above the usual allowable amount.
- **Admission Examination** – One charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.
- **Follow-up Surgery Charges** – Charges for follow-up surgery visits are considered to be included in the surgical service charge and are not reimbursed separately. Follow-up days included in the global surgical period vary by procedure and are based on CMS policy.

Multiple Surgical Procedures

Payment for multiple surgical procedures is based on:

- 100% of maximum allowable fee for primary surgical procedure
- 50% of maximum allowable fee for secondary surgical procedure
- 25% of maximum allowable fee for all other surgical procedures

The percentages apply when:

- Eligible multiple surgical procedures are performed under one continuous medical service; or
- When multiple surgical procedures are performed on the same day and by the same surgeon.

Assistant Surgeon

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

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

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

Co-surgeon

Each Provider will be paid 60% of the maximum allowable fee for the procedure code. In these cases, each surgeon should report his/her distinct operative work, by adding the appropriate modifier to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier '62' added.

For more information, refer to the Nebraska Medicaid policy manuals at dhhs.ne.gov/Pages/Medicaid-Provider-Bulletins.aspx.

Allied Health Providers

If there are no reimbursement guidelines on the Nebraska Medicaid website specific to payment for non-physician practitioners or Allied Health Professionals, WellCare follows CMS reimbursement guidelines regarding Allied Health Professionals.

Overpayment Recovery

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

WellCare will proactively identify and attempt to correct inappropriate payments. In situations where the inappropriate payment caused an overpayment, WellCare will adhere to Neb. Rev. Stat. Ann. § 68-974 and limit its notice of retroactive denial to 24 months from the last payment date. WellCare must seek recovery within 60 calendar days after the end of the month it learns of the existence of a liable third party after a claim is paid and will subrogate cases when claims in the aggregate equal or exceed \$250. However, no such time limit shall apply to overpayment recovery efforts, which are based on a reasonable belief of fraud or other intentional misconduct, or abusive billing, required by, or initiated at the request of, a self-insured plan, or required by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or Members.

In all cases, WellCare, or its designee, will provide a written notice to the Provider explaining the overpayment reason and amount, contact information and instructions on how to send the refund. If the overpayment results from coordination of benefits, the written notice will specify the name of the carrier and coverage period for the Member. The notice will also provide the carrier address WellCare has on file but recognizes that the Provider may use the carrier address it has on file. The standard request notification provides 45 days for the Provider to send in the refund or contact WellCare, or its designee, for further information or to dispute the overpayment.

Failure of the Provider to respond within the above timeframe will constitute acceptance of the terms in the letter and will result in offsets to future payments. The Provider will receive an EOP indicating if the balance has been satisfied. In situations where the overpaid balance has aged more than three months and no refund has been received, the Provider may be contacted by WellCare, or its designee, to arrange payment.

If the Provider independently identifies an overpayment, WellCare requires the Provider to: 1) report that an overpayment has been received; 2) return the overpayment within 60 calendar days of the date the overpayment was identified; and 3) notify WellCare in writing as to the reason for the overpayment to:

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

For more information on contacting Provider Services, refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Nebraska/Providers/Medicaid.

Benefits During Disaster and Catastrophic Events

Refer to Provider Contract.

Section 6: Credentialing

Overview

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

This review includes (as applicable to practitioner type):

- Background
- Education
- Postgraduate training
- Certification(s)
- Experience
- Work history and demonstrated ability
- Patient admitting capabilities
- Licensure, regulatory compliance and health status which may affect a practitioner's ability to provide healthcare
- Accreditation status, as applicable to non-individuals

Practitioners are required to be credentialed prior to being listed as participating network Providers of care or providing services to WellCare Members. WellCare will only register a participating Provider with MLTC after a background screening has been completed.

The Credentialing Department, or its designee, is responsible for gathering all relevant information and documentation through a formal application process. The practitioner credentialing application must be attested to by the applicant as being correct and complete. The application captures professional credentials and contains a questionnaire section that asks for information regarding professional liability claims history and suspension or restriction of hospital privileges, criminal history, licensure, Drug Enforcement Administration (DEA) certification or Medicare/Medicaid sanctions.

Please take note of the following credentialing process highlights:

- Primary source verifications are obtained in accordance with state and federal regulatory agencies, accreditation and WellCare policy and procedure requirements, and include a query to the National Practitioner Data Bank.
- Physician/Providers, allied health professionals and ancillary facilities/healthcare delivery organizations are required to be credentialed in order to be network Providers of services to WellCare Members.
- Satisfactory site inspection evaluations are required to be performed in accordance with state, federal, and accreditation requirements.
- After the credentialing process has been completed, a timely notification of the credentialing decision is forwarded to the Provider.

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

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

WellCare ensures initial credentialing and re-credentialing applications for all provider types are processed within 30 days of a completed application and documentation of required verifications.

Practitioner Rights

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

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

Written requests for information may be emailed to credentialinginquiries@wellcare.com. Upon receipt of a written request, WellCare will provide written information to the practitioner on the status of the credentialing/re-credentialing application, generally within 15 business days. The information provided will advise of any items pending verification, needing to be verified, any non-response in obtaining verifications and any discrepancies in verification information received compared with the information provided by the practitioner.

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

The practitioner may review documentation submitted by him/her in support of the application/re-credentialing application, together with any discrepant information received from professional liability insurance carriers, state licensing agencies and certification boards, subject to any WellCare restrictions. WellCare or its designee will review the corrected information and explanation at the time of considering the practitioner's credentials for Provider network participation or re-credentialing.

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

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

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

WellCare's written notification to the practitioner includes:

- The nature of the discrepant information
- The process for correcting the erroneous information submitted by another source
- The format for submitting corrections

- The time frame for submitting the corrections
- The addressee in Credentialing to whom corrections must be sent
- WellCare's documentation process for receiving the correction information from the Provider
- WellCare's review process

Baseline Criteria

Baseline criteria for practitioners to qualify for Provider network participation:

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

Drug Enforcement Administration Certificate – Practitioners must have a current, valid DEA Certificate (as applicable to practitioner specialty), and if applicable to the state where services are performed, hold a current CDS or CSR certificate (applicable for MD/DO/DPM/DDS/DMD).

Work History – Practitioners must provide a minimum of five years' relevant work history as a health professional.

Board Certification – Physicians (M.D., D.O., D.P.M.) must maintain Board Certification in the specialty being practiced as a Provider for WellCare or must have verifiable educational/training from an accredited training program in the specialty requested.

Hospital-Admitting Privileges – Specialist practitioners shall have hospital-admitting privileges at a WellCare-participating hospital (as applicable to specialty). PCPs may have hospital-admitting privileges or may enter into a formal agreement with another WellCare-participating Provider who has admitting privileges at a WellCare-participating hospital for the admission of Members.

Ability to Participate in Medicaid and Medicare – Providers must have the ability to participate in Medicaid and Medicare. Any individual or entity excluded from participation in any government program is not eligible for participation in any WellCare Company Plan. Providers are not eligible for participation if such Provider owes money to the Medicaid Program or if the Office of the Attorney General has an active fraud investigation involving the Provider. Existing Providers who are sanctioned and thereby restricted from participation in any government program are subject to immediate termination in accordance with WellCare policy and procedure.

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

Providers who Opt Out of Medicare – A Provider who opts out of Medicare is not eligible to become a participating Provider. An existing Provider who opts out of Medicare is not eligible to remain as a participating Provider for WellCare. At the time of initial credentialing, WellCare reviews the state-specific opt-out listing maintained on the designated state carrier's website to determine whether a Provider has opted out of Medicare. Ongoing/quarterly monitoring of the opt-out website is performed by WellCare.

Liability Insurance

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

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

Site Inspection Evaluation (SIE)

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

- Office-site criteria
 - Physical accessibility
 - Physical appearance
 - Adequacy of waiting room and examination room space
- Medical/treatment record-keeping criteria

SIEs are conducted for:

- Unaccredited facilities without a State or CMS SIE to provide
- When a complaint is received relative to office site criteria

In those states where initial SIEs are not required for credentialing, there is ongoing monitoring of Member complaints. SIEs are conducted for those sites where a complaint is received relative to office site criteria listed above. SIEs may be performed for an individual complaint or quality of care concern if the severity of the issue is determined to warrant an onsite review.

Covering Physician/Providers

Primary Care Physician/Providers in solo practice must have a covering Physician/Provider who also participates with or is credentialed with WellCare.

Allied Health Professionals

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

Dependent AHPs include the following and must provide collaborative practice information to WellCare:

- Advanced Practice Registered Nurse (APRNs)
- Certified nurse midwives (CNMs)
- Physician assistants (PAs)
- Osteopathic assistant (OAs)

Independent AHPs include:

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

Ancillary Healthcare Delivery Organizations

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

Re-Credentialing

In accordance with regulatory, accreditation and WellCare policy and procedure, re-credentialing is required at least once every three years.

Updated Documentation

In accordance with contractual requirements, Providers should furnish copies of current professional or general liability insurance, license, DEA certificate and accreditation information (as applicable to Provider type) to WellCare, before or concurrent with expiration.

Office of Inspector General Medicare/Medicaid Sanctions Report

On a monthly basis, WellCare or its designee accesses the listings from the Office of Inspector General (OIG) Medicare/Medicaid Sanctions (exclusions and reinstatements) Report, for the most current available information. This information is cross-checked against the network of Providers. If Providers are identified as being currently sanctioned, such Providers are subject to immediate termination and notification of termination of contract, in accordance with WellCare policies and procedures.

Eligibility in the Medicaid Program

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

Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials

On a monthly basis, WellCare or its designee contacts state licensure agencies to obtain the most current available information on sanctioned Providers. This information is cross-checked against the network of WellCare Providers. If a network Provider is identified as being currently under sanction, appropriate action is taken in accordance with WellCare policy and procedure. If the sanction imposed is revocation of license, the Provider is subject to immediate termination. Notifications of termination are given in accordance with contract and WellCare policies and procedures.

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

Provider Dispute Process

Providers have the right to dispute verbally an inquiry related to policies and procedures, policies related to payment, or any other communication or action taken by WellCare. A Provider may file a dispute by calling Provider Services.

Upon receiving a dispute from the Provider, the Customer Service Representative (“CSR”) will document the issue in accordance with established documentation standards. The goal for Provider disputes is First Call Resolution, which would yield an immediate response. If First Call Resolution is not achieved the dispute is escalated to our Provider Escalation Team. This team will review the dispute and work with internal partners to fully resolve the inquiry. The agent will call the Provider and notify them of the decision or a new Explanation of Payment will be sent. If the Provider cannot be reached after three attempts, a decision letter will be sent. The Company shall provide to all Providers written notice of the dispute procedure in the provider handbook.

Participating Provider Appeal through Dispute Resolution Peer Review Process

WellCare may immediately suspend, pending investigation, the participation status of a participating Provider who, in the opinion of the medical director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of Members. In such instances, the medical director investigates on an expedited basis.

WellCare has a Participating Provider dispute resolution peer review panel process in the event WellCare chooses to alter the conditions of participation of a Provider based on issues of quality of care, conduct or service, and if such process is implemented, may result in reporting to regulatory agencies.

The Provider dispute resolution peer review process has two levels. All disputes in connection with the actions listed below are referred to as a first-level peer review panel consisting of at least three qualified individuals of whom at least one is a participating Provider and a clinical peer of the practitioner that filed the dispute.

The practitioner also has the right to consideration by a second-level peer review panel consisting of at least three qualified individuals, of whom at least one is a participating Provider and a clinical peer of the practitioner that filed the dispute. The second-level panel is comprised of individuals who were not involved in earlier decisions.

The following actions by WellCare entitle the practitioner affected thereby to the Provider dispute resolution peer review panel process:

- Suspension of participating practitioner status for reasons associated with clinical care, conduct or service
- Revocation of participating practitioner status for reasons associated with clinical care, conduct or service
- Non-renewal of participating practitioner status at time of re-credentialing for reasons associated with clinical care, conduct; service or excessive claims and/ or sanction history

Notification of the adverse recommendation, together with reasons for the action, and the practitioner’s rights and process for obtaining the first- and/or second-level dispute resolution peer review panel processes, are provided to the practitioner. Notification to the practitioner will be mailed by overnight, recorded or certified return-receipt mail.

The practitioner has up to 30 days to file a written request via recorded or certified return-receipt mail to access the dispute resolution peer review panel process.

Upon timely receipt of the request, the medical director or his or her designee shall notify the practitioner of the date, time and telephone access number for the panel hearing. WellCare then notifies the practitioner of the schedule for the review panel hearing.

The practitioner and WellCare are entitled to legal representation at the hearing. The practitioner has the burden of proving by clear and convincing evidence that the reason for the termination recommendation lacks any factual basis, or that such basis or the conclusion(s) drawn there from, are arbitrary, unreasonable or capricious.

The dispute resolution peer review panel shall consider and decide the case objectively and in good faith. The medical director, within five business days after final adjournment of the dispute resolution peer review panel hearing, shall notify the practitioner of the results of the first-level panel hearing. In the event the findings are positive for the practitioner, the second-level review shall be waived.

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

Within 10 calendar days of the request for a second-level peer review panel hearing, the medical director or his or her designee shall notify the practitioner of the date, time and access number for the second-level peer review panel hearing.

The second-level dispute resolution peer review panel shall consider and decide the case objectively and in good faith. The medical director, within five business days after final adjournment of the second-level dispute resolution peer review panel hearing, shall notify the practitioner of the results of the second-level panel hearing via certified or overnight recorded delivery mail. In the event the findings of the second-level peer review panel result in an adverse determination for the practitioner, the findings of the second-level peer review panel shall be final.

A practitioner who fails to request the Provider dispute resolution peer review process within the time and in the manner specified waives any right to such review to which he or she might otherwise have been entitled. WellCare may proceed to implement the termination and make the appropriate report to the National Practitioner Data Bank and State Licensing Agency as appropriate and if applicable.

Delegated Entities

All participating Providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a monthly/quarterly basis and formal audits are conducted annually. Please refer to *Section 9: Delegated Entities* section in this Handbook for further details.

Section 7: Complaints, Appeals and Grievances

Provider and Member Appeals Process

Provider Appeal Process for Administrative and Medical Necessity Reviews

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

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

For the Provider to receive payment under the terms of the contract, WellCare must authorize or precertify certain Covered Services prior to them being rendered. Failure to obtain a prior authorization will result in an administrative denial. Members cannot be billed for an administrative denial. WellCare has 30 business days to review the case and conformity to WellCare guidelines.

If more information is needed, cases received without the necessary documentation will be denied for lack of information. It is the responsibility of the Provider to provide the requested documentation within 60 calendar days of the denial to reopen the case. Records and documents received after that time frame will not be reviewed and the case will remain closed.

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

Reversal of Denial of Provider Appeals for Administrative and Medical Necessity Reviews

If all of the relevant information is received, WellCare will make a determination within 30 business days. If it is determined during the review that the Provider has complied with WellCare protocols and that the appealed services were Medically Necessary, the denial will be overturned. The Provider will be notified of this decision in writing.

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

Affirmation of Denial of Provider Appeals for Administrative and Medical Necessity Reviews

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

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

Member Appeal Process

For a Member appeal, the Member, Member's representative, or a Provider acting on behalf of the Member and with the Member's written consent, may file an appeal request verbally with Member Services at the phone number below or on the back of the Member's ID card. An appeal may also be submitted in writing. All requests must be submitted within 60 calendar days from the date on the notice of Adverse Benefit Determination. WellCare shall acknowledge in writing within 10 calendar days of receipt of appeal except in the case of an expedited request.

The Member should send medical appeal requests to:

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

Fax: **1-866-201-0657**
Telephone: **1-855-599-3811**
Hours of Operation: Monday–Friday, from 8 a.m. to 5 p.m. Central time

The Member should send appeals for medications to:

WellCare Health Plans
Attn: Pharmacy Appeals
P.O. Box 31398
Tampa, FL 33631-3398

Fax: **1-866-865-6531**

If an appeal is filed verbally via WellCare's Member Services Department, the request must be followed up with a written, signed appeal request to WellCare, except when an expedited resolution has been requested. For verbal filings, the time frames for resolution begin on the date the verbal filing was received by WellCare.

If the Member's request for appeal is submitted after 60 calendar days from the date on the notice of Adverse Benefit Determination, then good cause must be shown for WellCare to accept the late request.

Examples of good cause include:

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

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

Members are given reasonable help in completing forms and other procedural steps for an appeal, including, but not limited to, providing interpreter services and toll-free telephone numbers with TTY capability.

Members may also present evidence and allegation of fact or law, in person as well as in writing and prior to, during and after the appeal, review their case files. The time frame to submit additional documentation for expedited appeals is limited due to the short timeframe to process the request for expedited appeal.

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

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

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

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

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by the state.
- The failure of the Company to act within 90 days from the date the Health Plan receives a grievance, or 30 days from the date the Health Plan receives an appeal;
- For a resident of a rural area with only one managed care entity, the denial of an enrollee's request to exercise the right to obtain services outside the network; and
- The denial of an enrollee's request to dispute a financial liability.

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

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

- Expedited request: **72 hours**
- Standard pre-service and retrospective request: **30 calendar days**

The appeals determination periods noted above may be extended by up to 14 calendar days if the Member asks for an extension or if WellCare justifies a need for additional information and documents how the extension is in the interest of the Member.

If WellCare extends the time frame for any extension not requested by the Member, the Plan will make reasonable efforts to give the Member prompt verbal notice of the delay. Also, within two calendar days of the decision to extend the timeframe, the Member will be given written notice of the reason for the delay and the Member will be informed of the right to file a grievance if he/she disagrees with that decision.

Expedited Appeals Process

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

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

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

Denial of an Expedited Request

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

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

Resolution of an Expedited Appeal

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

Reversal of Denial of an Expedited Appeal

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

Affirmation of Denial of an Expedited Appeal

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

- Verbally notify the Member of the decision
- Issue a notice of adverse action to the Member and/or appellant
- Include in the notice the specific reason for the appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based
- Inform the Member:
 - Of their right to request a State Fair Hearing within 120 calendar days of the date on the Appeal notice of resolution and how to do so
 - Of their right to representation
 - Of their right to continue to receive benefits pending a State Fair Hearing
 - That they may be liable for the cost of any continued benefits if WellCare's action is upheld

Standard Appeals Process

A Member, a Member's representative or a Provider on behalf of a Member with the Member's written consent, may file a standard appeal request either verbally or in writing within 60 calendar days from the date on the notice of Adverse Benefit Determination.

If an appeal is filed verbally through Member Services, it must be followed up with a written, signed appeal to WellCare. For verbal filings, the time frames for resolution begin on the date the verbal filing was received.

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

Reversal of Denial of a Standard Appeal

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

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

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

Affirmation of Denial of a Standard Appeal

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

- Issue a notice of appeal decision to the Member and/or appellant
- Include in the notice the specific reason for the appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, as well as informs the Member:
 - Of their right to ask for a State Fair Hearing within 120 calendar days of the date on the notice of resolution and how to do so
 - Of their right to representation

- Of their right to continue to receive benefits pending a State Fair Hearing
- That they may be liable for the cost of any continued benefits if WellCare's action is upheld

If the final appeal decision is not issued within 30 calendar days from the receipt of the appeal, the Member is deemed to have exhausted the health plan's internal appeals process and the Member may ask for a State Fair Hearing.

State Fair Hearing

A Member can ask for a State Fair Hearing if he or she is dissatisfied with the final decision within 120 days of the final appeal resolution by WellCare.

A Member or his/her representative may ask for a State Fair Hearing only after receiving notice that WellCare is upholding the Adverse Benefit Determination. The Member may also ask for a State Fair Hearing if the Plan fails to give the Member an appeal decision within 30 calendar days from the date of receipt of the appeal.

A Provider must have a Member's written consent before asking for a State Fair Hearing on behalf of a Member. The parties to a State Fair Hearing include WellCare, the Member, his or her representative or the representative of a deceased Member's estate, and the state.

Members or Providers can appeal in person, by telephone or in writing. To appeal in writing, they must write a letter telling WellCare why they think the decision is wrong

Members or Providers may call the Appeals Department at **1-855-599-3811** if they want to appeal by telephone. They may mail, fax or deliver their appeal to:

**WellCare Health Plans
Attn: Appeals Department
P.O. Box 31368
Tampa, FL 33631-3368**

Continuation of Benefits while the Appeal and State Fair Hearing are pending

WellCare shall continue the Member's benefits if all of the following occur:

1. The Member files the request for an appeal timely;
2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
3. The services were ordered by an authorized Provider;
4. The period covered by the original authorization has not expired; and
5. The Member requests continuation of benefits, timely files means on or before the later of the following:
 1. Within 10 calendar days of WellCare sending the Notice of Adverse Benefit Determination; or
 2. The intended effective date of WellCare's proposed Adverse Benefit Determination.

If WellCare continues or reinstates the Member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

6. The Member withdraws the appeal or request for state fair hearing;
7. The Member fails to request a state fair hearing and continuation of benefits within 10 calendar days after WellCare sends the notice of adverse resolution to the Member's

appeal.

8. A State Fair Hearing office issues a hearing decision adverse to the Member; or
9. The authorization expires or authorization service limits are met.

If the final resolution of the appeal is adverse to the Member, that is WellCare's action is upheld, WellCare may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that service were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b).

If WellCare or the State Fair Hearing process reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, WellCare must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires, but in no event later than 72 hours from the date WellCare receives notice reversing the determination.

WellCare must pay for disputed services if WellCare or State Fair Hearing decision reverses a decision to deny authorization of service and the Member received the disputed services while the appeal was pending.

Grievance Process

Provider Complaint Grievance Process

Providers have the right to file a complaint verbally by phone , in writing or in person with the Grievance Department regarding dissatisfaction with policies and procedures, policies related to payment, or any other communication or action taken by WellCare; reference the section above for the administrative/Medical Necessity process. Providers can file a complaint in person at any WellCare office and the complaint will be routed to the Grievance Department for logging, tracking, resolution and reporting. A Provider may file a grievance with the plan at any time as a Provider with WellCare. Written resolution will be provided by WellCare to the Provider within 90 calendar days from the date the complaint is received by WellCare. Upon receiving a complaint/grievance, either verbally, in writing or in person, from the Provider, the Customer Service Representative ("CSR") will document the issue in accordance with established documentation standards and route to the Grievance Department for resolution.

A Provider may file a complaint in writing regarding dissatisfaction with WellCare's policies, procedures, or any other communication or action taken by WellCare, by mailing or faxing a *Provider Complaint Form* with supporting documentation, to WellCare's Grievance Department.

For more information on how to contact the Grievance Department, refer to the *Quick Reference Guide* at www.wellcare.com/Nebraska/Providers/Medicaid.

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

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

Member

The Member, or Member's representative acting on the Member's behalf, may file a grievance. Examples of grievances that can be submitted include, but are not limited to:

- Provider service including:
 - Rudeness by Provider or office staff
 - Failure to respect the Member's rights
 - Quality of care/services provided
 - Refusal to see Member (other than in the case of patient discharge from office)
 - Office conditions

- Services provided by WellCare including:
 - Hold time on telephone
 - Rudeness of staff
 - Involuntary disenrollment from WellCare
 - Unfulfilled requests

- Access availability including:
 - Difficulty getting an appointment
 - Wait time in excess of 45 minutes
 - Handicap accessibility

A Member, a Member's representative or any Provider acting on behalf of the Member with written consent, may file a standard grievance at any time.

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

If the Member wishes to use a representative, then he or she must submit a signed statement naming the person he or she wishes to represent him or her. For the Member's convenience, WellCare has an Appointment of Representative (AOR) statement form that can be used. The Member and the person who will be representing the Member must sign the AOR statement. The form is at www.wellcare.com/Nebraska/Providers/Medicaid/Forms. Members are given reasonable help in completing forms and other procedural steps for a grievance, including interpreter services and toll-free telephone numbers with TTY capability.

Grievance Submission

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

A Member can file a grievance at any time while enrolled with WellCare.

When filing a grievance in writing, the Member should send the grievance request to:

WellCare Grievances
P.O. Box 31384
Tampa, FL 33631-3384
 Phone: **1-855-599-3811**
 Fax: **1-866-388-1769**
 Hours of Operation: Monday–Friday, 8 a.m. to 5 p.m. Central time

Grievance Resolution

WellCare will acknowledge the Member's standard grievance in writing within 10 business days from the date the grievance is received by WellCare. Upon the grievance resolution, a letter will be mailed to the Member no more than 90 calendar days from the date the standard grievance is received by WellCare; This resolution letter may not take the place of the acknowledgment letter, unless a decision is reached before the written acknowledgement is sent, then one letter shall be sent that includes the acknowledgement and the decision of the grievance.

The acknowledgement letter includes:

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

The resolution letter includes:

- The description of the reason for the grievance
- All information considered in the investigation of the grievance
- The date the grievance was received
- The date of the grievance resolution
- The name of the covered person filing the grievance

WellCare shall acknowledge and provide grievance resolutions in the Members primary language.

Section 8: Compliance

WellCare's Compliance Program

Overview

WellCare maintains a Corporate Compliance Program (Compliance Program) that promotes ethical conduct in all aspects of the company's operations and ensures compliance with WellCare policies and applicable federal and state regulations. The Compliance Program includes information regarding WellCare's policies and procedures related to fraud, waste and abuse, and provides guidance and oversight as to the performance of work by WellCare, WellCare employees, contractors (including delegated entities) and business partners in an ethical and legal manner. All Providers, including Provider employees and Provider sub-contractors and their employees, are required to comply with WellCare's Compliance Program requirements. WellCare's compliance-related training requirements include, but are not limited to:

- Compliance Program Training
 - To ensure policies, procedures and related compliance concerns are clearly understood and followed
 - To provide a mechanism to report suspected violations and implement disciplinary actions to address violations
- HIPAA Privacy and Security Training
 - Summarizes privacy and security requirements in accordance with the federal standards established pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act
 - Training includes, but is not limited to, discussion on:
 - Proper Uses and Disclosures of Protected Health Information (PHI)
 - Member Rights
 - Physical and technical safeguards
- Fraud, Waste and Abuse (FWA) Training
 - Must include, but not limited to:
 - Laws and regulations related to fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback statute, HIPAA, etc.)
 - Obligations of the Provider including Provider employees and Provider subcontractors and their employees to have appropriate policies and procedures to address fraud, waste and abuse
 - Process for reporting suspected fraud, waste and abuse
 - Protections for employees and subcontractors who report suspected fraud, waste and abuse
 - Types of fraud, waste and abuse that can occur
- Cultural Competency Training
 - Programs to educate and identify the diverse cultural and linguistic needs of the Members that Providers serve
- Disaster Recovery and Business Continuity
 - Development of a Business Continuity Plan that includes the documented process of continued operations of the delegated functions in the event of a short-term or long-term interruption of services

Providers, including Provider employees and/or Provider subcontractors, must report to WellCare any suspected fraud, waste or abuse, misconduct or criminal acts by WellCare, or any Provider, including Provider employees and/or Provider subcontractors, or by WellCare Members. Reports may be made anonymously through the WellCare fraud hotline at **1-866-678-8355**.

Details of the corporate ethics and compliance program may be found on WellCare's website at www.wellcare.com/Nebraska/Corporate/Compliance.

Provider Education and Outreach

Providers may:

- Display state-approved WellCare-specific materials in-office
- Announce a new affiliation with a health plan
- Make available and/or distribute marketing materials
- Co-sponsor events such as health fairs and advertise indirectly with a health plan via television, radio, posters, fliers and print advertisement

Health education materials must adhere to the following guidance:

- Health education posters cannot be larger than 16x24 inches
- Children's books, donated by Managed Care Plans, must be in common areas
- Materials may include the Managed Care Plans name, logo, telephone number and website address
- Providers are not required to distribute and/or display all health education materials provided by each Managed Care Plan with whom they contract

Providers are prohibited from:

- Verbally, or in writing, comparing benefits or Providers networks among health plans, other than to confirm their participation in a health plan's network
- Furnishing lists of their Medicaid patients to any health plan with which they contract, or any other entity
- Furnishing health plans' membership lists to the health plan, such as WellCare, or any other entity
- Assisting with health plan enrollment or disenrollment

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

Provider-Based Marketing Activities

Providers may:

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

Providers must comply with the following:

- To the extent that a Provider can help a recipient in an objective assessment of his/her needs and potential options to meet those needs, the Provider may do so

- May engage in discussions with recipients should a recipient seek advice. However, Providers must remain neutral when assisting with enrollment decisions

Providers are prohibited from:

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

Providers may also:

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

Provider Affiliation Information:

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

involved in the comparison and are approved by the Agency prior to distribution
(iii) The Managed Care Plans identify a lead Managed Care Plan to coordinate submission of the materials

International Classification of Diseases (ICD)

ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). WellCare utilizes ICD for all diagnosis code validation and follows all CMS mandates for any future ICD changes, which includes ICD-10 or its successor.

All Providers must submit HIPAA compliant diagnoses codes ICD-10-CM. Please refer to the CMS website for more information about ICD-10 codes at www.cms.gov, and the ICD-10 Lookup Tool at www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx for specific codes.

Information on the ICD-10 transition and codes can also be found at www.wellcare.com/Nebraska/Corporate/Compliance.

Code of Conduct and Business Ethics

Overview

WellCare has established a Code of Conduct and Business Ethics that outlines ethical principles to ensure that all business is conducted in a manner that reflects an unwavering allegiance to ethics and compliance. WellCare's Code of Conduct and Business Ethics policy can be found at www.wellcare.com/Nebraska/Corporate/Compliance.

The Code of Conduct and Business Ethics (the Code) is the foundation of WellCare's Corporate Ethics and Compliance Program. It describes WellCare's firm commitment to operate in accordance with the laws and regulations governing its business and accepted standards of business integrity. All Providers should familiarize themselves with WellCare's Code of Conduct and Business Ethics. Participating Providers and other contractors of WellCare are required to report compliance concerns and any suspected or actual misconduct. Report suspected fraud, waste and abuse by calling the WellCare FWA Hotline at **1-866-678-8355**.

Fraud, Waste and Abuse

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

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

WellCare's goal is to process claims consistently and in accordance with best practice standards. If a claim coding is identified as contrary to AMA, CMS, FDA and state Medicaid

guidelines, the Provider will be notified of the same, and WellCare will seek to remedy the issue. Providers will receive notification that claim coding error was detected based on edits that include, but are not limited to, AMA, CMS, FDA and state Medicaid guidelines. That includes high-dollar claims, unbundled procedures, modifiers, Correct Coding Initiatives edits, duplicates, maximum units, multiple surgeries, and bilateral procedures, all of which WellCare actively monitors for FWA.

Federal and state regulatory agencies, law enforcement, and WellCare vigorously investigate incidents of suspected fraud and abuse. Providers are cautioned that unbundling, fragmenting, upcoding and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD), Physicians' Current Procedural Terminology (CPT), the Healthcare Common Procedure Coding System (HCPCS), and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

In addition, Providers are reminded that medical records and other documentation must be legible and support the level of care and service indicated on claims. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including, but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized Provider, loss of licensure, and/or civil and/or criminal prosecution, fines and other penalties.

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

To report suspected fraud and abuse, please refer to the *Quick Reference Guide* on WellCare's website at www.wellcare.com/Nebraska/Providers/Medicaid or call the confidential and toll-free WellCare compliance hotline at **1-866-678-8355**. Details of the corporate ethics and compliance program, and how to contact the WellCare fraud hotline, are on WellCare's website at www.wellcare.com/Nebraska/Corporate/Compliance.

To report suspected Medicaid and Welfare fraud to the state, call the Medicaid Fraud and Patient Abuse Unit of the Attorney General's office at **1-402-471-3549** or toll free at **1-800-727-6432** Monday–Friday 7 a.m. to 6 p.m. Suspected fraud may also be reported to the U.S. Department of Health and Human Services at the Office of Inspector General website, forms.oig.hhs.gov/hotlineoperations/report-fraud-form.aspx.

Program Integrity Oversight

WellCare will notify Nebraska Medicaid Program Integrity (NMPI) if it identifies patterns of data mining outliers, audit concerns, critical incidences (serious reportable events and reportable adverse incidents), hotline calls, or other internal and external tips with potential implications about Provider billing anomalies and/or the safety of Nebraska Medicaid Members (42 CFR 455.15). Along with such notification, WellCare will take steps to triage or substantiate these tips and provide timely updates to NMPI.

WellCare will report all tips and make all referrals to MLTC in writing, a minimum of every two weeks. WellCare shall include all relevant documentation within this notification.

Confidentiality of Member Information and Release of Records

Medical records should be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules and regulations. All consultations or discussions involving the Member or his/her case should be conducted discreetly and professionally, in accordance with all applicable state and federal laws, including the HIPAA privacy and security rules and regulations, as may be amended. All Provider practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure there is a procedure or process in place for maintaining confidentiality of Members' medical records and other Protected Health Information (PHI), and the practice is following those procedures and/or obtaining appropriate authorization from Members to release information or records where required by applicable state and federal law. Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

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

Some examples of confidential information include:

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

Refer to *Section 3: Quality Improvement* for guidance in responding to WellCare's requests for Member health records for the purposes of treatment, payment and healthcare activities.

Disclosure of WellCare Information to WellCare Members

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

For more information on how to request this information, Members may contact WellCare's Member Services using the toll-free telephone number found on the Member's ID card.

Providers may contact WellCare's Provider Services by referring to the *Quick Reference Guide* at www.wellcare.com/Nebraska/Providers/Medicaid.

Section 9: Delegated Entities

Overview

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

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

Delegation Oversight Process

WellCare's Delegation Oversight Committee (DOC) was formed to be the governing body for the delegation oversight process, which provides oversight of subcontracted vendors where specific services are delegated. WellCare defines a "Delegated Entity" as a subcontractor which performs a core function under one of WellCare's government contracts. The Delegation Oversight Committee is chaired by the Sr. Director, Corporate Compliance Oversight. The committee members include appointed representatives from the following areas: Corporate Compliance, Legal, Shared Services Operations, Clinical Services Organization, and market representatives from each Regional Area. The Chief Compliance Officer has ultimate authority as to the composition of the Delegation Oversight Committee membership. The Delegation Oversight Committee will hold monthly meetings or more frequently as circumstances dictate.

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

WellCare monitors compliance through the delegation oversight process and the Delegation Oversight Committee through the following activities:

- Validating the eligibility of proposed and existing Delegated Entities for participation in the Medicaid and Medicare programs.
- Conducting pre-delegation audits and reviewing the results to evaluate the prospective entity's ability to perform the delegated function.
- Providing guidance on written agreement standards with Delegated Entities to clearly define and describe the delegated activities, responsibilities and required regulatory reports to be provided by the entity.
- Conducting ongoing monitoring of activities to evaluate an entity's performance and compliance with regulatory requirements and accreditation standards.
- Conducting annual audits to verify the entity's performance and processes support sustained compliance with regulatory requirements and accreditation standards.
- The development and implementation of Corrective Action Plans (CAPs) if the Delegated Entity's performance is substandard or terms of the agreement are violated.
- Review and initiate recommendations to Senior Management and the Chief Compliance Officer for the revocation and/or termination of those entities not performing to the expectations of the current contractual agreement and regulatory requirements.

- Track and trend compliance with oversight standards, entity performance, and outcomes.

Section 10: Behavioral Health

Overview

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

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

Some behavioral health services may require prior authorization, including all services provided by non-participating providers. WellCare uses Milliman Clinical Guidelines (MCG) for all Behavioral Health In-Patient Services and American Society for Addiction Medicine (ASAM) criteria, for substance use disorder. These criteria are well-known and nationally accepted guidelines for assessing level of care criteria for behavioral health.

For complete information regarding benefits and exclusions, or in the event a Provider needs to contact WellCare's Provider Services toll free phone number for a referral to a behavioral health Provider, refer to the *Quick Reference Guide* at www.wellcare.com/Nebraska/Providers/Medicaid.

Behavioral Health Program

WellCare requires prior authorization for some outpatient services. WellCare encourages community-based services and Member treatment at the least restrictive level of care, whenever possible.

Prior authorization is required for psychological testing, intensive outpatient, partial hospital programs, residential treatment programs and inpatient hospital services. Prior authorization requests for partial hospitalization, residential treatment or inpatient services can be completed by phone. In addition, prior authorization request forms for all levels of care are made available to Providers online or upon request. For complete information regarding authorization requirements please visit the behavioral health link at www.wellcare.com/Nebraska/Providers/Medicaid/Behavioral-Health.

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

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

Behavioral Health Providers must submit, with the Member's or Member's legal guardian's consent, an initial and quarterly summary report of the Member's behavioral health status to the PCP. Communication with the PCP should occur more frequently, if clinically indicated. WellCare encourages behavioral health Providers to pay particular attention to communicating with PCPs at the time of discharge from an inpatient hospitalization (WellCare recommends faxing the discharge instruction sheet, or a letter summarizing the hospital stay, to the PCP).

Please send this communication, with the properly signed consent, to the Members identified PCP noting any changes in the treatment plan on the day of discharge.

WellCare strongly encourages open communication between PCPs and Behavioral Health Providers to help guide and ensure the delivery of safe, appropriate, efficient and best quality clinical healthcare. If a Member's medical or behavioral condition changes, WellCare expects that both PCPs and Behavioral Health Providers will communicate those changes to each other, especially if there are any changes in medications that need to be discussed and coordinated between Providers.

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

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

Responsibilities of Behavioral Health Providers

WellCare monitors Providers against these standards to ensure Members can obtain needed health services within the acceptable appointment waiting times. The provisions below are applicable only to Behavioral Health Providers and do not replace the provisions set forth in *Section 2: Provider and Member Administrative Guidelines* for medical Providers. Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare.

Type of Appointment	Access Standard
BH Provider — Urgent	Within 24 hours of the request
BH Provider — Routine	Within 10 business days of the request
BH Provider — Emergency	Within 6 hours (both in and out of service area), 24 hours, 7 days a week (prior authorization not required)
Follow-up care after hospital stay	Within 7 days of discharge from the hospital.

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

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

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

Section 11: Pharmacy

Overview

WellCare of Nebraska's pharmaceutical management procedures are an integral part of the pharmacy program that ensure and promote the utilization of the most clinically appropriate agent(s) to improve the health and well-being of its Members. The utilization management tools that are used to optimize the pharmacy program include:

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

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

- Follow national standards of care guidelines for treating conditions, i.e., National Institutes of Health (NIH) Asthma guideline, Joint National Committee (JNC) Hypertension guidelines
- Prescribe drugs listed on the PDL
- Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class
- Evaluate medication profiles for appropriateness and duplication of therapy

To contact WellCare's Pharmacy Department, please refer to the *Quick Reference Guide* at www.wellcare.com/Nebraska/Providers/Medicaid.

Preferred Drug List

WellCare has adopted the Nebraska Medicaid Preferred Drug List (PDL) and provides all prescription drugs and dosage forms listed there.

The PDL is a published prescribing reference and clinical guide of prescription drug products selected by the Pharmaceutical and Therapeutics Committee (P&T Committee). WellCare shall provide all prescription drugs listed in the Nebraska Medicaid Preferred Drug List (PDL). The PDL denotes any of the pharmacy utilization management tools that apply to a particular medication.

WellCare of Nebraska's Supplemental PDL and Nebraska Medicaid's PDL can be found at www.wellcare.com/Nebraska/Providers/Medicaid/Pharmacy.

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

- Quarterly updates in Provider newsletters
- Website updates, including the link to Nebraska P&T PDL changes
- Links to Pharmacy and Provider communication that detail any major changes to a particular therapy or therapeutic class will be updated 30 days prior to changes

All pharmacy PDL changes are communicated by the State of Nebraska Medicaid Agency following the Pharmacy and Therapeutic meetings with an allowance for a 30-day implementation period.

For more information on asking for exceptions, refer to the *Coverage Determination Review Process* below.

Generic Medications

Generic medications are key to pharmaceutical management. Generic drugs are equally effective and generally less costly than their brand name counterparts. Their use can contribute to cost-effective therapy.

Step Therapy

Step therapy programs are designed to encourage the use of therapeutically equivalent, lower-cost medication alternatives (first-line therapy) before stepping up to less cost-effective alternatives.

Step therapy programs are a safe and effective method of reducing the cost of treatment by ensuring that an adequate trial of a proven safe and cost-effective therapy is tried before progressing to a more costly option. First-line drugs are recognized as safe, effective and economically sound treatments. The first-line drugs on Nebraska's PDL have been evaluated through the use of clinical literature and are approved by the corresponding P&T Committee.

Medications requiring step therapy are identified on the PDL.

Quantity Limits

Quantity limits are used to ensure that pharmaceuticals are supplied in a quantity consistent with Food and Drug Administration (FDA) approved dosing guidelines. Quantity limits are also used to help prevent billing errors.

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

Age Limits

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

Medications with age limits are identified on the PDL. Additional detail can be found on the Nebraska Medicaid Claims Limitation document.

Injectable and Infusion Services

Select injectable and infusion drugs are covered under the Nebraska outpatient pharmacy benefit.

Some injectable products and infusion drugs listed on the PDL require a coverage Determination Request Review using the *Injectable Infusion Form*.

Approved injectable and infusion drugs are covered when supplied by specialty pharmacies and infusion vendors contracted with WellCare. Please contact the WellCare Pharmacy

Department regarding criteria related to specific drugs. Specialty medications are available through our limited specialty pharmacy network.

Refer to WellCare's website at www.wellcare.com/Nebraska/Providers/Medicaid/Pharmacy for more information.

Coverage Limitations

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

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

WellCare follows EPSTD guidelines. Providers may submit a Coverage Determination Request form for Members effected by the guidelines.

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

Smoking Cessation therapy — Oral

WellCare provides smoking cessation medications consistent with the Nebraska PDL to Members who want to quit smoking and are working through the Nebraska QuitLine available by calling **1-800-QUIT-NOW (1-800-784-8669)**.

Over-the-Counter (OTC) Medications

OTC items covered under the Nebraska Medicaid pharmacy benefit require a prescription and in some cases a prior authorization. Covered drugs are listed on the WellCare drug lookup tool at www.wellcare.com/Nebraska/Members/Medicaid-Plans/WellCare-of-Nebraska/WellCare-of-Nebraska-Settings/Wellcare-of-Nebraska-Drug-Search-Page.

Examples of OTC items listed on the PDL include:

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

For a complete listing of covered OTC medications, please refer to the OTC List located on our website at www.wellcare.com/Nebraska/Members/Medicaid-Plans/WellCare-of-Nebraska/Pharmacy-Services

Compounded Prescriptions

A compounded prescription is a mixture of ingredients that the Provider prepares in the pharmacy. Reimbursement for compounded prescriptions will be limited to those ingredients that are indicated as covered on the Nebraska PDL. Any mixture of drugs that results in a commercially available OTC preparation is not considered a compounded prescription, for example, dilute HCL, MOM with cascara, OTC hydrocortisone preparations.

Member Co-Payments

- Brand name: \$3 per prescription

Pharmacy Reimbursement

WellCare will calculate dispensing fees, administration fees, and any other fee payment amounts as approved by the Nebraska Medicaid Agency. WellCare will maintain in each paid claim record which methodology was used to determine final payment amounts, i.e., state maximum allowable cost, national average drug acquisition cost, or the submitted usual and customary charge.

WellCare's dispensing fee reimbursement will be, at a minimum, the current Medicaid Managed Care rate for independent pharmacies (defined as those with ownership of six or fewer pharmacies), unless otherwise agreed between WellCare and the pharmacy Provider. Chain Pharmacy (those pharmacies with more than six pharmacies) will be contracted at the current CVS national reimbursement rates. There will be no transaction fees per state contract.

Coverage Determination Review Process (Requesting Prior Authorization)

The goal of the Coverage Determination Review Process (also known as prior authorization) is to ensure that medication regimens that are high-risk, have high potential for misuse, or have narrow therapeutic indices are used appropriately and according to FDA-approved indications.

The Coverage Determination Review Process is required for:

1. Duplication of therapy
2. Prescriptions that exceed the FDA daily or monthly quantity limit
3. Most self-injectable and infusion medications (administered in the home)
4. Drugs not listed on the PDL
5. Drugs prescribed outside the recommended age limits
6. Drugs listed on the PDL but still require prior authorization
7. Non-preferred brand-name drugs when a generic exists
8. Drugs that have a step therapy edit

Providers may ask for an exception to WellCare's PDL verbally or in writing. For written requests, Providers should complete a *Coverage Determination Request Form*, supplying pertinent Member medical history and information. A *Coverage Determination Request Form* may be accessed at www.wellcare.com/en/Nebraska/Providers/Medicaid/Forms.

To submit a request verbally, refer to the contact information listed on your *Quick Reference Guide* at www.wellcare.com/Nebraska/Providers/Medicaid.

Upon receipt of the coverage determination request, a decision is completed within 24 hours. If authorization cannot be approved or denied, and the drug is Medically Necessary, up to a 72-hour emergency supply of the non-preferred drug can be supplied to the Member.

WellCare completes a decision within 24 hours for both standard and expedited requests.

Restricted Services

Restricted services are a mechanism for restricting Medicaid recipients to a specific Provider and/or hospital, or a specific pharmacy Provider.

MLTC and/or WellCare may request that a Member be placed in a restricted services status when it determines that overutilization, duplication of services, non-compliance, or drug-seeking behavior is suspected of the Member.

WellCare, through retrospective utilization review or through the recommendation of a network Provider, may also determine that the services available to a Member be restricted and communicate these restrictions to MLTC.

Medication Appeals

To ask for an appeal of a Coverage Determination Review Decision, contact the WellCare Pharmacy Appeals Department via fax, mail, in person or phone. The *Medication Appeals Form* is at www.wellcare.com/en/Nebraska/Providers/Medicaid/Forms.

For contact information, refer to the *Quick Reference Guide* at www.wellcare.com/Nebraska/Providers/Medicaid.

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

Payer Sheets

Payer Sheets can be found at www.caremark.com/pharminfo.

Prospective DUR Response Requirements

DUR Conflict Codes and Text Messaging: All DUR messages appear in the claim response. The Provider must view all screens necessary to receive the message detail and act upon all such messages subject to the professional judgment of Provider.

Providers will receive the DUR message in a format consistent with its software vendor. Providers may need to consult with the software vendor for help with identifying or accessing DUR messages. Caremark, in accordance with current NCPDP standards, returns up to nine

DUR messages that can be received on the same claim and requires Providers to have the capability to accept up to nine DUR messages on the same claim.

Refer to the NCPDP standard at www.ncpdp.org/?ReturnUrl=%2fMembers%2fStandards-Lookup.aspx. Membership to NCPDP is required to view this information online.

Pharmacy Management – Provider Education Program (PEP)

The Pharmacy Provider Education Program (PEP) is designed to provide physicians with quarterly utilization reports to identify overutilization and underutilization of pharmaceutical products. The reports will also identify opportunities for optimizing best-practice guidelines and cost-effective therapeutic options. These reports are delivered by the WellCare of Nebraska state pharmacy director to physicians identified for the program.

Member Pharmacy Access

WellCare maintains a comprehensive network of pharmacies to ensure that pharmacy services are available and accessible to all Members 24 hours a day. Mail order is also an option for Members. WellCare of Nebraska's mail order pharmacy option is a convenient way for Members to get the prescription drugs they need to manage their health. This is an important consideration for Members who live in rural areas or have difficulty leaving their homes to pick up prescriptions. Using this option doesn't mean a Member won't still be able to use a local pharmacy.

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

Specialty Pharmacy

WellCare will contract with specialty pharmacies to the extent WellCare determines it is necessary to ensure the adequate availability of specialty drugs. WellCare may limit distribution of specialty drugs to a network of pharmacies that meet reasonable requirements to distribute specialty drugs. WellCare will not exclude a Nebraska pharmacy from participation in its specialty pharmacy network as long as the pharmacy is accredited and willing to accept the terms of WellCare's agreement with its specialty pharmacies.

Section 12: Definitions

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

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

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

Adverse Benefit Determination means any of the following:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by the state.
- The failure of the Company to act within ninety (90) calendar days from the date the Health Plan receives a grievance, or thirty (30) calendar days from the date the Health Plan receives an appeal.
- For a resident of a rural area with only one (1) managed care entity, the denial of an enrollee's request to exercise the right to obtain services outside the network.
- The denial of an enrollee's request to dispute a financial liability.

Agency or MLTC means state of Nebraska, Department of Medicaid and Long-Term Care.

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

Appeal means a request for review of an action.

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

Benefit Plan means a schedule of healthcare services to be delivered or other health Covered Service contract or coverage document (a) issued by WellCare or (b) administered by WellCare pursuant to a Government Contract. Benefit plans and their designs are subject to change periodically.

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

Calendar Days means all seven days of the week.

Carve-Out Agreement means an agreement between WellCare and a third-party Participating Provider whereby the third party assumes financial responsibility for or may provide certain management services related to particular Covered Services. Examples of possible Carve-Out Agreements include agreements for behavioral health, radiology, laboratory, dental, vision or hearing services.

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

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

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

Clean Claim means a claim, received by a MCO for adjudication, that requires no further information, adjustment, or alteration by the Provider of the services, or by a third party, in order to be processed and paid by the MCO. It does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

CLIA means the federal legislation commonly known as the Clinical Laboratories Improvement Amendments of 1988 as found at Section 353 of the federal Public Health Services Act (42 U.S.C. §§ 201, 263a) and regulations promulgated hereunder.

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

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

Code of Federal Regulation (C.F.R.) means the Code of Federal Regulations.

Emergency Medical Condition means 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 the following: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or, (3) serious dysfunction of any bodily organ or part.

Emergency Services and Care means covered inpatient and outpatient services that are either furnished by a Provider that is qualified to furnish these services under Title 42 CFR, or the services needed to evaluate or stabilize an emergency medical condition.

Encounter Data means line-level utilization and expenditure data for services furnished to Members through an MCO.

Grievance means a written or verbal expression of dissatisfaction about any matter other than an action.

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

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

Ineligible Person means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) Federal procurement or non-procurement programs, as may be identified in the Excluded Parties List System maintained by the General Services Administration, (b) has been convicted of a criminal offense subject to OIG's mandatory exclusion authority for Federal Health Care Programs described in section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in State medical assistance programs, including Medicaid or CHIP, or State procurement or non-procurement programs as determined by a state governmental authority.

Nebraska Contract means the contract between WellCare and the Nebraska Department of Medicaid and Long-Term Care (MLTC). It includes the collective documentation memorializing the terms of the agreement between the Agency and WellCare identified in the Contract Declarations and Execution Section. In addition to this section, it also includes the General Terms for Services Contracts, the Special Terms and any Special Contract Attachments, as documents may be amended from time to time.

LTAC means a Long-Term Acute Care hospital.

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

Medically Necessary (Medical Necessity) means healthcare services and supplies that are medically appropriate as defined by MLTC and:

- Necessary to meet the basic health needs of the Member
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Covered Service
- Consistent in type, frequency, and duration of treatment with scientifically-based guidelines of national medical, research, or healthcare coverage organizations or governmental agencies

- Consistent with the diagnosis of the condition
- Required for means other than convenience of the Member or his/her physician
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency
- Of demonstrated value
- No more intensive level of service than can be safely provided

Member means a Medicaid enrollee who is currently enrolled with a specific MCO.

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

Members/Individuals with Special Healthcare Needs means Members with special needs are defined as adults and children who face daily physical, mental or environmental challenges that place their health at risk and whose ability to fully function in society is limited.

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

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

Periodicity Schedule means the schedule which defines age-appropriate services and time frames for Screenings within the Early and Periodic Screening, Diagnosis and Treatment services (EPSDT) program and applies to well-child visits and immunizations for children enrolled in the Heritage Health program.

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

Primary Care Provider (PCP) means a medical professional chosen by or assigned to the Member to provide primary care services. Provider types that can be PCPs are doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) from any of the following practice areas: general practice, family practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN). Advanced practice nurses (APNs) and Provider assistants may also serve as PCPs when they are practicing under the supervision of a Provider who also qualifies as a PCP under this contract and specialize in family practice, internal medicine, pediatrics or obstetrics/gynecology.

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

Provider means any person (including physicians or other healthcare professionals), partnership, professional association, corporation, facility, hospital, or institution certified, licensed, or registered by the State of Nebraska to provide healthcare services that has contracted with WellCare to provide healthcare services to Members.

Provider Agreement means any written contract between the contractor and a Provider that requires the Provider to perform specific parts of the contractor's obligations for the provision of healthcare services under this contract.

Referral means a request by a PCP for a Member to be evaluated and/or treated by a specialty physician.

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

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

Service means healthcare, treatment, a procedure, supply, item or equipment.

Service Location means any location at which a Member may obtain any healthcare service covered by WellCare under the terms of the Provider Agreement.

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

WellCare Companion Guide means the transaction guide that sets forth data requirements and electronic transaction requirements for Clean Claims and Encounter Data submitted to WellCare or its Affiliates, as amended from time to time. The WellCare Claims/Encounter Companion Guides are part of the Provider Handbook.

Section 13: WellCare Resources

Important Telephone Numbers	
WellCare Customer Service/Provider Service	1-855-599-3811
TTY	711
24-Hour Nurse Advice Line	1-800-919-8807
24-Hour Behavioral Health Crisis Line	1-800-378-8013
Fraud, Waste and Abuse Hotline	1-866-678-8355
To report abuse, neglect or exploitation (including elder)	Nebraska Department of Health and Human Services: http://www.dhhs.ne.gov/Pages/complaints.aspx

Forms and Documents

www.wellcare.com/Nebraska/Providers/Medicaid/Forms

Quick Reference Guide

www.wellcare.com/Nebraska/Providers/Medicaid

Clinical Practice Guidelines

www.wellcare.com/Nebraska/Providers/Clinical-Guidelines/CPGs

Clinical Coverage Guidelines

www.wellcare.com/Nebraska/Providers/Clinical-Guidelines/CCGs

Job Aids and Resource Guides

www.wellcare.com/Nebraska/Providers/Medicaid

Provider Orientation

www.wellcare.com/Nebraska

Provider must be a registered user of WellCare's secure online provider portal to access.



www.wellcare.com/Nebraska | <http://dhhs.ne.gov/heritagehealth>

Quality care is a team effort.
Thank you for playing a starring role!