2024–2025 North Carolina Medicaid Provider Manual

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Partners in Quality Care

Dear Provider Partner:

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

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

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

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

Thank you again for being a trusted WellCare provider partner!

Sincerely,

WellCare

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 UM Decisions
- Care Management and Disease Management Programs

SECTION 7

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

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- Preferred Drug List

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Date	Section	Sub-Section	Page	Change

Section 1: Welcome to WellCare

Overview

WellCare of North Carolina is a wholly owned subsidiary of Centene Corporation, a leading multi-line healthcare enterprise. Centene serves approximately 26.6 million Members. Centene's experience and commitment to government-sponsored healthcare programs enables WellCare to serve its Members and Providers, as well as manage its operations effectively and efficiently. These qualities also allow WellCare to support the transition of the North Carolina State Medicaid Plan to the Prepaid Health Plan model.

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 Manual

This Provider Manual is intended for WellCare-contracted (participating) Medicaid Providers providing healthcare services to enrolled WellCare Members. This manual serves as a guide to the policies and procedures governing the administration of WellCare's Medicaid plan and is an extension of and supplements the Provider contract between WellCare and healthcare Providers who include, without limitation: primary care Providers, hospitals, and ancillary Providers (collectively, Providers).

This Manual replaces and supersedes any previous versions prior to the Agency's approval date of October 1, 2024, and is available on WellCare's website at www.wellcarenc.com/providers/medicaid. A paper copy may be obtained, at no charge, upon request by contacting Provider Services or a Provider Relations representative.

In accordance with the policies and procedures clause of the Provider contract, participating WellCare Providers must abide by all applicable provisions contained in this manual. Revisions to this manual reflect changes made to WellCare's policies and procedures. Revisions shall become binding 30 days after notice is provided by mail or electronic means, or after such other period of time as necessary

for WellCare to comply with any statutory, regulatory, contractual, and/or accreditation requirements. As policies and procedures change, updates will be issued by WellCare in the form of Provider bulletins and will be incorporated into subsequent versions of this manual. Provider bulletins that are state-specific may override the policies and procedures in this manual.

WellCare's Managed Care Plans

Medicaid is the medical assistance program that provides access to healthcare for low-income families and individuals. Medicaid also assists seniors and people with disabilities with the costs of nursing facility care, and other medical and long-term care expenses.

American Recovery and Reinvestment Act of 2009

WellCare may not impose enrollment fees, premiums, or similar charges on Indians serviced by an Indian healthcare provider; Indian Health Service; and Indian Tribe, Tribal Organization, or Urban Indian Organization; or through referral under contract health services, in accordance with the American Recovery and Reinvestment Act of 2009.

Copayment Provision

If copayments are waived as an expanded benefit, Providers must not charge Members copayments for Covered Services. If copayments are not waived, the amount paid to Providers by WellCare will be the contracted amount, less any applicable copayments.

Medicaid cost-sharing does not apply to certain subsets of the population, including Qualified Medicare Beneficiaries, children under age 21, pregnant individuals, individuals receiving hospice care, federally recognized American Indians/Alaska Natives, BCCCP beneficiaries, foster children, disabled children under Family Opportunity Act, individuals whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than that required for personal needs, and services for those with developmental disabilities, behavioral health issues, traumatic brain injuries, and substance use disorder.

Medicaid	
Physicians	$4/visit
Outpatient services	$4/visit
Podiatrists	$4/visit
Generic and brand prescriptions	$4/script
Chiropractic	$4/visit
Optical services/supplies	$4/visit
Optometrists	$4/visit
Non-emergency visit in hospital ER	$4/visit

Covered Services

Core Benefits and Services

As of the date of publication of this manual, the following core benefits and services (Covered Services) are provided to WellCare's North Carolina Medicaid Members. Covered Services listed are

no less in amount, duration, and scope of such services in the Medicaid State plan fee-for-service program:

Medicaid
• Allergies • Ambulance Services • Anesthesia • Auditory Implant External Parts* • Burn Treatment and Skin Substitutes • Cardiac Procedures • Certified Pediatric and Family Nurse Practitioner Services • Chiropractic Services • Clinic Services • Dietary Evaluation and Counseling and Medical Lactation Services • Durable Medical Equipment (DME) • Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) • Family Planning Services • Federally Qualified Health Center (FQHC) Services • Freestanding Birth Center Services (when licensed or otherwise recognized by the state) • Hearing Aids • Home Health Services • Home Infusion Therapy • Hospice Services • Inpatient Hospital Services • Inpatient Psychiatric Services for Individuals Under Age 21 • Laboratory and X-ray Services • Limited Inpatient and Outpatient Behavioral Health Services • Maternal Support Services • Non-emergent Transportation to Medical Care • Nursing Facility Services • Obstetrics and Gynecology • Occupational Therapy • Ophthalmological Services • Optometry Services • Other Diagnostic, Screening, Preventive and Rehabilitation Services • Outpatient Hospital Services • Personal Care • Pharmacy Services • Physical Therapy • Physician Services • Podiatry Services

Medicaid
• Prescription Drugs and Medication Management • Private Duty Nursing Services • Prosthetics, Orthotics, and Supplies • Reconstructive Surgery • Respiratory Care Services • Rural Health Clinic (RHC) Services • Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD) • Services in an Intermediate Care Facility for Individuals with Intellectual Disability • Speech, Hearing and Language Disorder Services • Telehealth, Virtual Patient Communications and Remote Patient Monitoring Services • Tobacco Cessation Counseling for Pregnant Individuals • Transplants and Related Services • Ventricular Assist Device • Vision Services

*For this benefit, only the device manufacturers are enrolled providers for auditory implant parts.

Vision Services

The fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses, and ophthalmic frames, is carved out and not included in WellCare's benefit plan:

- The Agency pays for one pair of fee-for-service eyeglasses, fabricated by the NCDHHS optical laboratory, per year for children ages 0 through 20.
- The Agency pays for one pair of fee-for-service eyeglasses, fabricated by the NCDHHS optical laboratory, every two years for adults ages 21 and older.
- Providers who supply eye exams and eyeglasses in their office must also provide Medicaid eye exams and fee-for-service eyeglasses to Members.

WellCare's Covered Services shall include:

- Routine eye exams
- Medically Necessary contact lenses
- Fitting and dispensing visual aids
- Providers obtain Medicaid fee-for-service eyeglasses through the traditional NCDHHS process and bill WellCare for the dispensing fees, after the fee-for-service eyeglasses are dispensed to the Member

For the most up-to-date information on Covered Services, refer to the Department of Health and Human Services website at **www.ncdhhs.gov**.

WellCare is proud to go beyond the basics. We offer additional Value-Added Benefits (VAB) to our members and their families at no extra cost. Details on the variety of extra benefits we offer can be found within the member handbook and online at **www.wellcarenc.com/members/medicaid/benefits/additional-benefits.html**.

Note: Some benefits have eligibility requirements and limits.

Value-Added Benefits can be accessed by contacting Member Services at 1-866-799-5318 (TTY 711).

Services Carved Out of WellCare

Entities other than WellCare provide the following services:

- Services provided through the Program of All-Inclusive Care for the Elderly (PACE).
- Services documented in an Individualized Education Program (IEP), Individual Family Service Plan (IFSP), a Section 504 Accommodation Plan pursuant to 34 C.F.R. § 104.36, an Individual Health Plan (IHP), or a Behavior Intervention Plan (BIP) as appropriate for each Covered Service and provided or billed by Local Education Agencies (LEAs).
- Services provided and billed by Children's Developmental Services Agency (CDSA) are included on the child's Individualized Family Service Plan.
- Dental services defined as all services billed as dental using the American Dental Association's Current Dental Terminology (CDT) codes, with the exception of the two CDT codes (D0145 and D1206) associated with the "Into the Mouths of Babes" (IMB)/Physician Fluoride Varnish Program.
- Services for Medicaid applicants provided prior to the first day of the month in which eligibility is determined in cases where retroactive eligibility is approved.
- Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses, and ophthalmic frames.

Tailored Plan

A Tailored Plan is an integrated health plan for individuals with significant behavioral health needs or intellectual/developmental disabilities. Tailored plans are required to contract with a licensed prepaid health plan, such as WellCare of NC. WellCare currently contracts with two Tailored Plans: Alliance Health, and Vaya.

Provider Services

Providers may contact the appropriate departments at WellCare by referring to the *Quick Reference Guide* at **www.wellcarenc.com/providers/medicaid**. Provider Relations representatives are available to assist with many requests for participating WellCare Providers.

Provider Relations representatives will conduct initial and ongoing training to ensure compliance with program standards and contractual obligations. Provider trainings may be accomplished by Provider orientations, newsletters, online learning modules, emails, faxes, letters, on-site training, summits, webinars, or other means. The company's Provider Relations Staff is responsible for:

A. Initial Orientation. Initial orientation of Providers shall be performed, in person, at the Provider's office, or at a mutually agreed upon site, within 30 days of placing a newly contracted Provider or Provider group on active status or at the first availability of the company and Provider after those days

have expired. The orientation can be administered in a variety of settings (e.g., group, seminar or one-on-one).

Providers are required to complete a comprehensive set of training modules within 30 days of contracting. Providers have the option of completing their training via web modules on the provider portal (with an attestation requirement) or in-person with their Provider Relations representative. A Provider Visit Information Form is used to document the in-person orientation and outline all topics covered. This form is signed and dated by the Provider, along with the names of participants who were present, and any follow-up items. Evidence of the initial orientation is stored in WellCare's internal customer relationship management system, along with the signed Provider Visit Information Form.

During the orientation, WellCare's provider portal is used to navigate the training documents, so Providers are aware of the tools and resources available for everyday use. Some of the topics discussed during initial orientation will include:

- Managed Care Program and Services
- Eligibility and Benefits
- Rights and Responsibilities
- Member Care and Quality
- Authorizations
- WellCare's Compliance Program
- Billing, Payment, and Encounters, including Electronic Visit Verification (EVV)
- Appeals and Grievances
- WellCare's Policies and Procedures
- Telemedicine Services
- Model of Care
- Timely Access Requirements
- Continuity of Care and Transition of Care
- Members with Special Needs
- Review of the Provider Manual
- Specialized Provider Education (for certain Long-Term Care, Serious Mental Illness specialty plan, and other Providers as identified by WellCare)

B. Ongoing Training. Ongoing training shall be provided as deemed necessary and to meet the requirements outlined by either WellCare or the NC Medicaid contract to ensure compliance with program standards. Ongoing monthly webinars are also conducted in adherence with contractual requirements. Ad hoc trainings may be initiated, as necessary, to address identified issues and/or updates as proposed by the plan, State of North Carolina, or the Provider. Methods of training include group orientations, seminars and summits, one-on-one Provider sessions, joint operating committee (JOC) meetings, webinars, phone calls, emails, etc.

Provider Relations representatives are available to provide up-to-date information on the training provided.

WellCare Self-Service Tools for Providers

WellCare offers technology options to save Providers time, including the secure web portal, Chat, and IVR (Interactive Voice Response System) self-service tools.

These self-service tools help Providers do business with WellCare. We want your interactions with us to be as easy, convenient, and efficient as possible. Giving Providers and their staff self-service tools, and access helps us accomplish this goal. Providers can access this information below or at **www.wellcarenc.com**.

Secure Provider Portal: Key Features and Benefits of Registering

WellCare's secure online provider portal offers immediate access to what Providers need most. All participating Providers who create an account and are assigned the appropriate role/permissions can use the following features:

- **Claims Submission, Status, Appeal, Dispute –** Submit a claim, check status, 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 may also print and/or save copies of the authorization.
- **Pharmacy Services and Utilization –** View and download a copy of WellCare's preferred drug list (PDL), view Member prescription history, and access pharmacy utilization reports.
- **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 for use with multiple practitioners / offices. Administrators can easily manage users and permissions. Once registered for the secure portal, Providers should retain username and password information for future reference.

How to Register

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

Additional Resources

The following resources are at **www.wellcarenc.com/providers/medicaid**:

- The ***Provider Resource Guide*** contains information about the secure online provider portal, Member eligibility, authorizations, filing paper and electronic claims, appeals, and more. For more specific instructions on how to complete day-to-day administrative tasks, please see the *Medicaid Resource Guide*.
- The ***Quick Reference Guide*** contains important addresses, phone/fax numbers, and authorization requirements.

Website Resources

WellCare's website, **www.wellcarenc.com**, offers a variety of tools to assist Providers and their staff. Available resources include:

- Provider Manuals

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

Using Chat: Get to Know the Benefits of Chat

Faster than email and easier than phone calls, Chat is a convenient way to ask simple questions and receive real-time support. Providers now have the ability to use our Chat application as an alternative to calling and speaking with agents. Chat can help Providers and their staff with web support assistance and real-time claim adjustments. Explore the benefits of live Chat!

- **Convenience**
  - Live Chat offers the convenience of getting real-time help and answers.
- **Documentation of Interaction**
  - Unlike phone support, live Chat software offers the option of receiving a transcription of the conversation.
- **Access Chat through the portal**
  - The *Chat Support* Icon is on our secure provider portal. From there, Providers can:
    - Log on to the provider portal at **https://provider.wellcare.com**.
    - Access the "Help" section.
    - Select the desired Chat topic.
    - If the Chat agent is unable to resolve the issue, the issue will be routed to the right team for further assistance.

Interactive Voice Response (IVR) System

IVR system

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

Self-Service features

- Ability to receive Member copay information
- Ability to receive Member eligibility information
- Ability to request authorization and/or status information
- Unlimited claims information on full or partial payments
- Receive status for multiple lines of claim denials
- Rejected claims information is 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 – the Member's ID number, date of birth, date of service, and dollar amount
- For authorization and eligibility inquiries – 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 Provider Service team from IVR for assistance when needed

Provider Services phone number (toll-free): **1-866-799-5318**

Section 2: Provider and Member Administrative Guidelines

Provider Administrative Overview

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

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

- Meet the requirements of all applicable state and federal laws and regulations, including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973.
- Agree to cooperate with WellCare in its efforts to monitor compliance 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 [42 C.F.R. § 422.504(a)(3)(iii).]
- Use physician extenders appropriately. Physician assistants (PAs) and advanced registered nurse practitioners (ARNPs) should provide direct Member care within the scope or practice established by the rules and regulations of approved North Carolina Department of Health and Human Services (DHHS) and WellCare guidelines.
- Assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations.
- Clearly identify physician extender titles (examples: ARNP, PA) to Members and to other healthcare professionals.
- Honor at all times any Member requests to be seen by a physician rather than a physician extender.
- Administer, within the scope of practice, treatment for any Member in need of healthcare services.
- Maintain the confidentiality of Member information and records.
- Ensure all documentation regarding services provided is timely, accurate, and complete.
- Allow WellCare to use Provider performance data for quality improvement activities.
- Respond promptly to WellCare's requests for medical records in order to comply with regulatory requirements.
- Maintain accurate medical records and adhere to all WellCare policies governing content and confidentiality of medical records as outlined in *Section 3: Quality Improvement* and *Section 8: Compliance*.
- Ensure that:
    - All employed physicians and other Providers comply with the terms and conditions of the Provider contract; and

    - To the extent the contracted Provider maintains written agreements with employed physicians and other Providers, such agreements are consistent with, and require adherence to, the contracted Provider's agreement with WellCare.
- 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 reviewed during medical/chart review. Upon request, provide timely transfer of clinical information to WellCare, the Member or the requesting party at no charge, unless otherwise agreed.
- Preserve Member dignity and observe the rights of Members to know and understand the diagnosis, prognosis, and expected outcome of recommended medical, surgical, and medication regimen.
- Not discriminate in any manner between WellCare Members and non-WellCare members, based on a person's:
    - Race, mental or physical disability, source of payment, cost of treatment, participation in benefit plans, genetic information, religion, gender, sexual orientation, health, ethnicity, creed, age or national origin.
- Ensure that the hours of operation offered to WellCare Members are no less than those offered to commercial members or comparable NC 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:
    - 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
- 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 services related to children's health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation, substance use disorder, 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.

Copayment Provision

If copayments are waived as an expanded benefit, the Provider must not charge Members copayments for Covered Services. If copayments are not waived as an expanded benefit, the amount paid to Providers by WellCare will be the contracted amount, less any applicable copayments.

Medicaid cost-sharing does not apply to certain subsets of the population, including Qualified Medicare Beneficiaries, children under age 21, pregnant individuals, individuals receiving hospice care, federally-recognized American Indians/Alaska Natives, BCCCP beneficiaries, foster children, disabled children under Family Opportunity Act, individuals whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than that required for personal needs, and services for those with developmental disabilities, behavioral health issues, traumatic brain injury, and substance use disorder.

Excluded or Prohibited Services

Providers must verify patient eligibility and enrollment prior to service delivery. WellCare is not financially responsible for non-covered benefits or for services rendered to ineligible recipients. Certain covered benefits, such as specific transplant services, are administered outside of the managed care program.

For Medicaid, excluded services are defined as those services that Members may obtain through other applicable Medicaid programs, including the NC Medicaid Fee for service system, and for which WellCare is not financially responsible. These services may be paid for by the Department of Health and Human Services (DHHS) on a fee-for-service basis or other basis. Providers are required to determine eligibility and Covered Services prior to rendering services. In the event the service is excluded, Providers must file a claim for reimbursement directly to the DHHS. In the event the service(s) is (are) prohibited, neither WellCare nor the DHHS is (are) financially responsible. For more information on prohibited services, refer to **www.wellcarenc.com/providers/medicaid**.

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 for abuse, neglect, or exploitation. Information on mandatory reporting in NC is at: **http://www.nccasa.org/cms/resources/criminal-statutes/mandatory-reporting-in-nc**.

To report suspected abuse, neglect, or exploitation of children or vulnerable adults, Providers should contact the Local County Department of Social Services Office. A list of offices is at **www.ncdhhs.gov/divisions/dss/local-county-social-services-offices**. If a Provider sees a child or vulnerable adult in immediate danger, the Provider should call **911**.

Providers must report suspected cases of abuse, neglect, and/or exploitation to the Agency's Department of Social Services.

- If the suspected activity involves a parent, guardian, or caretaker:
    - **Children** – Report what you know to the county Department of Social Services. Learn more at **https://www.ncdhhs.gov/divisions/social-services/child-welfare-services/child-protective-services/about-child-abuse-and**
    - **Adults** – Report what you know to the county Department of Social Services. Learn more at **https://www.ncdhhs.gov/assistance/adult-services/adult-protective-services**.
    - **Elders** – Report what you know to the county Department of Social Services. Learn more at **https://www.nia.nih.gov/health/elder-abuse**

- If the suspected activity is not a parent, guardian, or caretaker – Report what you know to the local law enforcement authorities.
- If the suspected activity involves personnel engaged in providing healthcare services – Report what you know to the N.C. Health Care Personnel Registry (HCPR). Learn more at **https://info.ncdhhs.gov/dhsr/hcpr/flohcinv.html**

Adult Protective Services (APS) are services designed to protect elders and vulnerable adults from abuse, neglect, or exploitation. The Department of Aging and Adult Services and APS 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 children and elderly victims of abuse, neglect and exploitation can be found in G.S. 108A Article 6, G.S. 7B Article 3 and 10A NCAC 27G.0610.

Providers may be asked to cooperate with WellCare to provide services or arrange for the Member to receive services at an alternative location. Training regarding abuse, neglect, and exploitation is available at **www.wellcarenc.com/providers/medicaid/training**.

Access Standards

All Providers must adhere to standards of timeliness for appointments and in-office waiting times. These standards take into consideration the immediacy of the Member's needs. WellCare will comply with the Agency's requirement to have the required participating Providers (as required by the state contract in section V.D.1d), by region, offer after-hours appointment availability to Medicaid Members.

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

Providers should be available for/or provide on-call coverage through another source twenty-four (24) hours a day for management of beneficiary care.

Appointment Wait Time Standards		
Provider Type	Visit Type	Standard
Primary Care	Preventive Care Service – adult, 21 years of age and older	Within 30 calendar days
	Preventive Care Service – child, birth through 20 years of age	Within 14 calendar days for Members less than 6 months of age Within 30 calendar days for Members 6 months of age and older
	Urgent Care Services	Within 24 hours
	Routine/Check-up without Symptoms	Within 30 calendar days

Appointment Wait Time Standards		
	After-hours Access – Emergent and Urgent	Immediately (available 24 hours a day, seven days a week, 365 days a year)
Prenatal Care	Initial Appointment – 1st or 2nd Trimester	Within 14 calendar days
	Initial Appointment – 3rd trimester	Within five calendar days
Specialty Care	Urgent Care Services	Within 24 hours
	Routine/Check-up without Symptoms	Within 30 calendar days
	After-hours Access – Emergent and Urgent	Immediately (available 24 hours a day, seven days a week, 365 days a year)

For the purposes of this document and the Network Adequacy Standards, “urban” is defined as non-rural counties or counties with average population densities of 250 or more people per square mile. This includes 20 counties that are categorized by the North Carolina Rural Economic Development Center as “regional cities or suburban counties” or “urban counties.” “Rural” is defined as a county with an average population density of less than 250 people per square mile.

WellCare will ensure Members have access to care through an adequate Provider network by monitoring travel times and distances between Providers and Members. In the event a geographic area does not have enough Providers to meet the standards listed below, WellCare will conduct outreach activities in order to add additional Providers to the network.

In order to ensure that all Members have timely access to all covered healthcare services, the network must meet, at a minimum, the following time and distance standards as measured from the Member’s residence for adult and pediatric Providers separately through geo-access mapping.

Service types not subject to separate adult and pediatric Provider standards are hospitals, pharmacies, occupational/physical/speech therapists, LTSS, and nursing facilities.

Network Adequacy Time and Distance Standards		
Service Type	Urban Standard	Rural Standard
Primary Care Provider (Adult or Pediatric)	WellCare will ensure its network meets, at a minimum, the following time/distance standards as measured from the member’s residence for adult and pediatric providers separately through geo-access mapping at least annually. >= Two Providers within 30 minutes or 10 miles for at least 95% of Members	WellCare will ensure its network meets, at a minimum, the following time/distance standards as measured from the member’s residence for adult and pediatric providers separately through geo-access mapping at least annually.

Network Adequacy Time and Distance Standards		
		>= Two Providers within 30 minutes or 30 miles for at least 95% of Members
Specialty Care (Adult or Pediatric)	>= Two Providers (per specialty type) within 30 minutes or 15 miles for at least 95% of Members	>= Two Providers (per specialty type) within 60 minutes or 60 miles for at least 95% of Members
Service types below are not subject to adult and pediatric provider standards		
Hospitals	>= One hospital within 30 minutes or 15 miles for at least 95% of Members	>= One hospital within 30 minutes or 30 miles for at least 95% of Members
Pharmacies	>= Two Providers within 30 minutes or 10 miles for at least 95% of Members	>= Two Providers within 30 minutes or 30 miles for at least 95% of Members
Obstetrics[1]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of Members
Occupational, Physical, or Speech Therapists	>= Two Providers (of each provider type) within 30 minutes or 10 miles for at least 95% of Members	>= Two Providers (of each provider type) within 30 minutes or 30 miles for at least 95% of Members
All State Plan LTSS (except nursing facilities)	WellCare must have at least two LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	WellCare must have at least two Providers accepting new patients available to deliver each State Plan LTSS in each county. Providers are not required to live in the same county in which they provide services.
Nursing Facilities	WellCare must have at least one nursing facility accepting new patients in every county.	WellCare must have at least one nursing facility accepting new patients in every county.

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

Responsibilities of All Providers

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

[1] Measured on members who are female and age 14 through age 44. Certified Nurse Midwives may be included to satisfy OB access requirements.

WellCare requires providers to deliver services to WellCare Members without regard to race, color, national origin, age, disability or sex. Providers must not discriminate against Members based on their payment status and cannot refuse to serve based on varying policy and practices and other criteria for the collecting of Member financial responsibility from WellCare Members.

Provider Identifiers

All participating Providers (with the exception of atypical 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, and who perform services for WellCare's Medicaid Members, must also obtain a North Carolina Medicaid Provider ID. The NPI associated to a Provider's North Carolina Medicaid Provider ID is used to submit a claim or encounter data for the services rendered under WellCare. It is the Provider's responsibility to obtain the North Carolina Medicaid ID and ensure the billing / rendering NPI and taxonomy codes billed on a claim or encounter match how the Provider is registered with NCDHHS.

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 the Member to designate another person to make a decision should the Member 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 the Member's medical record.

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

Provider Billing and Address Changes

Prior notice to a Provider Relations representative or Provider Services is required for any of the following changes:

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

Provider Termination

In addition to the Provider termination information included in the Provider contract, 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 contract for the details regarding the specific required days for providing termination notice, as the Provider may be required by contract to give different notice than listed above.

- Unless otherwise provided in the termination notice, the effective date of termination will be on the last day of the month.
- Members in active treatment may continue to receive care when such care is Medically Necessary, through the completion of treatment for which the Member was receiving at the time of the termination, or until the Member selects another treating provider, for a minimum of 60 days, is 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 of care shall be provided until the completion of postpartum care.

Please refer to *Section 6: Credentialing* of this manual for specific guidelines regarding rights to appeal termination by the plan, 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 North Carolina Medicaid requirements and/or regulations and statutes.

Out-of-Area Member Transfers

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

Priority Populations

Priority Population means populations likely to have care management needs and likely to benefit from care management. To learn more about the characteristics of a Priority Population, see Section 12 of this manual.

Providers who render services to WellCare Members who have been identified in a Priority Population have the following responsibilities:

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

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

Responsibilities of Primary Care Physicians (PCPs)

The following is a summary of responsibilities specific to PCPs who render services to WellCare Members. These are intended to supplement the terms of the Provider contract, 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 the age of 21.
- Ensure that copies of the referral are provided to the Member and kept in the Member's medical record each time a potentially eligible member is referred 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 HEDIS® (Healthcare Effectiveness Data and Information Set) service.
- Submit encounters. For more information on encounters, refer to *Section 5: Claims.*
- Determine if the Member has other insurance that should be billed first.
- 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* at **www.wellcarenc.com/providers/medicaid.**
- Comply with and participate in corrective action and performance improvement plan(s).

Vaccines for Children Program

Providers are strongly encouraged to participate in the Vaccines for Children (VFC) program. The VFC program is a federally funded program that provides vaccines at no cost to children, younger than 19 years of age, who might not otherwise be vaccinated because of an inability to pay. The Centers for Disease Control and Prevention purchases vaccines at a discounted rate and distributes them to grantees who, in turn, distributes them to VFC-enrolled public and private healthcare providers. The North Carolina Immunization Branch in the Division of Public Health is the state's VFC awardee. Since VFC vaccines are federally purchased, enrolled providers cannot bill for the cost of the vaccine. Providers, however, can bill for vaccine administration fees. VFC providers must maintain adequate stock of all vaccines that are recommended by the Advisory Committee on Immunization Practices (ACIP) as appropriate for their specific patient population. Non-VFC enrolled providers who choose to use private stock to vaccinate Medicaid-covered children will not be reimbursed for the cost of the vaccine. Visit **https://www.immunize.nc.gov/providers/enrollmentrequirements.htm** for more information or contact the NC Immunization Branch at **1-919-707-5598** to begin the VFC enrollment process.

Providers must report all immunizations administered to the North Carolina Immunization Registry (NCIR), **https://www.immunize.nc.gov/providers/ncir.htm**. To request access, contact the NC Immunization Branch at **1-877-873-6247**.

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

Medicaid offers its covered children and youth under age 21 a comprehensive benefit for preventive healthcare and medical treatment. WellCare Providers offer or arrange for the full range of preventive and treatment services available within the federal EPSDT benefit. Preventive (wellness) services are offered without copays or other charges, on a periodic schedule established by the state of North Carolina.

Early Periodic Screening services include physical exams, up-to-date health histories, developmental, behavioral and risk screens, vision, hearing and dental health screens, and all vaccines recommended by the Advisory Committee on Immunization Practices. Medically Necessary care and treatment to "correct or ameliorate" health problems must be provided directly or arranged by referral, even when a Medicaid-coverable service is not available under the state Medicaid plan.

Our pediatric primary care goal is to improve the health of Medicaid Members from birth to age 21 by increasing participation in comprehensive Early Periodic Screening (wellness) visits. When conducting Early Periodic Screenings, Providers will adhere to best practice guidelines published by the American Academy of Pediatrics in their Bright Futures publication.

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

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

Any Provider, including physicians, nurse practitioners, registered nurses, physician assistants, and medical residents who provide EPSDT screening services are responsible for:

- Providing all needed initial, periodic, and inter-periodic EPSDT health assessments, diagnosis, and treatment to all eligible Members in accordance with federal regulation 42 U.S.C. § 1396d(r)(5); NC State Contract Section V.C.2.i.iii; and as recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents" for all Members under the age of 21; including:
  - Screening for developmental delay at each visit through the fifth year
  - Screening for autistic spectrum disorders per AAP guidelines
  - Comprehensive, unclothed physical examination
  - All appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices
  - Laboratory testing (including blood lead screening appropriate for age and risk factors)
  - Health education and anticipatory guidance for both the child and caregiver

- Performing, during preventive visits and as necessary at any visit, oral health assessments, evaluations, prophylaxis, and oral hygiene counseling for children under 21 years of age in accordance with the Department's Oral Health Periodicity Schedule; and,
    - Refer infant Medicaid Members to a dentist or a dental professional working under the supervision of a dentist at age 1, per requirements of the Department's Oral Health Periodicity Schedule.
        - Services provided by a dentist are carved out of Medicaid Managed Care and should be billed to the NC Medicaid Fee for Service programs.
- Providing vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.
- Providing vaccinations in conjunction with EPSDT/well-child visits.
- Using vaccines available without charge under the Vaccines for Children (VFC) Program for Medicaid children younger than the age of 19.
- Addressing unresolved problems, referrals, and results from diagnostic tests, including results from previous EPSDT visits.
- Requesting Prior Authorization, if applicable, for special services resulting from an EPSDT visit, in the event other healthcare, diagnostic, preventive or rehabilitative services, treatment or other measures described in 42 U.S.C. § 1396d(r), and 42 C.F.R. § 441.50-62; and the particular needs of the Member, are not otherwise covered under NC Medicaid.
    - Prior Authorization of preventive care (early and periodic screens/wellness visits) for Medicaid Members less than 21 years of age is NOT required.
- Coordinating with behavioral health (BH) Providers and specialists when conducting EPSDT screenings.
- 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.
- Referring the Member to an out-of-network provider for treatment if the follow-up service is not available within WellCare's network.
- Monitoring, tracking, and following up with Members who have not had a health assessment screening or who miss appointments to assist them in obtaining an appointment.
- Assisting Members with transition to other appropriate care for children who age-out of EPSDT services.

For more information on EPSDT Covered Services, refer to *Section 1: Welcome to WellCare*. For more information on the NC Medicaid EPSDT Periodicity Schedule, refer to the DHHS website at **https://medicaid.ncdhhs.gov/medicaid/get-started/find-programs-and-services-right-you/medicaids-benefit-children-and-adolescents**. For more information on the Periodicity Schedule based on the American Academy of Pediatrics guidelines, refer to the AAP website at **www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx**.

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, Clinical Services, and Marketing and Sales departments, as well as the tools and resources at **www.wellcarenc.com.**

- Information on WellCare network Providers for the purposes of referral management and discharge planning.

Closing of Physician Panel

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

- Submit the request in writing at least 60 days (or such other period stated in the Provider contract) 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 should make arrangements with another WellCare-contracted (participating) and credentialed Provider to provide services on their behalf, except in cases of emergency care.

Covering physicians should be credentialed by the Agency and are required to sign an agreement accepting the negotiated rate and agreeing to not balance bill WellCare Members.

In non-emergency cases, if a Provider has a covering physician/Provider who is not contracted and credentialed, they should contact WellCare for approval. For more information, refer to the *Quick Reference Guide* at **www.wellcarenc.com/providers/medicaid**.

Termination of a Member

A WellCare Provider may not seek or request to terminate their relationship with a Member or transfer a Member to another provider of care based upon the Member's medical condition, amount or variety of care required, or the cost of Covered Services required by 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 the Provider's 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 that such transfer has occurred.

A WellCare Provider may utilize the provider portal or "PCP Request for Transfer of Member Form" on **www.wellcarenc.com** to request that a Member be removed from their patient panel if the physician feels that:

- the Member is non-compliant with the physician's treatment plan or plan of care,
- if there is evidence of abusive or inappropriate behavior, or
- if the physician is unable to adequately address the member's needs

In addition, if a WellCare Provider has evidence that the member has relocated or moved their care to another primary care practice, providers may contact their Provider Relations representative to member to discuss member re-assignment to another AMH/PCP.

Domestic Violence and Substance Use Disorder Screening

PCPs should identify indicators of substance use disorder or domestic violence and offer referral services to applicable community agencies. Sample screening tools for domestic violence and substance use disorder are located at **www.wellcarenc.com.**

My Health Pays® Program

WellCare of North Carolina will reward Members who complete specific preventive health, wellness, and engagement milestones as a part of our My Health Pays® program. The purpose of the program is to encourage Members to engage in preventive care and healthy habits. Incentives do not allow for gambling or for the purchase of alcohol, tobacco, firearms, or ammunition. The program is not mandatory for Members.

Healthy Behavior Program	Focus Area	Activity Criteria	Incentive Type	Incentive Value
Children's Health	0-30 Months	Complete well-child visits per well-child checkup schedule: Members may complete up to six (6) visits between 0 and 15 months, and two (2) visits between 15 and 30 months.	Prepaid	$15 per visit *(Members cannot exceed $75 per year)*
	3-21 years	Complete annual well care visit (each year)	Prepaid	$25 (Members cannot receive more than $75 per year)
	0-24 months	Requires completion of all of the following: -four (4) diphtheria, tetanus and acellular pertussis (DTaP) -three (3) polio (IPV) -one (1) measles, mumps and rubella (MMR) -three (3) haemophilus influenza type B (HiB) -three (3) hepatitis B (HepB) -one (1) chicken pox (VZV) -four (4)pneumococcal conjugate (PCV) -one (1) hepatitis A (HepA) -two or three (2 or 3) rotavirus (RV) -two (2) influenza (flu) vaccines	Prepaid	$25 (Members cannot get more than $75 per year)
	birth-13 years	Must complete all by 13th birthday: -one (1) dose of meningococcal vaccine -one (1) tetanus		$25 (Members cannot get more than $75 per year)

Healthy Behavior Program	Focus Area	Activity Criteria	Incentive Type	Incentive Value
		-diphtheria toxoids and acellular pertussis (Tdap) vaccine -human papillomavirus (HPV) vaccine series		
Healthy Pregnancy	Prenatal Care Visits (Age 12 and up)	Attend a prenatal visit during first trimester (or within 42 days of enrollment).	Prepaid	$25 (Members cannot receive more than $75 per year)
	Completion of Prenatal visit	Members who complete a prenatal visit will have the choice to receive one of the reward options listed.	Bonus Reward	Choice of a stroller, portable playpen, car seat, or six packs of diapers. Call Member Services to redeem reward.
	Postpartum Care Visit (Age 12 and up)	Attend a postpartum visit 21 days or less after the birth of the baby.	Prepaid	$25 (Members cannot receive more than $75 per year)
	Postpartum Care Visit 2 (Age 12 and up)	Attend a second postpartum visit between 22-84 days after the birth of the baby .	Prepaid	$25 (Members cannot receive more than $75 per year)
Chronic Care Management	Diabetes (Age 18- 75 years)	Members with diabetes complete an annual eye exam.	Prepaid	$25 (Members cannot receive more than $75 per year)
		Diabetics complete annual HbA1c lab test.	Prepaid	$25 (Members cannot receive more than $75 per year)
Well Women	Cervical Cancer Screening (Age 21-64)	Complete office visit for annual cervical cancer screening (pap smear).	Prepaid	$25 (Members cannot receive more than $75 per year)
Adult Health	Annual Adult Health Screening (Age 20 and older)	Complete annual adult screening (wellness visit).	Prepaid	$25 (Members cannot receive more than $75 per year)

Healthy Behavior Program	Focus Area	Activity Criteria	Incentive Type	Incentive Value
Behavioral Health	Behavioral Health (Age 6 and older)	Go to a behavioral health Provider within 30 days after a behavioral health hospital stay.	Prepaid	$25 (Members cannot receive more than $75 per year)
	Ages 1-17	To earn go to a counseling appointment within 30 days after anti-psychotic prescription.	Prepaid	$25 (Members cannot receive more than $75 per year)
	Tobacco Cessation Counseling (Age 18 and older)	Members should call the Quit Line at **1-866-QUIT-4-Life (1-866-784-8454)** to participate in the counseling program. Once completed, Members must log on to the Healthy Rewards site or contact WellCare or contact WellCare customer service to attest to completing the activity. To start, Members must call the Quit Line at 1-866-QUIT-4-LIFE (1-866-784-8454). Members must enroll in the program and complete 5 coaching sessions.	Gift Card or e-Gift Card Prepaid	$25 (Members cannot receive more than $75 per year)$25
	18 years and older	Once per flu season: September through April	Gift Card or e-Gift Card Prepaid	$25 (Members cannot receive more than $75 per year)

Prevention and Wellness

WellCare has incorporated the Agency's population health priorities to include obesity, infant mortality, low birth weight, early childhood health, and development to encourage improved health and wellness among Members. Additional information on tobacco cessation, weight loss, and diabetes prevention programs is listed below.

Smoking Cessation

PCPs should direct Members who smoke and wish to quit smoking to call WellCare's Member Services department and ask to be directed to the tobacco cessation program. A health coach will work with Members through tailored interactions based on their individual needs and health objectives associated with tobacco cessation.

WellCare will contract with the Agency's vendor, Quit for Life, to provide evidence-based tobacco cessation care to our Members. We will ensure that our Members are given complete information about the coverage of tobacco cessation items and services.

WellCare will partner with the Agency to, at a minimum:

- Promote the full tobacco cessation benefit to Members.
- Partner with the Agency and Quit for Life on outreach.
- Submit marketing and educational materials consistent with the requirements pursuant to WellCare's contract with the Department.

The Quit for Life program includes the following services to Members:

- Up to four coaching sessions.
- Up to 10 maternity coaching sessions, where applicable.
- Unlimited toll-free telephone access 24 hours a day, seven days a week for 12 months following the Member's enrollment date, excluding holidays.
- Access to web-based portal support for Members with email addresses.
- Text messages for up to 12 months following the Member's enrollment date, for Members with a cell phone and who opt into the texting program.
- A standard quit guide containing educational content, tips, and tools pertinent to tobacco cessation.
- Access to nicotine replacement therapy (NRT).

Members can call **1-866-QUIT-4-LIFE (1-866-784-8454)** for assistance to stop using tobacco products.

PCPs can also reference the Agency for Healthcare Research & Quality's Smoking Cessation *Quick Reference Guide* at **www.wellcarenc.com/providers/medicaid** or by contacting a Provider Relations representative.

Weight Loss

As a part of WellCare's weight-loss initiative, WellCare is partnering with the YMCA to help Members seeking a healthier weight to achieve their goals. Healthy Weight and Your Child (HWYC) is:

- A weight-management program that focuses on healthy eating, physical activity, and behavior change to empower children and families to live healthier and more active lifestyles.

- An evidence-based program offered through a YMCA Medical Membership. (A YMCA Medical Membership is one in which an individual is referred to the YMCA by a physician.)
- A program under which families registered for the program work with trained leaders through 25 educational sessions.

To qualify for the YMCA's HWYC, Members must:

- Be between 7 and 13 years old
- Carry excess weight
- Have a body mass index of the 95th percentile or higher
- Receive clearance from a healthcare provider to participate in physical activity

YMCA Youth Obesity Program Referral Process:

- To refer your North Carolina WellCare Medicaid Members between 7 and 13 years of age to this program, complete and submit a **YMCA Medical Membership.**
- Sessions and locations can be found at: **www.ymcatriangle.org/programs/fitness-and-wellness/healthy-weight-and-your-child**.
- YMCA Medical Membership staff can be reached at **1-919-582-9396** or **medical.membership@YMCATriangle.org.**

Diabetes Prevention

- WellCare is partnering with the YMCA for a CDC-approved Diabetes Prevention Program to help those at risk of developing type 2 diabetes adopt and maintain healthy lifestyles. By making and maintaining these modest and achievable lifestyle changes, a Member can help reduce the chances of developing diabetes.
- To qualify for the YMCA's Diabetes Prevention Program, Members must be:
  - At least 18 years old;
  - Overweight (BMI>25; Asian adults, BMI>22); and
  - At high risk for developing type 2 diabetes or have been diagnosed with prediabetes.
- To refer your North Carolina WellCare Medicaid Members 18 years of age and older to this program:
  - Visit the provider portal at **https://provider.wellcare.com** to get the referral form.
  - Complete and forward the referral to the YMCA in the Member's area. Locations are at **https://www.diabetesfreenc.com/find-a-program/.**
  - Providers also can refer WellCare Members who cannot attend in person to **.**

Adult Health Screening

An adult health screening should be performed by a physician or physician extender to assess the health status of all adult WellCare 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, to see that Members in need of linguistic services receive adequate communication

support, and to ensure that the needs of our Members with disabilities and their families are identified and fully addressed. 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, linguistic, or disability-related barriers for which alternative communication methods are needed.
- Use culturally sensitive and appropriate educational materials based on the Member's race, ethnicity, condition of disability, 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 that 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 and CHIP populations.
  - 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. 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.
    - Where WellCare enrolls significant numbers of Members who speak languages other than English or Spanish, WellCare seeks to recruit staff Members who are bilingual in English plus one of those other languages. WellCare does this even if the particular population is not of a size that triggers state agency mandates.
- Diversity of Provider Network:
    - Providers are inventoried for their language abilities. This information is made available in the Provider directory so 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 necessary 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 Members with hearing difficulties. These services are provided by vendors with such expertise and coordinated by WellCare's Member Services department.
    - Written materials are available for Members in large-print format and certain non-English languages prevalent in WellCare's service areas.
- Electronic Media:
    - Telephone system adaptations – Members have access to the TTY line for 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 highlighted above.

For more information about the Cultural Competency Program, registered provider portal users may access the full Cultural Competency Plan, cultural competency survey, and Provider trainings at **www.wellcarenc.com/providers/medicaid/training**. A paper copy may be obtained at no charge 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, and each Member's rights and responsibilities. WellCare will convey this information through various methods, including a Member handbook.

Member Handbook

All newly enrolled Members can access the Member handbook at **www.wellcarenc.com** and may request a hard copy handbook by contacting Member Services.

Enrollment

WellCare obeys laws that protect from discrimination or unfair treatment. WellCare does not discriminate based on a person's race, mental or physical disability, source of payment, cost of treatment, participation in benefit plans, genetic information, religion, gender, sexual orientation, health, ethnicity, creed, age, or national origin.

Upon enrollment in WellCare, Members are provided with:

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

Member Identification Cards

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

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

Eligibility Verification

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

Providers may do one of the following to verify eligibility:

- Access the secure, online provider portal of the WellCare website at **provider.wellcare.com**
- Access WellCare's interactive voice response (IVR) system
- Contact Provider Services

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

Member Engagement

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

If the Member cannot be reached by telephone, the Member's name and address is referred to the community health worker (CHW) assigned to the Member's ZIP code. Community health workers then make every attempt to connect with the Member and conduct a face-to-face session to complete the HRA. This interview, whether telephonic or in person, is a critical step to engaging Members in their own health management. WellCare's telephonic team and CHWs are trained in behavioral interviewing techniques that promote maximum engagement of the Member.

Assessments for Members

A Health Risk Assessment (HRA) is completed with the Member within the first 90 days of enrollment. Members have several options for completing the HRA. A paper version can be mailed to the Member. The Member can alternatively choose to take the HRA online via the Member portal. In addition, WellCare makes five attempts to contact the Member telephonically to complete an HRA. If the telephonic attempts are not successful, Members are referred to WellCare's community health workers for completion of the HRA. Community health workers utilize every method at their disposal to make contact with a Member to complete the HRA.

If 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 licensed clinical 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 the Member's Providers to view via the provider portal. Care managers collaborate with the Provider to ensure the most successful care plan is developed and implemented in order to effect positive outcomes for the Member.

Member Rights and Responsibilities

WellCare of North Carolina's Members have rights, as a Provider, participating or non-participating, the Member's rights must be respected. These include the following:

Member Rights

- WellCare of North Carolina will comply with any applicable Federal and State laws that pertain to Member rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to Members.
- Each Member has the right to receive information about WellCare of North Carolina, its services, its practitioners and Providers, and Member rights and responsibilities, in accordance with 42 C.F.R. §438.10.
- Each Member has the right to appoint someone they trust (a relative, friend, or lawyer) to speak for the Member if the Member is unable to speak for themselves about their care and treatment.
- Each Member has the right to use the State Fair Hearing system.
- Each Member has the right to give approval of any treatment or plan after that plan has been fully explained to the Member.
- Each Member is guaranteed the right to be treated with respect and with due consideration for their dignity and right to privacy.
- Each Member has the right to a candid discussion of appropriate or Medically Necessary treatment options for their condition(s), regardless of cost or benefit coverage.
- Each Member has the right to make recommendations regarding WellCare of North Carolina's Member Rights and Responsibilities policy.
- Each Member is guaranteed the right to receive health information and participate in decisions regarding their healthcare, including available and/or alternate treatment options presented in a manner appropriate to the Member's condition and ability to understand, and the right to refuse treatment.
- Each Member is guaranteed the right to request and receive a copy of their medical records and to request that they be amended or corrected, as specified in 45 C.F.R. 164.524 and 164.526; and be furnished, consistent with the scope of services of WellCare of North Carolina, healthcare services in accordance with 42 C.F.R 438.206-438.210.
- WellCare will not attempt to influence, limit, or otherwise interfere with the Member's decision to exercise their rights. Each Member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Each Member is free to exercise their rights. Exercising those rights will not adversely affect the way WellCare of North Carolina or its network providers treat the Member.
- Each Member has a right to voice complaints or appeals about WellCare of North Carolina or the care it provides. Each Member has the right to file a complaint when the Member believes their rights have been violated or restricted by the PHP process or by a Provider. The Member can use the WellCare complaint system to file a complaint.
- No Member will be denied the benefits of, or participation in, Covered Services based on race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated. WellCare of North Carolina will ensure compliance with all applicable federal and state laws and regulations prohibiting discrimination against Members in the course of obtaining or receiving services from the PHP or any network Provider.

Member, Parental, and/or Legal Guardian Responsibilities

WellCare of North Carolina expects Members to cooperate responsibly and to the full extent possible in matters regarding their healthcare. These include the following:

- The Member should present their WellCare identification card to each Provider before receiving service. Members are encouraged to carry a second form of identification.
- The Member should use the emergency department only for true emergencies. A true emergency is a situation in which your life could be threatened, or you could be hurt permanently if you don't get care right away.
- The Member is responsible for providing, to the extent possible, any and all information needed by WellCare or their practitioner or Provider to provide treatment and care.
- The Member is responsible for contacting their primary care provider (PCP) as their first point of contact when needing medical care.
- Members should inform their PCP of their desire for a second surgical and/or medical opinion.
- A second surgical and/or medical opinion referral is not required for a Member to see a specialist, but the PCP can assist the Member with scheduling an appointment.
- Each Member is responsible for scheduling and canceling appointments for services, including transportation. If the Member needs assistance WellCare has care coordinators and care managers who can assist members.
- If the Member cannot keep a scheduled appointment, they should call the Provider at least 24 hours in advance to cancel the appointment.
- Each Member must act in a responsible manner at a Provider's facility and when speaking with Providers or WellCare personnel and not use abusive language or aggressive body language toward any Providers or other WellCare personnel.
- Each Member should inform the Provider if the Member does not understand the Provider's explanation(s) concerning the Member's medical care and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Members are responsible for scheduling periodic checkups for infants and children in the Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Prenatal Members must schedule obstetrical checkups at the recommended intervals. If the Member needs assistance WellCare has care coordinators and care manager who can assist Members. Members are encouraged to participate in other available prevention and wellness programs that correlate with their checkups and treatments.
- Each Member must notify the local Department of Social Services of address changes, any changes in family size, or any other changes that may affect eligibility or enrollment (for example, marriage, birth, adoption, divorce, death, or guardianship).
- Each Member should use the WellCare of North Carolina Handbook as a resource to understand how to obtain services or how to contact the plan to present questions or concerns. Each Member is responsible for informing WellCare of North Carolina and/or the local Department of Social Services if they are covered by any other insurance, including Medicare, or if they have an accident at work, have a car accident, or are involved in a personal injury or malpractice lawsuit.
- Members with questions concerning benefits, grievances, appeals, medical provider qualifications, changing PCPs, etc., are to contact the WellCare of North Carolina Customer Services Department.

For more information, please visit www.WellCareNC.com/Member-Rights-and-Responsibilities.

Assignment of Primary Care Provider

Members enrolled in a WellCare plan must choose a PCP or they will be assigned to a PCP within WellCare's network. 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/AMH selection without cause twice per year: once within 30 days of notification of their assigned PCP/AMH and one other time within the year. Members may change their PCP/AMH with cause at any time. Members can make these changes by calling Member Services. The requested change will be effective the first day of the following month of the request if the request is received after the 10th day of the current month.

For-cause reasons for Members to request PCP/AMH changes may include difficulty with access to appointments, language issues or other communication barriers, Member concerns about their treatment plan, and changes in location or other availability issues.

OB/GYN Specialists

PCPs may also provide routine and preventive OB/GYN healthcare services to Members. If a Member selects a PCP who does not provide these services, the Member has the right to direct in-network access to an OB/GYN specialist for Covered Services related to this type of routine and preventive care. WellCare (Medicaid) Members have the right to obtain family planning services from any participating Medicaid Provider without Prior Authorization.

Hearing, Interpreter and Sign Language Services

Hearing, interpreter and sign language services are available to WellCare Members through WellCare's Member Services department. PCPs should coordinate these services for WellCare Members and contact Member Services if assistance is needed. For Provider Services telephone numbers, please refer to the *Quick Reference Guide* at **www.wellcarenc.com/providers/medicaid**.

Section 3: Quality Improvement

Overview

WellCare's Quality Improvement Program (QI Program) is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral healthcare and services. Strategies are identified and activities implemented in response to findings. The QI Program addresses the quality of clinical care and nonclinical aspects of service with a focus on key areas that include, but are not limited to:

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

The QI Program activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, Healthcare Effectiveness Data and Information Set (HEDIS®) measures, Child Health Checkup (CMS 416 Measures), other subset population data sets and metrics, and/or medical record audits. The Quality Improvement Committee is responsible for approving specific QI activities, including monitoring and evaluating outcomes, overall effectiveness of the QI Program, and initiating corrective actions plans when appropriate, when the results are less than desired or when areas needing improvement are identified.

Medical Records

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

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

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 their representative is entitled to one free copy of the Member's medical record. Additional copies shall be made available to Members at cost.

Each Provider is required to maintain a primary medical record for each Member 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:

- 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, languages 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 (e.g., documentation of chicken pox).
- Identification of current problems.
- The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering Provider's initials or other documentation indicating review.
- A current list of immunizations pursuant to 42 CFR 456.
- Identification and history of nicotine, alcohol use, or substance use disorder.
- Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department of Public Health pursuant to 42 CFR 456.
- Follow-up visits provided secondary to reports of emergency room care.
- Hospital discharge summaries.
- Advanced medical directives, for adults.
- Documentation that Member has received the Provider's office policy regarding office practices compliant to HIPAA.
- Documentation regarding permission to share protected health information with specific individuals has been obtained.
- Copies of any consent or attestation form used, or the court order for prescribed psychotherapeutic medication for a child younger than 13 years.
- Include the following items for services provided through telemedicine:
  - A brief explanation of the use of telemedicine in each progress note.
  - Documentation of telemedicine equipment used for the particular Covered Services provided.
  - A signed statement from the Member or the Member's representative indicating the Member's choice to receive services through telemedicine. This statement may be for a set period of treatment or onetime visit, as applicable to the service(s) provided.
  - A review of telemedicine should be included in WellCare's fraud and abuse detection activities.

- 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:
- 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, referrals, and directions, including time to return.
- Education and instructions whether verbal, written, or via telephone.

OB/GYN Medical Records

Medical records requirements and guidelines per current American College of Obstetrics and Gynecology standards:

The maternity chart will contain documentation of the following:
- Physical findings on each visit with a plan of treatment and follow-up for any abnormalities.
- Prenatal visit in the first trimester, on or before the enrollment date or within 42 days of the enrollment in WellCare
- Nutritional assessment and counseling for all pregnant Members that includes:
    - Promotion of breastfeeding and the use of breast milk substitutes to ensure the provision of safe and adequate nutrition for infants.
    - Offering a mid-level nutrition assessment as directed by clinical presentation.
- Member education (childbirth / maternal care).
- Postpartum care within 84 days of delivery.
- Family planning counseling and services for all pregnant and postpartum individuals.
- HIV testing / counseling is offered at the initial prenatal care visit and again at 28 weeks and 32 weeks.
- Screening for Hepatitis B. Providers must screen all pregnant Members during their first prenatal visit for Hepatitis B and again between 28 weeks and 32 weeks for Members who test negative and are considered high-risk for Hepatitis B.
- Providers refer all pregnant, breastfeeding, and postpartum individuals to the local Women, Infants, and Children (WIC) office:
    - Providers provide a completed North Carolina WIC program medical referral form with the current height or length and weight (taken within 60 calendar days of the WIC appointment).
    - Hemoglobin or hematocrit (H&H).
    - Any identified medical / nutritional problems.
    - Give a copy of the completed form to the Member.
    - Retain a copy of the completed form in the Member's medical record.

Provider Participation in the Quality Improvement Program

Participating Providers are contractually required to cooperate with quality improvement activities. Providers are invited to participate in the QI Program. Avenues for participation include committee representation, quality / performance improvement projects, and feedback / input via satisfaction surveys.

Information regarding the QI Program, available upon request, includes a description of the QI Program and the annual evaluation of progress toward goal. WellCare evaluates the effectiveness of the QI Program on an annual basis. An annual report summarizes a review of completed and continuing QI activities that address the quality of clinical care and service, trending of measures to assess performance in quality of clinical care and quality of service, any corrective actions implemented, corrective actions that 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, the Agency's Division of Health Benefits 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 standards.

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

Programs promoting patient safety are a public expectation, a 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.

Adverse incident reports must be completed in their entirety and need to include information, including the Member's identity, description of the incident, and outcomes, including current status of the Member.

The program relies on an incident reporting system to identify potential and/or actual quality of care events and/or adverse events that occur in order to select the most advantageous method of correcting, avoiding, reducing, or eliminating risks. The incident reporting system is based upon the affirmative duty of all Providers and all agents and employees of WellCare to report injuries and adverse events.

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

- Inadequate assessment/misdiagnose
- Delay or omission of care
- Medication issue
- Patient safety
- Post-op complications
- Procedural issue

Adverse Incidents are events involving situations where an injury of a Member occurs during delivery of managed care plan Covered Services that:

- Is associated in whole or in part with service provision rather than the condition for which such service provision occurred.
- Is not consistent with or expected to be a consequence of service provision.

- Occurs as a result of service provision to which the patient has not given his informed consent.
- Occurs as a result of any other action or lack thereof on the part of the staff of the Provider.

Examples of adverse incidents that result in the following and meet the above criteria are to be reported and can include but are not limited to:

- Member death
- Member brain damage
- Member spinal damage
- Permanent disfigurement
- Fracture or dislocation of bones or joints
- Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition
- Any condition requiring surgical intervention to correct or control
- Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care
- Any condition that extends the patient's length of stay
- Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility

Behavioral Health Potential Quality of Care and/or Critical Incidents are events that result in:

- Death of a Member while the Member is in a facility contracted by WellCare or in an acute care facility due to one of the following:
  (1) Suicide
  (2) Homicide
  (3) Abuse
  (4) Neglect
  (5) An accident or other incident that occurs while the Member is in a facility contracted by WellCare or in an acute care facility
- Member injury or illness – A medical condition that requires medical treatment by a licensed healthcare professional and which is sustained, or allegedly is sustained, due to an accident, act of abuse, neglect, or other incident occurring while a Member is in a facility contracted by WellCare or while the Member is in an acute care facility.
- Sexual battery while the Member is in a facility contracted by WellCare or in an acute care facility or an allegation of sexual battery, as determined by medical evidence or law enforcement involvement, by:
  (1) A Member on another Member
  (2) An employee of WellCare, a Provider, or a subcontractor, a Member
  (3) A Member on an employee of WellCare, a Provider, or a subcontractor
- WellCare shall report if one or more of the following events occur:
  (1) Medication errors in an acute care setting
  (2) Medication errors involving children / adolescents in the care or custody of Local County Department of Social Services (DSS) Offices
- Member suicide attempt – An act that clearly reflects an attempt by a Member to cause their own death while a Member is in a facility contracted by WellCare or while the Member is in an acute care facility, which results in bodily injury requiring medical treatment by a licensed healthcare professional.

- Altercations requiring medical intervention – Any untoward or adverse event that requires medical intervention other than minimal first aid treatment occurring while a Member is in a facility contracted by WellCare or while the Member is in an acute care facility.
- Member escape – To leave a locked or secured facility contracted by WellCare.
- Member elopement – To leave a facility contracted by WellCare, an acute care facility, vehicle, or supervised activity that would endanger a Member's personal safety.

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 individuals
- Well-baby care
- Immunizations for children, adolescents, and adults
- Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, 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 improvement activities are reviewed and approved by the Utilization Management Medical Advisory Committee with input from participating Providers and the Quality Improvement Committee. Improvement activities include, but are not limited to, distribution of information to Members and Providers, Member and Provider incentives, and telephonic outreach to Members with gaps in care. 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 adherence.

Clinical Practice Guidelines

WellCare adopts validated evidence-based Clinical Practice Guidelines and utilizes the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other Provider may supersede Clinical Practice Guidelines, the guidelines provide clinical staff and Providers with information about medical standards of care to assist in applying evidence from research in the care of both individual Members and populations. The Clinical Practice Guidelines are based on peer-reviewed medical evidence, are integrated to focus on whole person care, and are relevant to the population served. Approval of the Clinical Practice Guidelines occurs through the Utilization Medical Advisory Committee which reports to Quality Improvement Committee. Clinical Practice Guidelines, to include preventive health guidelines, are at **www.wellcarenc.com/providers/tools/clinical-guidelines**.

Advanced Medical Home Program

WellCare supports the North Carolina Advanced Medical Home (AMH) Program and the state-designated AMH practices to provide local care management services. Providers participating in the Advanced Medical Home Program will be classified or tiered by NC DHHS, and this classification will drive the value of all AMH tier payments. Key responsibilities include but are not limited to:

- Accepting Members and being listed as a primary care Provider in the plan's Member-facing materials for the purpose of providing care to Members and managing their healthcare needs.

- Providing primary care and patient care coordination services to each Member, in accordance with plan policies.
- Providing or arranging for primary care coverage for services, consultation, referral, and treatment for emergency medical conditions, 24 hours per day, seven days per week.
- Providing preventive services.
- Maintaining a unified medical record for each Member following the plan's medical record documentation guidelines.
- Promptly arranging referrals for Medically Necessary healthcare services that are not provided directly and documenting referrals for specialty care in the medical record.
- Authorizing care for the Member or providing care for the Member based on the standards of appointment availability as defined by the plan's network adequacy standards.
- Referring for a second opinion as requested by the Member, based on DHHS guidelines and plan standards.
- Reviewing and using Member utilization and cost reports provided by the plan for the purpose of AMH level utilization management and advising the plan of errors, omissions, or discrepancies if they are discovered.
- Reviewing and using the monthly enrollment report provided by the plan for the purpose of participating in plan or practice-based population health or care management activities.

Healthcare Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90 percent of health plans to measure performance on important dimensions of care and service. Annual HEDIS reporting is required by the state Medicaid programs and the health plan accreditation agencies. The tool comprises 96 measures across six domains of care, including:

- Effectiveness of care
- Access / availability of care
- Experience of care
- Utilization and risk adjusted utilization
- Health Plan descriptive information
- Measures collected using electronic clinical data systems

A key element in our partnership is the evaluation of the quality of care and services delivered to our Members. One of the most important ways we measure that quality is through HEDIS. Quality measures are based on specifications developed by the National Committee for Quality Assurance (NCQA) and other state-defined measures. All HEDIS data reported is audited and certified by an NCQA-designated auditing firm as required by accreditation bodies, our state partners, and the Centers for Medicare & Medicaid Services (CMS). This HEDIS audit is a standard part of the NCQA HEDIS data collection process and NCQA Accreditation Standards. As part of the HEDIS audit, we may contact Providers for patient records to review according to HEDIS clinical documentation standards. In compliance with the HEDIS standards, we request medical records annually for certain measures to collect information that typically cannot be found in a claim or an encounter. WellCare will contact the Provider's office to schedule medical record collection for Member charts because we have identified that you are either the assigned or previous primary care provider, or PCP, of the Member or have submitted a claim or encounter that relates to a HEDIS measure. The requirement of an audit is also part of your Provider contract with WellCare, which requires that you submit needed records at no charge within three business days of the request or as otherwise stated. Please refer to your contract for more information.

Web Resources

WellCare periodically updates clinical, coverage, and preventive guidelines as well as other resource documents posted on the WellCare website. Please check WellCare's website frequently for the latest news and updated documents at **www.wellcarenc.com/providers.**

Section 4: Utilization Management (UM), Care 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 manual, or both.

WellCare's UM program includes components of Prior Authorization and prospective, concurrent, and retrospective review activities. Each component is designed to evaluate the extent and appropriateness of services based on the Member's benefits.

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 Service is Medically Necessary requires compliance with the requirements established in North Carolina Administrative Code, 10A NCAC 25A.0201, WellCare's agreement with the Department of Health and Human Services and EPSDT requirements as outlined in 42 U.S.C. § 1396d(r) and 42 C.F.R. § 441.50-62 for Medicaid members under 21 years of age.

"Medically Necessary" or "Medical Necessity" means Medically Necessary Covered Services and supplies as determined by generally accepted North Carolina community practice standards and as verified by independent Medicaid consultants. As required by 10A NCAC 25A.0201, a Medically Necessary service may not be experimental in nature.

In accordance with 42 CFR 440.230, 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, physicians, or other individuals or entities performing UM activities for issuing denials of coverage, services, or care. WellCare does not provide financial incentives to encourage or promote underutilization.

Criteria for UM Decisions

WellCare's UM program uses nationally recognized review criteria based on sound scientific medical evidence. Physicians with an unrestricted license in the state of North Carolina 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:

- InterQual™
- WellCare Clinical Coverage Guidelines
- Medical Necessity
- State Medicaid Contract
- North Carolina Clinical Coverage Policies
- State Provider Handbooks, as appropriate
- Local and federal statutes and laws
- Hayes Health Technology Assessment
- American Society of Addition Medicine Level of Care Guidelines
- Early Childhood Services Intensity Instrument (ESCII)

The clinical reviewer and/or medical director involved in the UM process applies 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 and are posted on the WellCare provider portal. Providers may request a copy of the criteria used for specific determination of Medical Necessity by contacting the Utilization Management Department via Provider Services. The phone number is on the *Quick Reference Guide* at **www.wellcarenc.com/providers/medicaid**.

The UM program follows EPSDT criteria for EPSDT service requests defined in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62 for Medicaid members under 21 years of age. The specific EPSDT criteria may be found in the North Carolina EPSDT Policy Instructions at **EPSDT Policy Instructions**. EPSDT service requests must meet the following criteria:

- The service must be Medically Necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner.
- The requested service must be determined to be medical in nature.

- The service must be safe.
- The service must be effective.
- The service must be generally recognized as an accepted method of medical practice or treatment.
- The service must not be experimental / investigational.
- Additionally, services can only be covered if they are provided by a North Carolina Medicaid enrolled provider for the specific service type. This may include an out-of-state provider who is willing to enroll if an in-state provider is not available.

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.wellcarenc.com/providers/medicaid/forms**.

Notification

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

- **Prenatal services** – This enables WellCare to identify pregnant Members for inclusion into the care coordination program for pregnant Members. OB Providers are required to notify WellCare of pregnancies via fax using the *Prenatal Notification Form* as soon as possible after the initial visit. This process will expedite care management and claims reimbursement.
- **A Member's admission to a hospital** – This enables WellCare to log the hospital admission and follow up with the facility on the following business day to receive clinical information. The notification should be received by fax or telephone and include Member demographics, facility name, and admitting diagnosis.
- **A Member's inpatient admission to a hospital** – WellCare requires Providers to notify WellCare by the next business day of a Member's inpatient admission to a hospital. This includes transfers and readmissions as a new authorization request will be required for either. Failure to notify WellCare of admission by the next business day may result in a denial of the inpatient authorization and/or claim.

Referrals

For an initial referral, WellCare does not require authorization as a condition of payment. WellCare does not require referrals for Emergency Services, family planning services, OB/GYN specialists, including routine and preventive healthcare services, and children's screening services or services performed in the Local Health Department. Behavioral health services the initial mental health or substance dependence assessment completed in 12 months will not require a referral.

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 requested by the Member's PCP, treating specialist or facility.

Reasons for requiring Prior Authorization may include:

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

Prior Authorization is **required** for select elective or non-emergency services as designated by WellCare. Guidelines for Prior Authorization requirements by service type may be found in the *Quick Reference Guide* at **www.wellcarenc.com/providers/medicaid** or by calling WellCare.

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

The process for obtaining this authorization is as follows:

- The Provider submits an authorization request.
- A non-clinical associate will log the request and send to the reviewer.
- The reviewer will review the request against the benefit plan and the clinical criteria.
- If services meet the benefit plan and/or the appropriate criteria, the service will be authorized, and the Provider will be notified by fax or phone.
- If not met, the request will be sent to the medical director or other appropriate reviewer for review of Medical Necessity.
- If medical director or other reviewer approves the request, the service will be authorized, and Provider will be notified by fax or phone.
- If medical director or other reviewer denies the request, the Provider will be notified, and a Notice of Adverse Benefit Determination (denial letter) will be sent to the Member and Provider.

Providers are not required to obtain prior authorization for preventive care (early and periodic screens/wellness visits) for Medicaid Members under 21 years of age. However, Providers may be required to obtain prior authorization for other diagnostic and treatment products and services provided under EPSDT. Providers are required to obtain authorization of any Medically Necessary EPSDT services for Members under the age of 21 years when the service is not listed in the service-specific Medicaid Coverage and Limitations Handbook or fee schedule; is not a Covered Service of the plan; or the amount, frequency, or duration of the service exceeds coverage limitations.

Provider documentation for EPSDT prior authorization requests must show how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the member's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does not eliminate the requirement for prior approval.
The attending physician or designee is responsible for obtaining the Prior Authorization of the elective or non-urgent admission. Refer to the *Quick Reference Guide* at **www.wellcarenc.com/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 clinician 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 nationally recognized criteria (e.g., Milliman Care Guidelines [MCG], InterQual™ or NC Clinical Coverage Policies) for appropriateness of a 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 or care coordination.

The concurrent review process incorporates the use of nationally recognized criteria (e.g., InterQual™, , American Society of Addiction Medicine, or WellCare Clinical Coverage Guidelines) to assess quality and appropriate level of care for continued medical treatment. Reviews are performed by licensed clinicians 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 clinician. Failure to submit necessary documentation for concurrent review may result in nonpayment.

Facilities can submit clinical chart information for review for continued stay appropriateness and discharge planning through to following:

- Electronic
    - On-site chart review completed by the on-site or electronic medical record review access, as well as through the state
    - HIE or ADT system
- Fax transmission
- Phone outreach to the UM Department

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. Discharge plans from behavioral health inpatient admissions will be monitored to ensure that they incorporate the Member's needs for continuity in existing behavioral health therapeutic relationships. WellCare's concurrent review clinician works with the attending physician, hospital discharge planner, family Members, guardians, 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.

Providers who identify the Member is ready to discharge from a higher level of care to a lower level of care should outreach the inpatient concurrent review or behavioral health reviewer by phone, fax, or electronic records to notify WellCare of the anticipated discharge and any discharge needs the Member has for a smooth transition to a lower level of care.

Examples of higher level of care transfers that require notification to the health plan for discharge planning assistance include, but are not limited to:

- Hospital / inpatient acute care and long-term acute care
- Nursing facility
- Adult care home
- Inpatient behavioral health services
- Facility-based crisis services for children
- Facility-based crisis services for adults
- ADATC

An inpatient review nurse may refer an inpatient Member with identified complex discharge needs to transitional care management for in-facility outreach.

Transitional Care Management
The Transitional Care Management Department's role is designed to identify and outreach to Members in the hospital and/or recently discharged who are at high risk for readmission to the hospital. The program involves a twofold process; it may begin with a pre-discharge screening to identify Members with complex discharge needs and to assist with the development of a safe and effective discharge plan. Post-discharge, the process focus is to support recently discharged Members through short-term care management to meet immediate needs that allow the Member to remain at home and reduce avoidable readmissions.

The care manager's work includes, but is not limited to:

- Screening for Member needs
- Education
- Care coordination
- Medication reconciliation
- Referrals to community based services

The goal of the Transitional Care Program is to ensure that complex, high-risk Members are discharged with a safe and effective plan in place to promote Members' health and well-being and to reduce avoidable readmissions. The transitional care manager will refer Members with long-term needs to the Care Management Program or Disease Management Program.

Timely follow-up is critical to quickly identifying and alleviating any care gaps or barriers to care.

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

WellCare will give a written notification to the requesting Provider and Member within 30 calendar days of receipt of a request for a UM determination. If WellCare is unable to make a decision due to matters beyond its control, it may extend the decision 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* at **www.wellcarenc.com/providers/medicaid**.

Peer-to-Peer Reconsideration of Adverse Benefit Determination

In the event Medical Necessity is not established, a peer-to-peer discussion is offered to the attending or ordering physician. The peer-to-peer review may be conducted prior to rendering a Medical Necessity decision, or in the event of an adverse determination, following a Medical Necessity review, offered to the treating physician via fax (reconsideration). The attending or ordering physician is provided a toll-free number to the Medical Director Hotline to request a discussion with the WellCare medical director who made the denial determination. Peer-to-peer discussion is offered within three business days from the decision date.

Services Requiring No Authorization

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

- Certain diagnostic tests and procedures considered by WellCare to routinely be part of an office visit and plain film X-rays.
- Clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories, and physician offices under a Clinical Laboratory Improvements Amendments (CLIA) waiver do not require Prior Authorization. There are exceptions to this rule for specialty laboratory tests which require authorization regardless of place of service:

    - Reproductive laboratory tests;
    - Molecular laboratory tests; and
    - 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.
- Refugee health assessments do not require prior approval when provided through local health departments.

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

WellCare Notice of Adverse Benefit Determination

An adverse benefit determination is an action taken by WellCare to deny a request for services. In the event of an adverse benefit determination, WellCare will notify the Member and the requesting Provider in writing of the determination. The notice will contain the following:

- The action WellCare has taken or intends to take.
- The reason(s) for the action.
- The Member's right to appeal.
- The Member's right to request a state hearing.
- Procedures for exercising Member's rights to appeal or file a grievance.
- Circumstances under which expedited resolution is available and how to request it.
- The Member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.

Second Medical Opinion

A second medical opinion may be requested in any situation where there is a question related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. A second opinion may be requested by any Member of the 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 the network or a non-participating provider if there is not a participating Provider with the expertise required for the condition.

In accordance with North Carolina Prepaid Health Plan Services contract Statute 641.51, the Member may elect to have a second opinion provided by a non-contracted provider. WellCare will pay the amount of all charges that are usual, reasonable, and customary in the community for second opinion services performed by a physician not under contract with WellCare. WellCare may require that any tests deemed necessary by a non-contracted provider be conducted by a participating WellCare Provider.

Individuals in a Priority Population

Individuals in a Priority Population 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. They may have special healthcare needs. Factors include:

- Individuals with intellectual disabilities or related conditions
- Individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia, or degenerative neurological disorders
- Individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema, or diabetes
- Children / adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to placement in foster care

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

- Allow the Members needing a course of treatment or regular care monitoring to have direct access through standing authorization or approved visits, as appropriate for the Member's condition or needs:
  - To obtain a standing authorization, the Provider should complete the NC Standard Prior 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 their 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.

Specialty Care Providers

Wellcare of North Carolina is required to use the following provider types as "specialty care" providers:

Service Types			
Allergy/Immunology	Anesthesiology	Cardiology	Dermatology
Endocrinology	ENT/Otolaryngology	Gastroenterology	General Surgery
Gynecology	Infection Disease	Hematology	Nephrology
Neurology	Oncology	Ophthalmology	Optometry
Orthopedic Surgery	Pain Management	Psychiatry	Pulmonology
Radiology	Rheumatology	Urology	

Service Authorization Decisions

Type of Request	Decision	Extension
Standard Pre-service	14 calendar days	14 calendar days
Expedited Pre-service	72 hours	14 days
Urgent Concurrent	24 hours	48 hours
Post-service	30 calendar days	15 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 an additional 14 calendar days if the Member or the Provider requests an extension or if WellCare justifies a need for additional information and the extension is in the Member's best interest.

Expedited Service Authorization

If 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 of 14 days may be granted if the Member or the Provider requests an extension or if WellCare justifies a need for additional information and the extension is in the Member's best interest. **Requests for expedited decisions for Prior Authorization should be requested by telephone,** not by 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.wellcarenc.com/providers/medicaid**.

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

Urgent Concurrent Authorization

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

Emergency / Urgent Care and Post-Stabilization Services

Emergency services are not subject to Prior Authorization requirements and are available to Members 24 hours a day, seven days a week. Urgent care services should be provided within one day. See *Section 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 to improve or resolve the Member's condition. Post-stabilization services are covered without Prior Authorization up to the point WellCare is notified that the Member's condition has stabilized.

Emergency service Providers shall make a reasonable attempt to notify WellCare within 24 hours of the Member's presenting for emergency behavioral health services.

Mobile crisis assessment and intervention for Members in the community may be provided in lieu of emergency behavioral healthcare.

Continuity of Care

Members in active treatment may continue care when such care is Medically Necessary, through the completion of treatment of a condition for which the Member was receiving at the time of the termination or until the Member selects another treating Provider, for a minimum of 60 days, not to exceed six months after the Provider termination.

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

New WellCare Members will have a 90-day transition of care period.

The following services may extend beyond the 90-day transition of care period, and WellCare shall continue the entire course of treatment with the Member's current Provider as described below:

- **Prenatal and postpartum care** – WellCare shall continue to pay for services provided by a pregnant Member's current Provider for the entire course of her pregnancy, including the completion of her postpartum care (six weeks after birth), regardless of whether the Provider is in WellCare's network.
- **Transplant services (through the first-year post-transplant)** – WellCare shall continue to pay for services provided by the current Provider for one-year post-transplant, regardless of whether the Provider is in WellCare's network.
- **Oncology (radiation and/or chemotherapy services for the current round of treatment)** – WellCare shall continue to pay for services provided by the current Provider for the duration of the current round of treatment, regardless of whether the Provider is in WellCare's network.
- **Full-course therapy Hepatitis C treatment drugs**

During the first 90 days of enrollment, authorization is not required for certain Members with previously approved services by the state or another managed care plan. WellCare will continue to be responsible for the costs of continuation of such Medically Necessary Covered Services, without any form of prior approval and without regard to whether such services are being provided within or outside WellCare's network until such time as WellCare can reasonably transfer the Member to a service and/or network Provider without impeding service delivery that might be harmful to the Member's health. However, notification to WellCare is necessary to properly document these services and determine any necessary follow-up care.

WellCare will cooperate with the receiving health plan regarding the course of ongoing care with a specialist or other Provider when Members move to a new health plan for transition of care needs.

When WellCare becomes aware that a covered Medicaid Member will be disenrolled from WellCare and will transition to an NC Medicaid Fee for Service (FFS) program or another managed care plan, a WellCare review nurse / case manager who is familiar with that Member will provide a transition of care (TOC) report to the receiving plan or appropriate contact person for the designated FFS program.

If a Provider receives an adverse claim determination which they believe was a transition of care issue, the Provider should fax the adverse claim determination to the Appeals department with documentation of approval from agency or previous managed care organization for reconsideration. Refer to the *Quick Reference Guide* for the Appeals department contact information at **www.wellcarenc.com/providers/medicaid**.

Authorization Request Forms

WellCare requests Providers use the standardized authorization request forms provided by the State to ensure receipt of all pertinent information and enable a timely response to their request. The *Authorization Request Form* is used for services such diagnostic testing, transplants, office procedures, ambulatory surgery, radiation therapy, out-of-network services, DME and Skilled Therapy Services (OT, PT, ST) as well as planned elective / non-urgent inpatient, observation, and skilled nursing facility and inpatient rehabilitation authorizations.

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.

Incomplete forms are not processed and will be returned to the requesting Provider. If Prior Authorization is not granted, all associated claims will not be paid.

Providers must immediately notify WellCare of a Member's pregnancy. A *Prenatal Notification Form* and screening tool 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. Notification of OB services enable WellCare to identify Members for inclusion into the Prenatal Program (WellCare Smart Start for Your Baby) and/or Members who might benefit from WellCare's High Risk Pregnancy Program, and for reporting pregnancies to DHHS.

All forms are located at **www.wellcarenc.com/providers/medicaid/forms** and should be submitted via fax to the number listed on the form.

In no instance may the limitations or exclusions imposed by WellCare be more stringent than those specified in the North Carolina Medicaid Rules, Policies, and Handbooks.

Special Requirements for Payment of Services

The following services have special requirements from North Carolina:

Abortion

Prior Authorization is not required for the administration of an abortion, whether therapeutic or non-therapeutic. The consent form, along with pertinent documentation and physician statement, must be submitted with the claim.

Therapeutic abortions are covered only in the case where an individual 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 physician, place the individual in danger of death unless an abortion is performed; therapeutic abortions are also covered in cases of rape or incest.

An *Abortion Statement* certifying to the above situation must be properly executed and submitted to WellCare with the Provider's claim. This form may be completed and signed by the physician.

Claims for payment will be denied if the required consent is not attached or if incomplete or inaccurate documentation is submitted.

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

Any required state forms must be completed and submitted to WellCare.

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

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

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

In the case of premature delivery or emergency abdominal surgery, the sterilization consent form must have been signed by the Member 30 calendar days prior to the originally planned date of sterilization. A sterilization consent form must be properly filled out and signed for all sterilization procedures and attached to the claim at the time of submission to WellCare. The Member must sign the consent form at least 30 calendar days, but not more than 180 calendar days, prior to the sterilization. The physician must sign the consent form after the sterilization has been performed.

Hysterectomy

Prior Authorization is not 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 Member was informed, verbally and in writing, prior to the hysterectomy that they would be permanently incapable of reproducing (this does not apply if the Member was sterile prior to the hysterectomy or in the case of an emergency hysterectomy).
- Prior to the hysterectomy, the Member and the attending physician must sign and date the state-provided hysterectomy statement.
- In the case of prior sterility or emergency hysterectomy, a Member is not required to sign the consent form.
- The Provider submits the properly executed hysterectomy statement with the claim prior to submission to WellCare.

WellCare will deny payment on any claim(s) submitted without the required documentation or with incomplete or inaccurate documentation. WellCare does not accept documentation meant to satisfy informed consent requirements 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 located at **www.wellcarenc.com/providers/medicaid/forms**.

Delegated Entities

WellCare delegates some utilization management activities to external entities and provides oversight and accountability of those entities.

In order to receive a delegation status for utilization management activities, the delegated entity must demonstrate that ongoing, functioning systems are in place that meet the required utilization management 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 NCDHHS prior to implementation.

Delegation of select functions may occur only after an initial audit of the utilization management activities has been completed and there is evidence that WellCare's delegation requirements are met. These requirements include:

- A written description of the specific utilization management delegated activities
- Semi-annual reporting requirements
- Evaluation mechanisms
- Remedies available to WellCare if the delegated entity does not fulfill its obligations

On an annual basis, or more frequently as needed, audits 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.*

Visit https://www.wellcarenc.com/providers/medicaid.html to view the Utilization Management Program Policy.

Care Management Program

WellCare offers comprehensive care management services to facilitate health status assessment, care planning, and advocacy to improve health outcomes for its Members. The WellCare Care Management Program is built around every Member's unique healthcare needs. WellCare is committed to identifying Members with needs, reaching them where they live, understanding how they prefer to engage with the healthcare system, assessing their needs, facilitating their access to care, and helping them when they need coordination.

WellCare understands that care management must complement primary care, behavioral health services, ancillary services, outpatient, and inpatient services. WellCare's care management services are specifically designed to:

- Foster the relationship between a Member and their primary care Provider (PCP)
- Empower Members to take control of their health by initiating and reinforcing healthy behaviors
- Help Members obtain timely, effective, quality, and culturally sensitive care and minimize gaps in care behaviors
- Assist Members with understanding and accessing their benefits

WellCare adheres to Agency requirements for care management programs as listed below:

- High-risk care management (e.g., Members with significant healthcare needs)
- Care needs screening
- Identification of Members in need of care management
- Development of care plans (across priority populations)
- Development of comprehensive assessments (across priority populations)
- Transitional care management: Management of Member needs during transitions of care (e.g., from hospital to home)
- Care management for special populations (including pregnant individuals and children at-risk of physical, development, or socio-emotional delay)
- Chronic care management (e.g., management of multiple chronic conditions)
- Coordination of services (e.g., appointment / wellness reminders and social services coordination/referrals)
- Management of unmet health-related resource needs and high-risk social environments
- Management of high-cost procedures (e.g., transplant, specialty drugs)
- Management of rare diseases (e.g., transplant, specialty drugs)
- Management of medication-related clinical services to promote appropriate medication use and adherence, drug therapy monitoring for effectiveness, and avoidance of medication related adverse effects
- Development and deployment of population health programs.

Care management and care coordination Agency requirements that apply to WellCare also apply to the WellCare contracted AMH Tier 3 practices. These requirements are incorporated into the AMH Tier 3 provider contracts.

WellCare (Medicaid) multidisciplinary care management teams are led by a registered nurse (RN) or a licensed clinical social worker (LCSW) who performs a comprehensive assessment of the Member's health status, develops an individualized care plan with agreed upon goals, monitors outcomes, and updates the care plan as necessary. The care managers share the care plans and work collaboratively with Providers, schools, and other relevant agencies to coordinate and facilitate access to care and services when needed. Care plans are available by mail or fax and can be accessed on the provider portal. WellCare requests that Providers participate as active Members of the multidisciplinary care team for those Members who are engaged in care and disease management programs.

Members commonly identified in Care Management Program include:

- **Catastrophic** – Traumatic injuries (e.g., amputations, blunt trauma, spinal cord injuries, head injuries, burns, and multiple traumas).
- **Multiple Chronic Conditions** – Multiple comorbidities such as diabetes, COPD and hypertension, or multiple barriers to quality healthcare (e.g., HIV, AIDS, or a comorbid behavioral health and complex medication condition).
- **Transplantation** – Organ failure, donor matching, post-transplant follow-up, etc.
- **Complex Discharge Needs** – Members discharged home from acute inpatient or Skilled Nursing Facility (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 and adults who have serious medical or chronic conditions with severe chronic illnesses, physical, mental, and developmental disabilities.
- Children younger than 6 years who have been prescribed a psychotropic medication, Members with two or more admissions to a residential psychiatric treatment center, and those who have exceeded prescription limits.
- **At Risk Populations**: Members who have resided in a state mental health facility for at least six months out of the past 36 months or have had two or more admissions in that time frame; homeless individuals; and populations with involvement, or at risk for involvement with, the justice system, DJJ, or DHHS.
- **Transitional Care Management:** The goal of the Transitional Care Program is to ensure that complex, high-risk Members are discharged with a safe and effective plan in place to promote Members' health and well-being and reduce avoidable readmissions. The transitional care manager will refer Members with long-term needs to the Care Management Program or Disease Management Program. Details on the WellCare Transitional Care Management Program may also be found above in the Utilization Management section.

Care Management for At-Risk Children (CMARC)

The CMARC program is an at-risk population care management program that serves children from birth to 5 years of age who meet certain risk criteria. The main goals of the program are to improve health outcomes through the use of high-quality, cost-effective care for enrolled children. The program provides coordination, linkages, and referrals between healthcare providers and other community programs and supports, as well as family supports. Each child served by this program is linked to a specific medical home and a care manager. The care manager, in collaboration with the child's family, coordinates the child's care to ensure the child obtains appropriate medical care, social services, and other supports.

At-Risk Children

The CMARC program will accept referrals for children with the following needs:

- Children with Special Healthcare Needs
- Children exposed to severe stress in early childhood, including, but not limited to:
    - Extreme poverty in conjunction with continuous family chaos
    - Recurrent physical or emotional abuse
    - Chronic neglect
    - Severe and enduring maternal depression
    - Persistent parental substance use
    - Repeated exposure to violence in the community or within the family

- Children in neonatal intensive care needing help transitioning to community / medical home care.

Referrals to the CMARC program can be made by completing the referral form on our website and submitting it to the child's Local Health Department, or by calling the Local Health Department.

Care Management for High-Risk Pregnancy (CMHRP)

The Local Health Department-directed High-Risk Pregnancy care management model consists of education, support, linkages to other services, management of high-risk behaviors, and response to social determinants of health that may have an impact on birth outcomes. Individuals identified as having a high-risk pregnancy are assigned a pregnancy care manager from their Local Health Department to coordinate their care and services through the end of the postpartum period.

Members are referred for CMHRP through a Provider-submitted Pregnancy Risk Screening Forms or by calling the pregnant Member's Local Health Department.

Smart Start for Your Baby Maternity Care Management Program

WellCare Maternity Care Coordinators will reach out to all pregnant Members not enrolled in the CMHRP program. Once the Member is contacted by the Care Management team and gives consent, the Member will be welcomed into Smart Start for Your Baby. This program leverages identified best practices from across the industry with the goal of improving maternity and birth outcomes. Enrollment is optional.

Pregnant Members will receive care management services throughout the prenatal and postpartum periods, such as:

- Linkage with community resources
- Timely prenatal and postpartum care
- Member education on pregnancy, post-partum and newborn care:
  - Preparing for delivery.
  - Vaccines/immunizations.
  - Newborn hearing screenings.
  - Newborn screening tests.
- Interventions that can prevent adverse birth outcomes

Care management during the postpartum period will focus on ensuring Members:

- Attend postpartum appointments
- Have access to family planning services
- Are assessed for postpartum depression and anxiety
- Continue to access appropriate care for themselves and their children, including well-baby checkups and routine tests (vaccines, newborn screenings, etc.).

This program provides all pregnant Members, regardless of risk level, with care management services, education, and supports for a minimum of 60 days postpartum and for up to 90 days postpartum. Through this program, Members receive benefit education including assistance with appointment scheduling and

Provider coordination, care planning, pregnancy education, in-home maternity services, and community-based resource engagement to address the social determinants of health.

WellCare performs ongoing and proactive monitoring to assess the effectiveness of the program and to identify successes and opportunities for improvement.

Additional Care Management Programs available to Members in North Carolina

Tobacco Cessation Program

The Tobacco Cessation Program is part of WellCare's population health program to address cessation and provide guidance from a health and wellness coach to support Members in their goal to quit using tobacco.

Opioid Misuse Prevention Program

The Opioid Misuse Prevention Program contains interventions that support and promote safer prescribing of opioids; management of chronic pain with non-opioid pharmacologic and nonpharmacologic modalities; early detection of opioid misuse and intervention; Screening, Brief Intervention, and Referral to Treatment (SBIRT); and increased access to Naloxone and substance use disorder treatment, including medication-assisted therapy.

In alignment with Clinical Coverage Policy 9, the program limits overutilizing Members to a single prescriber and a single pharmacy for their controlled substance prescription medication needs for a 24-month period. A North Carolina Member shall be locked in to one prescriber and one pharmacy for controlled substances — categorized as opiates or benzodiazepines and certain anxiolytics — when one or more of the following criteria are met:

1) Member who has at least one of the following:
    a. Benzodiazepines and certain anxiolytics: more than six claims in two consecutive months
    b. Opiates: more than six claims in two consecutive months
2) Receiving prescriptions for opiates and/or benzodiazepines and certain anxiolytics from more than three prescribers in two consecutive months

Disease Management Program

Disease management is integrated with the Care Management Program. Clinically trained disease managers support Members with targeted chronic conditions. WellCare's primary role is to give its Members the education and the tools that they need to take control of their health. To accomplish this, WellCare identifies Members with chronic diseases and provides education and health coaching to empower them to make behavior changes and self-manage their condition(s).

To support the Members' relationship with their physicians, WellCare will provide the disease management plan of care through its provider portal. WellCare's physician engagement strategies are designed to give Providers feedback and information about their patients' progress as well as any care gaps or risk management issues.

The integrated Disease Management Program incorporates the following conditions in our Care Management model:

- Asthma

- Coronary artery disease (CAD)
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- Hypertension

WellCare (Medicaid) disease management process consists of five phases:

1. **Identification:** Identify and outreach to all Members to perform an initial screening to determine who has chronic conditions and may benefit from disease management program(s).
2. **Stratification:** Assign a level and a care manager to each Member identified with chronic conditions. Introduce Member to the Disease Management Program and invite them to participate.
3. **Assessment and Plan:** Assessment completed and individualized disease management plan of care developed
4. **Education and Support:** Develop a disease management-focused care plan in collaboration with the Member and guide them through the disease management milestones.
5. **Program Evaluation:** Evaluate the effectiveness of the disease management program, both from a patient-centered and population management perspective.

Disease Management Programs employ evidence-based Clinical Practice Guidelines. Disease-specific *Clinical Practice Guidelines* adopted by WellCare (Medicaid) are at **www.wellcarenc.com/providers/tools/clinical-guidelines**. Interventions are individualized by level of need. Members with low care needs are offered an education and support program available through the mail or on the Member portal. Members identified with high care needs receive a comprehensive assessment by a disease management nurse, disease-specific educational materials, an individualized care plan, and follow-up assessments to monitor adherence to the plan and progress toward goals.

WellCare (Medicaid) disease management offerings employ innovative biometric monitoring solutions for high-risk Members diagnosed with CHF, COPD, CAD, and diabetes. Biometric measurement devices provide critical, actionable data to the Member's disease management nurse, as well as to their Provider, regarding biometric values such as weight, glucose levels, or blood pressure readings, combined with Member-reported symptom data specific to their condition.

WellCare (Medicaid) makes education available to Providers and Members regarding their health conditions on both the Member and Provider portals, which can be accessed at **www.wellcarenc.com**.

Care and Disease Management Referrals

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

- Referral from their primary care Provider or specialist
    - Community programs
    - State Agencies
- 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 (Medicaid) 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* at **www.wellcarenc.com/providers/medicaid**.

Community Connections Helpline:

If you are assisting someone needing food, rent, and more resources, call our Community Connections Helpline at 1-888-860-1605 (TTY: 711) Monday through Saturday, 7 a.m. to 6 p.m., Eastern time.

Healthy Opportunities (HOP) Helpline:

No one should ever have to pick between food and medicine. Healthy Opportunities offers ways to help our community get the resources individuals and their families need to live healthier lives. If you are assisting someone with questions about the HOP program benefits, services, or resources, call our Healthy Opportunities Helpline at 1-844-901-3800 (TTY: 711) Monday through Saturday, 7 a.m. to 6 p.m., Eastern time. You can also visit our website to learn more. Go to:
https://www.wellcarenc.com/members/medicaid/benefits/healthy-opportunities.html

Section 5: Claims

Overview

WellCare of North Carolina follows Centers for Medicare & Medicaid Services (CMS) rules and regulations, specifically the Federal requirements set forth in 42 USC § 1396a(a)(37)(A), 42 CFR § 447.45 and 42 CFR § 447.46; and in accordance with State laws and regulations, as applicable.

The focus of WellCare's Claims Department is to process claims in a timely manner. WellCare has established toll-free telephone numbers for Providers to access a representative in its Member Services department. For more information, refer to the *Quick Reference Guide* at **www.wellcarenc.com/providers/medicaid**.

For Providers who are unaccustomed to submitting claims, WellCare provides detailed claims submission procedures on its website. The *North Carolina Medicaid Provider Resource Guide* at **www.wellcarenc.com/providers/medicaid** provides information regarding how to submit both paper and electronic claims.

The claims submission address, telephone numbers for contacting Provider Services, how to file a claims dispute, and authorization information in the *Quick Reference Guide* on WellCare's website.

Additional information regarding reimbursement policies and *Claims Companion Guides* are located on WellCare's website at **www.wellcarenc.com/providers/medicaid/claims**.

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

WellCare, in conjunction with PaySpan, have implemented an enhanced online Provider registration process for electronic funds transfer (EFT) and electronic remittance advice (ERA) services.

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

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

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

Providers can register using PaySpan's enhanced Provider registration process at **payspan.com.** 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 at **payspanhealth.com**.

Timely Claims Submission

Unless otherwise stated in the Provider contract, participating Providers must submit claims (initial and corrected) for date of service 7/1/23 and after within 365 calendar days from the date of service for outpatient services and the date of discharge for inpatient services. For dates of service prior to 7/1/23, providers must submit claims within 180 days from the date of service for outpatient services and the date of discharge for inpatient services.

When WellCare is the secondary payer, Providers must submit claims within 90 days from the primary payer's EOB date, except for Medicare Crossover. The limit for Medicare claims crossing over to Medicaid is the greater of 36 months from the date of service or 12 months from Medicare EOB date. Unless prohibited by federal law or the Centers for Medicare & Medicaid Services (CMS), WellCare may deny payment for any claims that fail to meet WellCare's submission requirements for Clean Claims or that are received after the time limit in the Provider contract for filing Clean Claims.

Nonparticipating providers must submit claims within 180 calendar days from the date of service.

For reconsiderations, disputes, grievances and appeals, please see those sections for further guidance around timely filing limits.

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

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

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

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

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

WellCare requires the payer-issued Tax ID and NPI on all claims submissions. WellCare will reject claims without the Tax ID and NPI, with the exception of atypical Providers. Atypical Providers must pre-register with WellCare before submitting claims to avoid NPI rejections. More information on NPI requirements, including HIPAA's NPI Final Rule Administrative Simplification, is available at **www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/index.html**.

Taxonomy

Providers are required to submit claims with the correct taxonomy code consistent with the 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.

Preauthorization number

If a preauthorization 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 guidelines.

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

Claims Submission Requirements

WellCare requires all participating hospitals to properly code all relevant diagnoses and surgical and obstetrical procedures on all inpatient and outpatient claims submitted. WellCare requires all diagnosis coding to be ICD-10-CM, or its successor, as mandated by CMS. *Refer to Compliance section for additional information.* In addition, the CPT-4 coding and/or Healthcare Common Procedure Coding System (HCPCS) is required for all outpatient surgical, obstetrical, injectable drugs, diagnostic laboratory, and radiology procedures. When coding, the Provider must select the code(s) that most closely describe(s) the diagnosis(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 they have an affirmative duty to:

- Supervise the provision of, and be responsible for, the services provided
- Supervise and be responsible for preparation and submission of the claim
- Present a claim that is true and accurate, and that is for WellCare Covered Services that: (a.) have actually been furnished to the Member by the Provider prior to submitting the claims; and (b.) 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 UB-04, or their successors. Claims shall include the Provider's NPI, Tax ID, and the valid taxonomy code that most accurately describes the services reported on the claim. The Provider acknowledges and agrees that no reimbursement is due for a Covered Service and/or no claim is complete for a Covered Service unless performance of that Covered Service is fully and accurately documented in the Member's medical record prior to the initial submission of any claim. The Provider also acknowledges and agrees that at no time shall Members be responsible for any payments to the Provider with the exception of Member expenses and/or non-covered services.

For more information on paper submission of claims, refer to the *Quick Reference Guide* at **www.wellcarenc.com/providers/medicaid**. For more information on Covered Services under WellCare's

North Carolina Medicaid plans, refer to **www.wellcarenc.com**. For more information on claims submission requirements, refer to North Carolina Statute 641.3154.

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 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 in ICD-10-CM code structure. 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 is at **www.wellcare.com/North-Carolina/Providers/ICD10-Compliance.**

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.wellcarenc.com/providers/medicaid/claims**.

Since most clearinghouses can exchange data with one another, Providers should work with their existing clearinghouse, or a WellCare-contracted clearinghouse, to establish EDI with WellCare. For a list of WellCare contracted clearinghouse(s), for information on the unique WellCare Payer Identification (Payer ID) numbers used to identify WellCare on electronic claims submissions, or to contact WellCare's EDI team, refer to the *Provider Resource Guide*, which may be found on WellCare's website at **www.wellcarenc.com/providers/medicaid**.

275 Claim Attachment Transactions via EDI

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

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

For more information on EDI implementation with WellCare, refer to the *WellCare Companion Guides* on WellCare's website at **www.wellcarenc.com/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.wellcarenc.com/providers/medicaid/claims.**

Paper Claims Submissions

For timelier processing of claims, Providers are encouraged to submit electronically. Claims not submitted electronically may be subject to penalties as specified in the Provider contract. For assistance in creating an EDI process, contact WellCare's EDI team by referring to the *Quick Reference Guide* at **www.wellcarenc.com/providers/medicaid.**

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

- Paper claims must only be submitted on original (red ink on white paper) claim forms.
- Any missing, illegible, incomplete, or invalid information in any field will cause the claim to be rejected or processed incorrectly.
- Per CMS guidelines, the following process should be used for Clean Claims submission:
  - **The information must be aligned within the data fields and must be:**
    - On an original red ink on white paper claim form
    - Typed. Do not print, handwrite, or stamp any extraneous data on the form
    - In black ink
    - In large, dark font such as HELVETICA, 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

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

CMS Fact Sheet about CMS-1500
https://www.cms.gov/files/document/837p-cms-1500pdf

The Medicare Learning Network®
https://www.cms.gov/training-education/medicare-learning-network/resources-training

Claims Processing

Readmission

WellCare may choose to review claims if data analysis deems it appropriate. WellCare may review hospital admissions on a specific Member if it appears that two or more admissions are related based on the data analysis. Based upon the claim review (including a review of medical records if requested from the Provider), WellCare will make all necessary adjustments to the claim, including recovery of payments 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.

72-Hour Rule

Please note that we review claims for quality of care and Medical Necessity when a Member is readmitted within 72 hours of discharge as an acute hospital inpatient for the same or related conditions as the original admission.

Itemized Bills

To help reduce claim denials, ensure prompt payment, and reduce administrative hardship on providers, WellCare of North Carolina has defined a high dollar pre-payment and post-payment review process. Providers should submit itemized bills with claims that meet the criteria below:

Effective 9/19/2022, Itemized Bills for high dollar pre-payment review when the following conditions apply:

- a hospital inpatient claim is submitted with a header or total billed amount greater than $250,000.
- a hospital outpatient claim is submitted with a header or total billed amount greater than $75,000.
- a professional claim is submitted with a header or total billed amount greater than $25,000.

Itemized bills can sent be via mail, and electronic attachment through standard HIPAA X12 transactions. Providers may submit itemized bill attachments (related to pre-adjudicated claims). Electronic attachments (275 transactions) are supplemental documents providing additional patient medical information to the payer that cannot be accommodated within the ANSI ASC X12, 837 claim format. Common attachments are certificates of medical necessity (CMNs), discharge summaries, itemized bills, and operative reports to support a healthcare claim adjudication. The 275 transaction is not intended to initiate Provider or Member appeals, grievances, or payment disputes. Providers can locate this information on the WellCare provider portal and contact their provider representative at NCProviderRelations@wellcare.com if additional assistance is needed.

Prompt Payment

WellCare will follow state guidance on prompt payment of Clean Claims and will apply interest and penalties in conjunction with the state's corresponding interest and penalty rate for claims processed beyond prompt pay guidelines.

For Clean Claims, WellCare shall pay interest to the Provider on the portion of the claim payment that is late at the annual percentage rate of eighteen percent (18%) for each Calendar Day beginning on the first day following the date that the claim should have been paid or was underpaid.

In addition to the interest on late payments required, WellCare shall pay a penalty to the Provider on the portion of the claim payment that is late equal to one percent (1%) of the claim for each Calendar Day following the date that the claim should have been paid or was underpaid. The penalty shall not exceed an amount equal to one hundred percent (100%) of the late payment or the underpayment amount.

Interest and penalties are calculated based on the portion of the claim that was not paid during the Timely Claim Payment, Dispute, and Appeals limits.

If additional information was requested by WellCare of North Carolina, interest on health benefit claim payments shall begin to accrue on the 31st day after WellCare receives the additional information. A payment is considered made on the date upon which a check or draft is placed in the United States Postal Service in a properly addressed, postpaid envelope or, if not mailed, on the date of the electronic transfer or other delivery of the payment.

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 make reasonable efforts to collect third-party liability insurance information from the Member prior to billing the claim. 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, copayments, and other cost-sharing expenses up to the allowed amount or the difference between the primary payer's amount and WellCare's allowed amount, whichever is less. The contractor's total liability shall not exceed the allowed amount minus the amount paid by the primary payer. WellCare may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services to the extent permitted by applicable laws. Providers shall follow WellCare policies and procedures regarding subrogation activity.

WellCare may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services, to the extent permitted by applicable laws.

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

- A claim is submitted for payment consideration secondary to primary insurance carrier, other primary insurance information, such as the primary carrier's EOB, must be provided with the claim. WellCare has the capability of receiving EOB information electronically. To submit other insurance information electronically, refer to the *WellCare Companion Guides* at **www.wellcarenc.com**.
- WellCare has information on file to suggest the Member has other insurance primary to WellCare's, WellCare may deny the claim.

- The primary insurance has terminated, the Provider is responsible for submitting the initial claim with proof that coverage was terminated. If primary insurance has retroactively terminated, the Provider is responsible for submitting the initial claim with proof payment has been returned back to the primary insurance carrier.
- Benefits are coordinated with another insurance carrier as primary and the payment amount is equal to or exceeds WellCare's liability, no additional payment will be made.

Unless the applicable benefit plans (the benefit plan issued by WellCare and the benefit document issued by the other payer) or applicable law provide otherwise, the order of benefit makes North Carolina Medicaid always the payer of last resort.

If the provider is unsuccessful in obtaining necessary cooperation from an enrollee to identify potential third-party liability, the provider shall notify the health plan that efforts have been unsuccessful. WellCare will work with the provider and take necessary actions to determine liability coverage.

Providers can utilize the WellCare provider portal prior to rendering services to determine if a member has third-party coverage.

Claim Adjustment Codes

Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) are codes used to explain why a claim was processed differently than billed.

CARCS

CARCs explain why a claim was paid differently than billed. CARCs are often found on the electronic remittance advice (ERA) and explanation of benefits (EOB) statements. CARCs are only used when there is an adjustment to a claim.

RARCs

RARCs provide additional information or clarification for an adjustment described by a CARC. RARCs can also provide information about remittance processing.

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 including, but not limited to, 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, which relate to the claim.

Providers may request reconsideration of any adjustments produced by 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.

Encounters Data

Overview

This section is intended to provide delegated vendors and Providers (IPAs) with the necessary information to allow them to submit encounter data to WellCare. WellCare is authorized to take whatever steps are necessary to ensure that the Provider is recognized by the Department of Health and Human Services (DHHS) and its agent(s) as a participating Provider of WellCare and that the Provider's submission of encounter data is accepted by the DHHS. If encounter data does not meet the service level agreements (SLAs) for timeliness of submission, completeness or accuracy, DHHS has the ability to impose significant financial sanctions on WellCare. WellCare requires all delegated vendors and delegated Providers to submit encounter data, even if they are reimbursed through a capitated arrangement.

Timely and Complete Encounters Submission

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

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

Fines/Penalties

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

Accurate Encounters Submission

All encounter transactions submitted via DDE or electronically will be validated for transaction integrity / syntax based on the SNIP guidelines as per the state requirements. SNIP Levels one through five 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.wellcarenc.com/providers/medicaid/claims.**

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

Encounters Submission Methods

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

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

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

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. For more information on free DDE options, refer to the North Carolina Medicaid *Provider Resource Guide* at **www.wellcarenc.com/providers/medicaid.**

Encounters Data Types

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

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

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

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

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

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 North Carolina Statutes 641.3154 and 641.3155 (5)a.(8). Additionally, Providers shall not charge WellCare Members for missed appointments.

Hold Harmless Dual-Eligible Members

Those dual-eligible Members whose Medicare Part A and B Member expenses are identified and paid for at the amounts provided for by North Carolina 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 North Carolina Medicaid. Providers shall accept WellCare's payment as payment in full or will bill North Carolina Medicaid if WellCare has not assumed DHHS' financial responsibility under an agreement between WellCare and DHHS.

Provider Preventable Conditions

WellCare follows CMS guidelines regarding "Hospital Acquired Conditions," "Never Events," and other "Provider Preventable Conditions (PPCs)." Under federal regulations, 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, but 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.

Healthcare Providers may not bill, attempt to collect from, or accept any payment from the Member for PPCs or hospitalizations and other services related to these non-covered procedures

Claims Disputes

The claims disputes 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 or denial disputes must be submitted to WellCare within 90 calendar days of the date of denial of the explanation of payment (EOP) or as otherwise stated in the Provider's contract.

Documentation consists of:

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

- Total billed charges
- The Provider's statement explaining the reason for the dispute

Supporting documentation when necessary (e.g., proof of timely filing, medical records)

Claim Payment Policy Disputes

For disputes related to Explanation of Payment Codes beginning with IH###, CE###, CV### (Medical records required), or PD### medical record review is required. Disputes for payment policy-related issues must be submitted to WellCare in within 90 calendar days of the date of denial on the EOP.

Disputes can be filed through WellCare's provider portal, via mail or fax. To initiate the process, please refer to the *Quick Reference Guide* at **www.wellcarenc.com/providers/medicaid**.

Note: Medical Necessity disputes should follow the Grievance and Appeals process and timely filling limits. Please refer to that section for further guidance.

Maximus Claim Dispute Resolution Program

If a Provider's issue is not resolved to their satisfaction, the Provider may have the opportunity to utilize Maximus, an independent dispute resolution organization as an appeal process, **if both the Provider and WellCare agree to use the process**. **WellCare reserves the right not to use Maximus at its sole discretion and may decline to use Maximus at any time, including if a claim meets the criteria for review by Maximus as indicated below.**

General Information

To qualify, claim disputes must have been denied in full or in part, or were presumed to have been underpaid or overpaid.

Application forms and instructions on how to file claims are available from Maximus directly at **1-866-763-6395. Select 1 for English or 2 for Spanish, then select Option 2.** Ask for North Carolina Provider Appeals Process.

Eligible Claims

The following claim disputes can be submitted by physicians, hospitals, institutions, other licensed healthcare Providers, HMOs, Prepaid Health Clinics, Prepaid Health Plans, and Exclusive Provider Organizations (EPOs):

- Claim disputes for services rendered after October 1, 2000 (the effective date of the legislation).
- Claim disputes related to payment amounts only – Provider disputes payment amount received, or HMO disputes payback amount. **Claim disputes related exclusively to late payment are not eligible.**
- Hospitals and Physicians are required to aggregate claims *(for one or more patients for same insurer)* by type of service to meet certain minimum thresholds:
  - Hospital Inpatient Claims (contracted Providers): $25,000
  - Hospital Inpatient Claims (non-contracted Providers): $10,000
  - Hospital Outpatient Claims (contracted Providers): $10,000
  - Hospital Outpatient Claims (non-contracted Providers): $3,000
  - Physicians / Dentists: $500
  - Rural Hospitals: none

- Other Providers: none

Ineligible Claims

- Claims for less than minimum amounts listed above for each type of service.
- Claim disputes that are the basis for an action pending in State / Federal court.
- Claim disputes that are subject to an internal binding managed care organization's resolution process for contracts entered into prior to October 1, 2000.
- Claims solely related to late payment and/or late processing.
- Interest payment disputes.
- Medicare claim disputes that are part of Medicare Managed care internal grievance or that qualify for Medicare reconsideration appeal.
- Medicaid claim disputes that are part of a Medicaid Fair Hearing.
- Claims related to health plans not regulated by North Carolina.
- Claims filed more than 12 months after final determination by health plan or Provider.

Maximus Review Process/Timeframes

Maximus has 60 days to resolve claim disputes and make recommendations to the Department of Health and Human Services (DHHS) after receipt of the appropriate forms and documentation. The filing party has to submit a copy of the documentation to the adversely affected party at the same time. Maximus has the right to request additional documentation from both parties. The total review time shall not exceed 90 days following receipt of the initial claim dispute.

DHHS has 30 days to issue a final order based on the recommendation made by Maximus.

Review Cost

The North Carolina legislature did not provide any funding for this program with the exception of funding for one Agency attorney.

Pursuant to North Carolina statutes, the full review costs have to be paid by the non-prevailing party. If both parties prevail in part, the review cost will be apportioned based on the disputed claim amount. If the non-prevailing party or parties fail(s) to pay the ordered review costs within 35 days after DHHS' final order, the non-paying party or parties are subject to a fine of $500 per day. Entities filing a claim that is settled prior to any decision rendered by Maximus have to pay the full review costs.

DHHS has no fine authority to enforce payment of the disputed claim amount. However, the Agency has authority to enforce its final order based on section 641.52(1) (e), North Carolina Statutes.

Fee Schedule

Since each claim dispute is different and of varying complexity, the contractor will not be able to estimate the full cost in advance, Maximus has agreed by contract to the following fee schedule:

Physician Expert Review:	$215.00/hr
Utilization Review Nurse;	$95.00/hr
Medical Claim Coding Expert:	$125.00/hr
Legal Expert:	$175.00/hr
Initial Review Fee to Determine Eligibility:	$75.00 flat fee

Maximus will provide a review cost estimate in advance, if requested, at no additional charge beyond the initial review fee. However, review costs based on the final order from NCDHHS must be paid directly to Maximus.

Corrected or Voided Claims

Corrected 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, the 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
b. MED. REC. #			117
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7

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 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:

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

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

Reimbursement

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

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 percent of the Medicaid rate in effect on the date of service with the exception of emergency services which are reimbursed at not more than 100% of the Medicaid rate

Claims Payment Calculator

WellCare has a real-time claims reimbursement calculator that allows Providers to see the estimated contract reimbursement rate for Covered Services.

Surgical Payments

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

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

Multiple Procedures

Payment for multiple procedures is based on:

- 100 percent of maximum allowable fee for primary surgical procedure
- 50 percent of maximum allowable fee for second through sixth surgical procedures billed

The percentages apply when eligible multiple surgical procedures are performed under one continuous medical service or when multiple surgical procedures are performed on the same day and by the same surgeon.

Assistant Surgeon

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

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

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

Co-Surgeon

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

Modifier

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

Allied Health Providers

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

For more information on reimbursement payments, refer to the NCTracks Coverage Limitations at **www.nctracks.nc.gov/content/public/providers.**

Telemedicine

Telemedicine is a covered plan benefit subject to limitations and administrative guidelines. Telemedicine is defined as the practice of healthcare delivery by a practitioner at a site other than the site where a recipient is located for the purpose of evaluation, diagnosis or treatment. Telemedicine services provide the Member with

enhanced healthcare services, the opportunity to improve health outcomes, and information when meeting face-to-face is unavailable.

WellCare agrees to provide coverage for services provided through telemedicine, when appropriate, for services covered under this contract, to the same extent the services would be covered if provided through a face-to-face (in-person) encounter with a practitioner. WellCare also covers store-and-forward and remote patient monitoring services, when appropriate, as a part of its Quality Enhancement programs, in accordance with the requirements specified in Attachment B, Section VI.F., Quality Enhancements, of the SMMC ITN.

WellCare reimburses for:

- Practitioners providing telemedicine services licensed within their scope of practice to perform the service.
- Telemedicine services using interactive telecommunications equipment that includes, at a minimum audio and video equipment permitting two-way, real time, interactive communication between a recipient and a practitioner.
- Providers must include modifier GT on the CMS-1500 claim form to indicate the delivery method was telemedicine.
- For services on or after January 1, 2017, to indicate that the billed service was furnished as telemedicine from a distant site, submit claims for telemedicine services using Place of Service (POS) 02: Telehealth.

WellCare does not reimburse for:

- Standard phone calls, chart review(s), faxes, or email — in combination or individually — as these are not considered telemedicine services.
- Issuing a prescription based solely on an online questionnaire does not constitute a telemedicine service and is not covered.
- Equipment required to provide telemedicine services.

Overpayment Recovery

WellCare strives for 100 percent payment accuracy but recognizes that a small percentage of overpayments may 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 when the inappropriate payment caused an overpayment, WellCare will limit its recovery effort to 24 months from the original claim payment date. These time frames do not apply to fraudulent or abusive billing, and there is no deadline for WellCare to seek recovery from the Provider in those cases.

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, request further information, appeal, or dispute the retroactive denial.

Failure of the Provider to respond within the above time frame 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 a Provider independently identifies an overpayment, WellCare requires the Provider to:

- Report that an overpayment has been received
- Return the overpayment within 60 calendar days of the date the overpayment was identified
- Notify WellCare in writing as to the reason for the overpayment at:

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

Providers with any questions about this can call Provider Services toll-free at **1-866-799-5318.** Representatives are available Monday through Saturday from 7 a.m. to 6 p.m., Eastern time. For more information on contacting Provider Services, refer to the *Quick Reference Guide* at **www.wellcarenc.com/providers/medicaid**.

Benefits During Disaster and Catastrophic Events

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

Provider Hardship Payments

For various reasons, such as claims payment issues, growth, etc., WellCare of North Carolina (WellCare) may have a need to provide hardship funds to providers to help them continue to provide high-quality services to WellCare members for situations that are out of a providers control.

The WellCare Chief Financial Officer (CFO), along with other appropriate WellCare personnel, shall negotiate the terms of the hardship, including the structure, which may be in the form of cash hardship repayable in cash or an advance against future claim payments for the WellCare members who use their facilities, and the repayment terms. The repayment timeframe should, generally, not exceed six months.

Hardship payments are meant to be a short-term measure to address issues that are beyond a provider's control and are used in circumstances that cannot be resolved through engagement with a provider to immediately address any claims adjudication issues. In order for a provider to qualify for a hardship advancement the provider must meet the following criteria:

- Providers must demonstrate material need for hardship.
- Provider claims payment delays are not related to claims submission errors that are within their control.

All Provider advances are initiated by the provider through the WellCare Provider Relations team. Any advancement request will be sent to the WellCare CFO to determine if the provider has met the hardship eligibility requirements. A Hardship Agreement is required and must be fully executed prior to final approval and payment initiation. Hardship resolution is reliant on providers to demonstrate need at time of request, promptly respond with documentation when additional details are required, and execute the required Hardship Agreement. Funds disbursement cannot occur until hardship eligibility has been approved and Hardship Agreement has been executed.

Providers needing to request an advance will need to complete the Provider Hardship Payment Request form and email all supporting documentation for the request to NCProviderRelations@WellCare.com. Upon receipt of the request, a provider relations representative will be in contact with the provider to answer any questions about the request and facilitate the next steps in the process. Download the Provider Hardship Provider Request Form by visiting **https://www.wellcarenc.com/providers/medicaid/claims/provider-hardship.html**.

Section 6: Credentialing

Credentialing & Recredentialing

Screening, Enrollment, Credentialing, and Re-credentialing based on the North Carolina Medicaid Participating Provider File submission. The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by WellCare, as well as government regulations and standards of accrediting bodies. WellCare will assume any credentialing decision as indicated on the WellCare Medicaid Provider Enrollment File by the WellCare Medicaid program and does not have any additional Decision requirements.

Note: In order to maintain a current provider profile, providers are required to notify WellCare of any relevant changes to their credentialing information in a timely manner.

Providers must submit at a minimum documentation to the state Medicaid program and credentialing determinations will be based off Medicaid provider data credentialing file provided to all contracted MCOs.

Note: As of January 1, 2018, according to federal regulation 42 CFR 438.602, states must screen and enroll, and periodically revalidate, all network providers of Managed Care Organizations (MCOs). This requirement applies to Ordering Prescribing and Referring (OPR) providers in the Medicaid Managed Care setting, as well.

This requirement does not cause Medicaid Managed Care network providers to see Fee- For-Service (FFS) Medicaid clients. Providers who are already enrolled as an FFS or OPR provider do not need to submit another application as a MCO Network Provider.

Medicaid Audit & Compliance has created two enrollment application forms for MCO network providers to enroll as a non-participating provider.

WellCare will use the WellCare Medicaid file to confirm.

Providers must be credentialed on the WellCare Medicaid file prior to accepting or treating beneficiaries. PCPs cannot accept beneficiary assignments until they have completed their process with WellCare.

Site visits are performed at practitioner offices within sixty (60) days of identification of two or more beneficiary complaints related to physical accessibility, physical appearance, and adequacy of waiting and examining room space. If the practitioner's site visit score is less than eighty

(80) percent, the practitioner may be subject to termination and/or continued review until compliance is achieved. A site review evaluates appearance, accessibility, record-keeping practices and safety procedures.

Recredentialing Process

During the Provider Credentialing Transition Period, as a provider is re-credentialed through the Provider Enrollment process, the PHP shall evaluate a contracted provider's continued eligibility for contracting by confirming the appearance of the provider on the daily Provider Enrollment File.

After the Provider Credentialing Transition Period, the PHP shall evaluate a contracted provider' s continued eligibility for contracting by confirming the appearance of the provider on the daily Provider Enrollment File.

Right to Review and Correct Information
All providers participating within the WellCare network have the right to review information obtained by WellCare and will be directed to the NC Medicaid program to resolve any issues with their NC Medicaid Status.

Providers on Review
It is the policy of WellCare that providers who do not pass the credentialing process and/or who lose their license to practice medicine will not be reimbursed for services rendered to WellCare beneficiaries. These providers will be set up or modified in WellCare systems so that all claims are denied, and an appropriate denial code appears on the provider Explanation of Payment (EOP).

WellCare will not make a quality determination or use independent credentialing quality standards to evaluate Providers. Instead, at the Department's request, and with its representation that its Medicaid Participating Provider Enrollment File and accompanying process comply with state and federal screening, enrollment, and credentialing guidelines, WellCare will consider any Providers included by DHHS in the Medicaid Participating Provider File submission as being screened, enrolled, and credentialed and acceptable for network inclusion subject to completion of WellCare's provider contracting process. WellCare will not make independent screening, enrollment, or credentialing determinations and will not request the submission of additional documentation from any Provider. As part of the contracting process, however, WellCare will collect the roster information including all data elements required for claims payment and directory display, in accordance with the model contract.

During the Provider Credentialing Transition Period, as a Provider is re-credentialed through the Provider Enrollment process, WellCare shall evaluate a contracted Provider's continued eligibility for contracting by confirming the appearance of the Provider on the daily Provider Enrollment File. During the Provider Credentialing Transition period, re-credentialing is done every 5 years and After the Provider Credentialing Transition period, it will be every 3 years.

WellCare's process to update the WellCare Provider data system will align with the state's credentialing process.

WellCare Provider Enrollment and Dis-enrollment

- WellCare shall follow the screening, enrollment, Credentialing, and Recredentialing procedures for in-state, border (i.e., Providers that reside within 40 miles of the North Carolina state line), and out-of-state network Providers.
- WellCare shall accept Provider screening, enrollment, credentialing, and verified information from the Department or designated Department vendor.
- WellCare shall not request any additional screening, enrollment, or credentialing information from a Provider without the Department's written prior approval.
- WellCare shall not be permitted to delegate any part of the centralized screening, enrollment, or credentialing approach to another Provider entity.
- WellCare shall not solicit or accept Provider screening, enrollment, credentialing, or verified information from any other source except as permitted by the Department.

- Through the uniform credentialing process, the Department will screen and enroll, and periodically revalidate, all WellCare network Providers as Medicaid Providers in compliance with state and federal law.
    - WellCare may execute network Provider contracts — pending the outcome of Department screening, enrollment, and revalidation — of up to 120 days but must terminate a network Provider immediately upon notification from the state that the network Provider cannot be enrolled or upon the expiration of the 120-day period without enrollment of the Provider and notify affected Members.
- WellCare shall suspend claims payment to any Provider, for dates of service after the effective date provided by the Department, from its network within one business day of receipt of a notice from the Department that Provider payment has been suspended for failing to submit re-credentialing documentation to the Department or otherwise failing to meet Department requirements.
- WellCare shall reinstate payment to the Provider upon notice that the Department has received the requested information from the Provider. If the Provider does not provide the information with 50 days suspension, the Department will terminate the Provider from Medicaid.
- WellCare shall not be liable for interest or penalties for payment suspension due to re-credentialing.

Termination as a Medicaid Provider by the Department

- WellCare shall remove any Provider from the network and claims payment system and terminate its contract consistent with the effective date provided by the Department within one business day of receipt a notice from the Department that the Provider is terminated as a Medicaid Provider. This applies to all Providers, regardless of the Provider's network status.
- If WellCare suspends Provider payment, upon notice by the Department that the Provider is terminated from Medicaid, WellCare shall release applicable claims and deny payment.

WellCare Provider Termination

- WellCare may terminate a Provider from its network with cause. Any decision to terminate must comply with the requirements of the contract between WellCare and the Department.
- WellCare shall comply with the Program Integrity Provider Termination Requirements outlined in Section V.J.2. Program Integrity of the contract between WellCare and the Department.
- Office of Inspector General Medicare / Medicaid Exclusion Report: Any Provider found to be excluded during monthly report monitoring shall be terminated immediately by WellCare. Monthly monitoring is completed by the Department or the Department's designated vendor.
- WellCare shall monitor state licensure reports monthly. Any Provider found to have a revoked or terminated licensure status will be terminated immediately by WellCare.
- WellCare will provide written notice to the Provider of its decision to terminate to the Provider. The notice, at minimum, will include:
    - The reason for the decision
    - The effective date of termination
    - How to request an appeal
- The provider's right to appeal the decision

Section 7: Appeals and Grievances

Appeals Process

Provider

Medicaid Provider Appeals Process

A Provider may request an appeal to challenge certain plan decisions. Providers may also request an appeal regarding WellCare's policies, procedures, or any aspect of WellCare's administrative functions, including proposed actions, claims/billing disputes, and service authorizations. The provider must follow the dispute process prior to filing an appeal related to a claim/billing dispute.

Network Providers also have the right to request an appeal for the following:

- Program Integrity related findings or activities
- Finding of fraud, waste, or abuse by WellCare
- Finding of, or recovery of, an overpayment by WellCare
- Withholding or suspension of a payment related to fraud, waste, or abuse concerns
- Termination of, or determination not to renew, an existing contract based solely on objective quality reasons outlined in WellCare's Objective Quality Standards
- Termination of, or determination not to renew, an existing contract for LHD care/case management services
- Determination to lower an AMH Provider's Tier Status
- Violation of terms between WellCare and Provider

Out-of-network providers may appeal certain actions taken by WellCare. Out-of-network providers have the right to request an appeal for the following:

- A determination to not initially credential and contract with a provider based on objective quality reasons outlined in WellCare's Objective Quality Standards
- An out-of-network payment arrangement
- Finding of waste or abuse by WellCare
- Finding of, or recovery of, an overpayment by WellCare

Based on the request being appealed, the request will be assigned to the appropriate department for handling. For example, WellCare's Grievance Department will address Providers' expression of dissatisfaction with WellCare policies, procedures, or any aspect of the WellCare's administrative function. Information regarding the Grievance Process can be found below. Provider expression of dissatisfaction regarding billing disputes (claim appeals outlined under section 5) will be handled by WellCare's Claims Department.

The Appeals Department will address Provider concerns regarding proposed actions, service authorization denials, and denied claims payment. Providers may request an appeal on their own behalf by mail, fax, or WellCare's provider portal. The request to WellCare should include a letter of appeal and/or an appeal form with supporting documentation, such as medical records.

Providers have 30 calendar days from the notice of decision giving rise to the Provider's right to appeal such as the original utilization management or claim denial notice. Cases appealed after that time will be denied for untimely filing. If the Provider feels they have filed their case within the appropriate time frame, the Provider may submit documentation showing proof of timely filing. Acceptable proof of timely filing can be, but is not limited to, a registered postal receipt signed by a representative of WellCare or a similar receipt from other commercial delivery services.

WellCare shall extend the time frame by 30 calendar days for Providers to request an appeal for good cause shown as determined by WellCare. Examples of good cause include, but are not limited to:

- The Provider did not receive the denial notice or received it late.
- The Provider was given the wrong or incomplete information about how to appeal.
- An accident destroyed important records needed to request an appeal.
- The appeal of an adverse quality decision.
- The need for supporting documentation in order to request an appeal.
- The voluminous nature of required evidence.

WellCare shall acknowledge requests for Provider appeals in writing within five calendar days of receipt of appeal. WellCare has 30 calendar days to review the case and make a determination. Providers may have an attorney represent them during the appeals process.

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

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

If all of the relevant information is received, WellCare will decide within 30 calendar days. If it is determined during the review that the Provider has complied with WellCare protocols and/or 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

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

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

Member

For a Member appeal, the Member, Member's representative, or a Provider acting on behalf of the Member and with the Member's written consent may file an appeal request verbally with 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 Determinations (NABD). WellCare shall acknowledge requests for standard appeals in writing within five calendar days of receipt of appeal and shall acknowledge requests for expedited appeals in writing within 24 hours of receipt of appeal.

There is only one level for an internal appeal. For medical appeals, the Member should send their appeal request to:

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

Fax: **1-844-205-3382**
Telephone: **1-866-799-5318**
Hours of Operation: Monday through Saturday, 7 a.m. to 6 p.m., Eastern time

If the Member would prefer to file an appeal in person, they can do so at the Raleigh, NC, location at 3128 Highwoods Blvd, Ste 200 Raleigh, NC 27604. Hours of Operation: Monday through Friday, 8 a.m. to 5 p.m., Eastern time.

For pharmacy appeals, the Member should send the appeal request to:

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

Fax: **1-888-865-6531**
Telephone: **1-866-799-5318**
Hours of Operation: Monday through Saturday, 7 a.m. to 6 p.m., Eastern time

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

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

- The Member did not personally receive the notice of Adverse Benefit Determination or received the notice late.

- The Member was seriously ill, which prevented a timely appeal.
- 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, they must submit a signed statement naming the person whom the Member wishes to represent them. This appointment is also required for the Member's PCP or Provider to assist with the Member's request for appeal. For the Member's convenience, WellCare has an Appointment of Representative (AOR) statement form that can be used. The Member and the person who will be representing the Member must sign the AOR statement. The form is located at **www.wellcarenc.com**. Members are provided reasonable assistance in completing forms and other procedural steps for an appeal, including, but not limited to, providing interpreter services and toll-free telephone numbers with TTY capability.

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

The Member, Member's representative, or a Provider acting on the Member's behalf with the Member's consent may file for an expedited, standard pre-service or retrospective appeal determination.

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 a standard appeal or an expedited appeal.

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

- Denial or limited authorization of a requested service, including the type or level of service pursuant to 42 CFR 438 400(b)
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of a payment for service
- The failure to provide services in a timely manner, as defined by DHHS
- The failure of WellCare to act within 60 calendar days; or maximum of 90 calendar days if the grievance involves the collection of information outside of the service area; or 30 calendar days from the date WellCare receives an appeal
- For a resident of a rural area with only one managed care entity, the denial of a Member's request to exercise their right to obtain services outside the network

WellCare ensures that decision makers on appeals were not involved in previous levels of review or decision-making. The appeal reviewers will be healthcare professionals with clinical expertise in treating the Member's condition / disease (or individuals who have sought advice from Providers with expertise in the field of medicine related to the request) when deciding any of the following:

- An appeal of a denial based on lack of Medical Necessity
- A grievance regarding denial of expedited resolution of an appeal
- A grievance or appeal involving clinical issues

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

- Expedited Request: **72 hours**
- Standard Pre-Service Request: **30 calendar days**
- Retrospective Request: **30 calendar days**

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

Expedited Appeals Process

To request an expedited appeal, a Member or a Provider (regardless of whether the Provider is contracted with WellCare) must submit a verbal or written request directly to WellCare. A request to expedite an appeal of a determination will be considered in situations where applying the standard procedure could seriously jeopardize the Member's life, health, or ability to regain maximum function, including cases in which WellCare makes a less than fully favorable decision to the Member. If a Provider submits an appeal on behalf of a Member and indicates a medical need for an expedited review, along with supporting documentation, the request will automatically be processed as an expedited appeal.

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

Members are also provided reasonable opportunity to present evidence and allegations of fact or law in person or in writing. The time frame to submit additional information for an expedited appeal is limited due to the short time frame to process the file. Members may also review a copy of their case file any time during and/or after the completion of the appeal review.

Denial of an Expedited Request

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

- That WellCare will automatically transfer and process the request using the 30 calendar-day time frame for standard Appeals beginning on the date WellCare received the original request
- The Member's right to file an expedited grievance if they disagree with the organization's decision not to expedite the appeal and provide instructions about the expedited grievance process and its time frames

Extension of Standard and Expedited Appeal Resolution

The Health Plan may extend the timeframe for expedited resolution of an appeal request by up to 14 calendar days if:

- The member requests the extension.
- The Health Plan determines that there is a need for additional information and the delay is in the member's interest.

If the timeframe is extended other than at the member's request, the Health Plan completes the following:

- Make reasonable efforts to give the member prompt verbal notice of the delay.
- Within two (2) calendar days, provide written notice and inform the member of the right to file a grievance if he or she disagrees with the decision to extend the appeal.
- Resolve the appeal as expeditiously as the member's health condition requires and no later than the date on which the extension expires.

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 an authorization to cover the requested service and notify the Member verbally by end of business the day the decision is made, followed by written notification of the appeal decision.

Affirmation of Denial of an Expedited Appeal

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

- Verbally notify the Member of the decision by end of business the day the decision is made.
- Issue a Notice of Adverse Benefit Determination (NABD) to the Member and/or appellant
- Include in the notice the specific reason for the appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based.
- Inform the Member:
    - Of their right to request a Medicaid Fair Hearing within 120 calendar days of receipt of the notice of plan appeal resolution and how to do so;
    - Of their right to representation;
    - Of their right to continue to receive benefits pending a Medicaid Fair Hearing; and
    - That they may be liable for the cost of any continued benefits if WellCare's action is upheld.

Standard Appeals (Pre-Service and Retrospective) 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 (NABD).

Members are also provided reasonable opportunity to present evidence and allegations of fact or law in person and in writing. Members may also review a copy of their case file any time during and/or after the completion of the appeal review.

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, then WellCare will issue an authorization or payment for the request.

WellCare will issue an authorization for the disputed services 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 action and/or denial (in whole or in part), it will:

- Issue a Notice of Adverse Benefit Determination (NABD) to the Member and/or appellant.
- Include in the notice the specific reason for the appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based.
- Inform the Member:
    - Of their right to request a Medicaid Fair Hearing within 120 calendar days of receipt of the notice of Plan Appeal Resolution (NPAR) and how to do so;
    - Of their right to representation;
    - Of their right to continue to receive benefits pending a Medicaid Fair Hearing; and
    - That they may be liable for the cost of any continued benefits if WellCare's action is upheld.

If the Member is not satisfied with WellCare's appeal decision, the Member can ask for a Medicaid Fair Hearing.

State Fair Hearing

Members may ask for a State Fair Hearing (SFH). Here are some details about Members asking for SFHs.

Members may ask for a State Fair Hearing any time up to 120 calendar days after they get the Notice of Plan Appeal Resolution. Members may ask for a State Fair Hearing only after they complete WellCare's internal appeal process.

They may ask for a State Fair Hearing by filling out the State Fair Hearing form that is included with the appeal decision. A Member may mail, fax and or call to submit their request for a State Fair Hearing.

Mail Request for a State Fair Hearing to:
Office of Administrative Hearings
1711 New Hope Church Road
Raleigh, NC 27609

Telephone: **1- 984-236-1860**
Fax: **1- 984-236-1871**

For Medicaid-Specific Inquiries:
Office of Administrative Hearings Medicaid Hotline
Telephone: **1-984-236-1850**

A Member's written request for a State Fair Hearing or state review must include the following information:

- Name
- Member number

- Medicaid ID number
- Phone number where WellCare can reach the Member or the Member's authorized representative

Members are encouraged to include the following information if they have it:

- Why they think WellCare should change the decision
- Any medical information to support the request
- Whom they would like to help them with the fair hearing

After getting a Member's fair hearing or state review request, the Office of Fair Hearing will tell the Member in writing that the request was received.

Continuation of Benefits while the Appeal and Medicaid Fair Hearing are Pending

Members may ask that WellCare continue to cover their medical services during the appeals process. To do this:

- Members must file their appeals with WellCare within 10 calendar days of WellCare mailing the Notice of Adverse Benefit Determinations (NABD) to them or within 10 days after the date the service will be reduced, suspended, or stopped, whichever is later.
- The Member's appeal involves an action WellCare is taking to reduce, suspend, or stop a service it already had approved.
- The service must have been ordered by an authorized Provider.
- The original time period covered by the approval WellCare gave has not yet ended. Members must ask for a continuation of benefits.

WellCare will continue a Member's benefits until one of the following happens:

1. The Member withdraws the appeal.
2. Ten days pass after WellCare sends the Member the notice of plan appeal resolution of the appeal against the Member, unless the Member has asked for a Medicaid Fair Hearing with continuation of benefits within those 10 days.
3. The Medicaid Fair Hearing office issues a hearing decision against the Member.
4. The time period or service limits of a previously authorized service have been met.

Continuation of Benefits during the Medicaid Fair Hearing Process

The Member may ask that WellCare continue to cover the Member's medical services during the Medicaid Fair Hearing process. To do this:

- The Member must file the request with WellCare within 10 calendar days of WellCare mailing the Plan Appeal Resolution letter to the Member or within 10 days after the date the service will be reduced, suspended, or stopped, whichever is later.
- The appeal involves an action WellCare is taking to reduce, suspend, or stop a service that already had been approved.
- The service must have been ordered by an authorized Provider.
- The original time period covered by the approval has not yet ended.
- The Member needs to ask for a continuation of benefits.

If the final resolution of the appeal is adverse to the Member (i.e., WellCare's decision was upheld), WellCare may recover from the Member the cost of the services furnished to the Member while the appeal was pending, to the extent that they were furnished solely because of the requirements of the contract.

If the Medicaid Fair Hearing officer reverses WellCare's action and services were not furnished while the appeal was pending, WellCare shall authorize or provide the disputed services promptly.

If the Medicaid Fair Hearing officer reverses WellCare's action and the Member received the disputed services while the appeal was pending, WellCare shall pay for those services in accordance with the contract.

Grievance Process

Provider Grievance

Providers may file a grievance orally or in writing or dispute over any aspects of the operations, activities, or behavior of the plan except for any dispute over for which the Provider has appeal rights. A Provider may file a grievance by mailing or faxing a Complaint Request Form with supporting documentation to WellCare's Grievance Department.

Providers must file their grievance no later than 30 calendar days from the date the Provider becomes aware of the issue generating the complaint.

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

For more information on the Grievance Department, refer to the *Quick Reference Guide* at **www.wellcarenc.com/providers/medicaid**.

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

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

Other than Member out-of-pocket costs as established by the Member's benefit plan, Providers may not bill North Carolina Medicaid Members for services covered by WellCare.

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

Office of the Ombudsman

Providers may contact the NCDHHS Ombudsman Program established to assist Providers with submitting a complaint about WellCare.

Providers may call the Medicaid Managed Care Provider Ombudsman Program at **1- 866-304-7062**. Providers can also find more information about the Medicaid Managed Care Provider Ombudsman Program and how to submit a complaint by sending an email to **Medicaid.ProviderOmbudsman@dhhs.nc.gov**

Member

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

- Provider service including, but not limited to:

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

A Member, a Member's representative, or any Provider acting on behalf of the Member with written consent may file a 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 the Member must submit a signed statement naming the person whom they wish to represent them. For the Member's convenience, WellCare has an Appointment of Representative (AOR) statement form that can be used. The Member and the person who represents the Member must sign the AOR statement. The form is located at **www.wellcarenc.com**. Members are provided reasonable assistance in completing forms and other procedural steps for a grievance, including, but not limited to, providing interpreter services and toll-free telephone numbers with TTY 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.

The Member should send the grievance request to:

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

Fax: **1-866-388-1769**
Telephone: **1-866-799-5318**
Hours of Operation: Monday through Friday, 7 a.m. to 6 p.m., Eastern time

Grievance Resolution

WellCare will acknowledge the Member's standard grievance in writing within five business days from the date the grievance is received by WellCare. Upon the grievance resolution, a letter will be mailed to the Member

within 30 calendar days from the date the standard grievance is received by WellCare. This resolution letter may not take the place of the acknowledgment letter, unless a decision is reached before the written acknowledgement is sent. In this case, one letter will be sent that includes the acknowledgement and the decision of the grievance.

A Member has the right to request a 14-day extension if the Member has additional information to support the Member's grievance. WellCare has the right to request to extend the Member's resolution if it is in the Member's best interest. If WellCare extends the grievance, WellCare will provide the Member with a reason for the delay in writing within two calendar days of the decision.

The acknowledgement letter includes:

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

The resolution letter includes:

- The results/findings of the resolution
- All information considered in the investigation of the grievance
- The date of the grievance resolution

WellCare shall notify Members of grievance resolutions in their 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 subcontractors and their employees, are required to comply with WellCare Compliance Program requirements. WellCare's compliance-related training requirements include, but are not limited to:

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

Providers, including Provider employees and/or Provider subcontractors, must report to WellCare any suspected fraud, waste, or abuse as well as 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 Fraud, Waste, and Abuse Hotline at **1-866-685-8664**.

Details of the Corporate Ethics and Compliance Program can be found at **www.centene.com/who-we-are/ethics-and-integrity**.

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 state-approved marketing materials as long as the Provider and/or the facility distributes, or makes available, marketing materials for all Managed Care Plans with which the Provider participates.
- Co-sponsor events such as health fairs and advertise indirectly with a health plan via television, radio, posters, fliers, and print advertisement.

Providers are prohibited from:

- Verbally, or in writing, comparing benefits or Provider 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.

Provider-Based Marketing Activities

Providers may:

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

Providers must comply with the following:

- To the extent that a Provider can assist a recipient in an objective assessment of the recipient's 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 or disenroll from a particular 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 the Provider for care.
- 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 the Managed Care Plan lists of their Medicaid patients or the membership of any Managed Care Plan.

Providers may:

- Provide the names of the Managed Care Plans in 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 from the DHHS website or CMS website with patients.

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 Contract.
- Providers may make one announcement to patients of a new affiliation that names only the Managed Care Plan when such announcement is conveyed through direct mail, email, or phone.
- Additional direct mail and/or email communications from Providers to their patients regarding affiliations must include a list of all Managed Care Plans with which the Provider contracts.
- Any affiliation communication materials that include Managed Care Plan-specific information (e.g., benefits, formularies) must be prior approved by the Agency.
- Multiple Managed Care Plans can either have one Managed Care Plan submit the material on behalf of all the other Managed Care Plans or have the piece submitted and approved by the Agency prior to use for each Managed Care Plan. Materials that indicate the Provider has an affiliation with certain Managed Care Plans and that only list Managed Care Plan names and/or contact information do not require Agency approval.
- Providers may distribute state-approved 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:
  - Materials do not “rank order” or highlight specific Managed Care Plans and include only objective information.
  - Such materials have the concurrence of all Managed Care Plans involved in the comparison and are approved by the Agency prior to distribution.
  - The Managed Care Plans identify a lead Managed Care Plan to coordinate submission of the materials.

All subcontractors and Providers providing marketing and/or information materials (printed, web-based, etc.) that are Member-facing require NCDHHS approval prior to use. In such cases, the materials should be submitted to WellCare. In turn, WellCare will file the materials with NCDHHS for approval on behalf of the subcontractor or Provider.

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. Details of the Corporate Ethics and Compliance Program can be found at **www.centene.com/who-we-are/ethics-and-integrity.html.**

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 Fraud, Waste, and Abuse Hotline at **1-866-685-8664**.

Fraud, Waste, and Abuse

WellCare is committed to the prevention, detection, and reporting of healthcare fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements. WellCare has developed an aggressive, proactive fraud and abuse program designed to collect, analyze and evaluate data in order to identify suspected fraud and abuse. Detection tools have been developed to identify patterns of 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 our 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 with the Provider. 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 (§423.504), Providers and their employees must complete an annual FWA training program.

To report suspected fraud and abuse, please refer to the *Quick Reference Guide* at **www.wellcarenc.com/providers/medicaid** or call the confidential and toll-free WellCare compliance hotline. Details of the corporate ethics and compliance program, and how to contact the WellCare fraud hotline, are at **www.wellcare.com.**

To report suspected fraud and/or abuse in North Carolina Medicaid, call the Consumer Complaint Hotline toll-free at **1-888-419-3456** or complete a Medicaid Fraud and Abuse Complaint Form at **https://www.wellcarenc.com/providers/medicaid.html**.

If a Provider reports suspected fraud and the report results in a fine, penalty, or forfeiture of property from a doctor or other healthcare Provider, the Provider may be eligible for a reward through the Attorney General's Fraud Rewards Program. Call toll-free at **1-866-966-7226** or **1-850-414-3990**. The reward may be up to 25 percent of the amount recovered or a maximum of $500,000 per case (North Carolina Statutes Chapter 409.9203). Providers can talk to the Attorney General's Office about keeping their identity confidential and protected.

Prepayment Review

To help ensure program integrity and payment accuracy, WellCare's SIU Prepayment Review team routinely reviews provider claims data to identify any instances of irregular, improper, or erroneous billing. The SIU prepay team receives both proactive and reactive referrals for review from the lead sources identified above. When such instances of potential FWA are identified, the SIU Prepay team may request additional documentation prior to the payment of claims or services to better understand the basis for the billing activity and to ensure service met applicable medical necessity, policy, and coding requirements. Prepayment review is conducted in accordance with North Carolina Policy 108C-7.

If a provider has been selected for Prepayment Review, the provider will be notified via letter. The prepayment review notice informs the provider that the prepayment review was initiated to verify the extent and nature of the services rendered for the patient's condition, and to confirm that the claim is coded correctly for the services billed to meet applicable medical necessity, policy, and coding requirements. The notice also details the process for submitting supporting documentation, examples of documentation to be submitted, and timeframe to submit the requested documentation.

Prepayment review shall be instituted no less than 20 calendar days from the date of the mailing or written notification. After review of submitted documentation by the SIU clinical review team, the Provider will receive written notification of any missing or deficient documentation for every claim reviewed. This letter also contains appeal instructions should the provider wish to appeal the review determination.

In order to be removed from review, a provider must meet 3 consecutive months on prepay with a minimum of 70% clean claim rate, provided that the number of claims submitted per month is no less than 50% of the

provider's average monthly submissions of Medicaid claims for the 3-month period prior to the Provider being placed on prepay. Supplemental claims data will also be analyzed to identify any shifts in billing behaviors that may warrant expansion to the scope of the active Prepayment Review.

If a provider does not submit any claims following placement on prepayment review in any given month, then the claims accuracy rating shall be zero percent (0%) for each month in which no claims were submitted.

If the provider does not meet the seventy percent (70%) clean claims rate minimum requirement for three consecutive months within six months of being placed on prepayment claims review, the Health Plan may take administrative action, including termination.

If the denial rate is extremely low (for example, less than 30%), or there is immediate concern the claims reviewed are fraudulent, the Health Plan may pursue immediate administrative action, including termination.

If it determined the Provider is withholding claims to avoid the claims review process, or to circumvent the clean claim rate, the Health Plan may take administrative action, including termination.

Provider Self Audit

WellCare recommends that providers conduct periodic, voluntary self-audits to identify instances where services reimbursed are not in compliance with the Programs' requirements. Self-auditing is a critical component in compliance plans. This protocol does not affect the requirements of WellCare or other independent audit requirements. If a self-audit is conducted and an issue is found , please email details to ncproviderrelations@wellcare.com. A representative will reach out to address.

Confidentiality of Member Information and Release of Records

Medical records should be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules, and regulations. All consultations or discussions involving the Member, or their case should be conducted discreetly and professionally, in accordance with all applicable state and federal laws, including the 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 their 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, etc.)
- Member transfer to a facility for treatment of drug abuse, alcoholism, behavioral, or psychiatric problem

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.wellcarenc.com/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 and marketing, utilization management, quality management, case management, disease management, claims processing, network management, Provider appeals, and customer service. WellCare may delegate all or a portion of these activities to another entity (a Delegated Entity).

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

Delegation Oversight Process

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

Refer to *Section 8: Compliance* of this Manual for additional information regarding compliance requirements.

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

- 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 activities to evaluate an entity's performance and compliance with regulatory and accreditation requirements.
- Conducting annual audits to verify the entity's performance and processes support sustained compliance with regulatory requirements and accreditation standards.
- The development and implementation of Corrective Action Plans (CAPs) if the Delegated Entity's performance is substandard or terms of the agreement are violated.
- The review and initiation of recommendations to Senior Management and the Chief Compliance Officer for the revocation and/or termination of those entities not performing to the expectations of

the current contractual agreement and regulatory requirements of WellCare's Medicare and Medicaid program.

- Tracking and trending internal compliance with oversight standards, entity performance, and outcomes.

Section 10: Behavioral Health

Overview

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

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

Some behavioral health services may require Prior Authorization, including all services provided by non-participating providers. WellCare utilizes industry standard criteria for making Medical Necessity decisions. These criteria are well-known and nationally accepted guidelines for assessing level of care criteria for behavioral health. WellCare also uses its own proprietary Clinical Coverage Guidelines to determine Medical Necessity.

For complete information regarding benefits and exclusions, or in the event a Provider needs to contact WellCare's Member Services department for a referral to a behavioral health Provider, refer to the *Quick Reference Guide* at **www.wellcarenc.com/providers/medicaid**.

Behavioral Health Program

WellCare encourages community-based services and Member treatment at the least restrictive level of care whenever possible.

Many behavioral health services have a pass-through period or a number of unmanaged units, which vary, dependent on service type. Prior Authorization is required for units beyond the unmanaged amount for outpatient behavioral health services, psychological testing, peer support services and research based behavioral health treatment (RB-BHT). Prior authorization is required for many of the enhanced mental health and substance use services, as well as residential treatment (when coverable under EPSDT) and inpatient psychiatric/substance use services beyond the passthrough period . 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.wellcarenc.com/providers/medicaid/behavioral-health.**

Continuity and Coordination of Care between Medical Care and Behavioral Healthcare

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 are required to submit, with the Member's or Member's legal guardian's consent, an initial and quarterly summary report of the Member's behavioral health status to the PCP. Communication with the PCP should occur more frequently, if clinically indicated. WellCare encourages behavioral health Providers to pay particular attention to communicating with PCPs at the time of discharge from an inpatient

psychiatric hospitalization. (WellCare recommends faxing the discharge instruction sheet, or a letter summarizing the hospital stay, to the PCP.) Please send this communication, with the properly signed consent, to the Member's identified PCP, noting any changes in the treatment plan on the day of discharge.

Upon obtaining properly signed consent, WellCare strongly encourages open communication between PCPs and behavioral health Providers to help guide and ensure the delivery of safe, appropriate, efficient, and quality clinical 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 healthcare Providers and medical care Providers is critical, especially for Members with comorbidities receiving pharmacological therapy. Fostering a culture of collaboration and cooperation will help sustain a seamless continuum of care between medical and behavioral health and thus impact Member outcomes.

Responsibilities of Behavioral Health Providers

WellCare monitors Providers against the standards listed below to ensure Members can obtain needed health services within the acceptable appointments waiting times. The standards 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. Behavioral Health Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare.

Appointment Wait Time Standards		
Provider Type	Visit Type	Standard
Behavioral Healthcare	Mobile Crisis Management Services	Within two hours
	Urgent Care services for mental health / SUDs	Within 24 hours
	Routine Services for mental health / SUDs	Within 14 calendar days
	Emergency Services for mental health / SUDs	Immediately (available 24 hours a day, 365 days a year)

One annual audit is performed for Medicaid in the fourth quarter of the year. Results are typically received in the first quarter of the following year. Behavioral Health Provider Relations associates at WellCare will reach out to Providers who did not pass the audit to notify them that another audit will be scheduled approximately 30 days later and will educate Providers on what is required to pass.

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

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

Behavioral Health Providers are expected to assist Members in accessing emergent, urgent, and routine behavioral services as expeditiously as the Member's condition requires. Members also have access to a toll-free behavioral crisis hotline that is staffed 24 hours a day. The behavioral crisis phone number is printed on the Member's card and is available on WellCare's website. The behavioral health crisis hotline phone number is also in the Quick Reference Guide at **www.wellcarenc.com/providers/medicaid.**

WellCare will ensure Members have access to care through an adequate Provider network by monitoring travel times and distances between Providers and Members. In the event a geographic area does not have enough Providers to meet the standards listed below, WellCare will conduct outreach activities in order to add additional Providers to the network.

In order to ensure that all Members have timely access to all covered healthcare services, the network must meet, at a minimum, the following time and distance standards as measured from the Member's residence for adult and pediatric Providers separately through geo-access mapping.

Network Adequacy Time and Distance Standards		
Service Type	Urban Standard	Rural Standard
Outpatient Behavioral Health Services	>= Two Providers of each outpatient behavioral health services within 30 minutes or 30 miles of residence for at least 95% of Members Research-based behavioral health treatment for Autism Spectrum Disorder (ASD): Not subject to standard	>= Two Providers of each outpatient behavioral health services within 45 minutes or 45 miles of residence for at least 95% of Members Research-based behavioral health treatment for Autism Spectrum Disorder (ASD): Not subject to standard
Location-Based Services (Behavioral Health)	>= Two Providers of each service within 30 minutes or 30 miles of residence for at least 95% of Members	>= Two Providers of each service within 45 minutes or 45 miles of residence for at least 95% of Members
Crisis Services (Behavioral Health)	>= One Provider of each crisis service within each WellCare region	
Inpatient Behavioral Health Services	>= One Provider of each inpatient BH services within each WellCare region	
Partial Hospitalization (Behavioral Health)	>= One Provider of partial hospitalization within 30 minutes for at least 95% percent of Members	>= One Provider of specialized services partial hospitalization within 60 minutes for at least 95% of Members

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'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)
- Mandatory Generic Policy
- Step Therapy (ST)
- Quantity Limit (QL)
- Age Limit (AL)
- Coverage Determination Review Process
- Pharmacy Lock-In Program
- Provider Education Program (PEP)
- AcariaHealth™ Specialty Pharmacy

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

- Follow national standards of care guidelines for treating conditions, e.g., National Institutes of Health (NIH) Asthma guidelines, Joint National Committee (JNC) Hypertension guidelines, etc.
- 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.wellcarenc.com/providers/medicaid**.

Preferred Drug List

For WellCare Medicaid, WellCare will adopt the DHHS Medicaid Preferred Drug List (PDL) and provide all prescription drugs and dosage forms listed therein.

Drugs are selected based on the drug's efficacy, safety, side effects, pharmacokinetics, clinical literature, and cost-effectiveness profile. The medications on the PDL are organized by therapeutic class, product name, strength, form, and coverage details (quantity limit, age limitation, Prior Authorization, or step therapy).

The DHHS PDL can be found at **www.wellcarenc.com/providers/medicaid/pharmacy**.

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

- Quarterly updates in Provider newsletters
- Website updates, including P&T PDL change notices
- Pharmacy and Provider communication that detail any major changes to a particular therapy or therapeutic class

Medicaid Drug Coverage Request Form

Providers can request an addition to the PDL list by submitting a request at **www.wellcarenc.com/Coverage_Request_Form.pdf**. For more information on how to request an exception, visit **www.wellcarenc.com/providers/medicaid/pharmacy**.

Generic Medications

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

Generic drugs must be dispensed by the pharmacist when listed on the PDL. A Coverage Determination Request Form should be completed and submitted to WellCare's pharmacy department along with clinical justification when requesting a non-PDL branded medication as well as when requesting a brand name medication when the generic is available on the PDL.

For more information on the *Coverage Determination Review* Process, including how to access the Coverage Determination Request form, see *Coverage Determination Review Process* below.

Step Therapy

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

Step therapy programs are a safe and effective method of reducing the cost of treatment by ensuring that an adequate trial of a proven safe and cost-effective therapy is attempted before progressing to a more costly option. First-line drugs are recognized as safe, effective, and economically sound treatments. The first-line drugs on the DHHS' PDL have been evaluated using 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.

WellCare covers all drug categories currently available through the NC Medicaid Fee for Service program. The following is a list of non-covered (i.e., excluded from the Medicaid benefit) drugs and/or categories:

- Agents used for anorexia, weight gain, or weight loss
- Agents used to promote fertility
- Cough and cold medications used for the symptomatic relief of cough and colds that contain expectorants or cough suppressants
- Drugs for the treatment of erectile dysfunction
- DESI drugs or drugs that may have been determined to be identical, similar, or related
- Investigational or experimental drugs
- Agents prescribed for any indication that is not medically accepted

For an all-inclusive list of exclusions, please refer to the DHHS policy for outpatient pharmacy. **https://medicaid.ncdhhs.gov/9-outpatient-pharmacy-program/download**.

Smoking Cessation Therapy

WellCare offers the following services to help Members achieve their smoking cessation goals: nicotine replacement therapy, multimodal communication approach (e.g., secure email, secure instant chat, telephone), and online resources. WellCare will provide Members who want to quit smoking with nicotine replacement therapy for no more than 24 weeks per year or for the manufacturer's recommended duration.

Hemophilia Medications

WellCare benefits cover hemophilia factor-related medications. For WellCare Members, hemophilia factor-related medications are identified by the DHHS for distribution through the Comprehensive Hemophilia Disease Management Program.

Safety Monitoring Documentation (A+ KIDS)

A request for an antipsychotic medication meeting any of the descriptions as outlined below will require safety monitoring documentation by the prescriber in order for the claim to successfully complete point of sale processing:

- An antipsychotic prescribed without a clinical diagnosis corresponding to an FDA approved indication.
- An antipsychotic prescribed in an amount differing from the FDA approved dosage for that indication for a Medicaid beneficiary up to and including age 17.
- An antipsychotic prescribed that meets the definition of intraclass polypharmacy.

Note: Intraclass polypharmacy is defined as combination therapy with two or more agents outside of a 60-calendar day window allowing for cross titration when converting agents.

The documentation form is located at **www.wellcarenc.com/providers/medicaid/forms.**

Over the Counter (OTC) Medications

OTC items listed on the PDL require a prescription. All other OTC items offered as an expanded benefit by WellCare do not require a prescription can be found in our OTC catalog here: https://www.wellcarenc.com/members/medicaid/overview.html. Examples of OTC items listed on the PDL include:

- Smoking deterrent agents (nicotine)
- Proton pump inhibitors
- Second generation antihistamines
- Second generation antihistaminesdecongestant combination products
- Insulin
- Syringes
- Test strips
- Control solution
- Lancets
- Pen Needles
- Oral Contraceptives (levnorgestrel)
- Cathartics and Laxatives -limited to polyethylene glycol 3350
- Naloxone OTC

For a complete list of covered OTC medications, please refer to the PDL at **medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies** .

Pharmacy Lock-In Program

Members identified as overutilizing drugs in certain therapeutic classes, receiving duplicative therapy from multiple physicians, or frequently visiting the emergency department seeking pain medication will be placed in Pharmacy Lock-in (Lock-in) status for a minimum of two years. While in lock-in, the Member will be restricted to one PCP and one pharmacy to obtain their medications. Claims submitted by other pharmacies will not be paid for the Member.

Members identified will also be referred for case management. The Care Management team will work with the Member to create an individualized care plan. Care managers provide monitoring, education, communication, and collaboration and can assist with access to alternative treatments to improve a Member's health. For questions or concerns regarding the lock-in program, Members or Providers may call **1-866-799-5318**, Monday through Saturday, 7 a.m. to 6 p.m., Eastern time TTY users may call **711**. The program improves quality and safety of care, provides continuity of medical care, minimizes excessive drug quantities, and reduces inappropriate physician, pharmacy, and/or emergency room services.

Emergency Supplies for the Beneficiary Management Lock-In Program

Members are eligible to receive a four (4)-day supply of a prescription when locked into a different pharmacy and prescriber in response to an emergent situation. One emergency occurrence is allowed per beneficiary during each year of the two (2) year lock-in period.

Member Copayments

The below screenshot outlines our services that require a copay:

Service	Copay
• Doctor visits • Non-emergency and emergency department visits • Optometrist and optical visits • Outpatient visits • Podiatrist visits • Chiropractic visits	$4 per visit
Generic and brand prescriptions	$4 per prescription

WellCare of North Carolina does not require a copay for:

- Members under age 21
- Members who are pregnant
- Members who get hospice care
- Federally recognized tribal members
- North Carolina Breast and Cervical Cancer Control Program (NC BCCCP) beneficiaries
- People living in an institution who get coverage for cost of care
- Children/youth in foster care
- Behavioral health, intellectual/developmental disability (I/DD) or traumatic brain injury (TBI) services

For more information regarding North Carolina copay, please refer to **www.medicaid.ncdhhs.gov/about-nc-medicaid/nc-medicaid-copays**.

Coverage Determination Review Process (Requesting Exceptions)

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

- Duplication of therapy
- Prescriptions that exceed the FDA daily or monthly quantity limit
- Most self-injectable and infusion medications (including chemotherapy)
- Drugs not listed on the PDL
- Drugs that have an age edit
- Drugs listed on the PDL but still require Prior Authorization
- Brand-name drugs when a generic exists
- Drugs that have a step therapy edit, and the first-line therapy is inappropriate

Providers may request an exception to the State 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.wellcarenc.com/providers/medicaid/forms**.

To submit a request orally, refer to the contact information listed on your Quick Reference Guide at **www.wellcarenc.com/providers/medicaid**.

If Authorization cannot be approved or denied, a 72-hour emergency supply may be provided by the pharmacy if a beneficiary is waiting for acknowledgment of the prior authorization request.
Prior Authorization protocols are developed and reviewed at least annually by the P&T Committee. These protocols indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.).

Medication Appeals

To request an appeal of a Coverage Determination Review decision, contact the Pharmacy Appeals department via fax, phone, mail, or in person. The *Medication Appeals Form* is at **www.wellcarenc.com/providers/medicaid/forms**.

For contact information, refer to the *Quick Reference Guide* at **www.wellcarenc.com/providers/medicaid**.

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

Pharmacy Management – Provider Education Program (PEP)

The 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 state Pharmacy Director and/or Clinical Pharmacy Manager to physicians identified for the program.

Member Pharmacy Access

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

For areas where there are no pharmacies open 24 hours a day, Members may call Express Scripts at 1-833-750-4515 for information on how to access pharmacy services. Contact information is located on the *Quick Reference Guide* at **www.wellcarenc.com/providers/medicaid**.

AcariaHealth™ Specialty Pharmacy

AcariaHealth is a national comprehensive specialty pharmacy focused on improving care and outcomes for patients living with complex and chronic conditions. AcariaHealth is comprised of dedicated healthcare professionals who work closely with physician’s offices, including support with referral and prior authorization processes. This collaboration allows our patients to receive the medicine they need as fast as possible.

Representatives are available from Monday through Thursday from 8 a.m. to 7 p.m., and Friday from 8 a.m. to 6 p.m., Eastern time.

AcariaHealth Pharmacy #26, Inc.
8715 Henderson Rd., Tampa, FL 33634
Phone: **1-866-458-9246** (TTY **1-855-516-5636**)
Fax: **1-866-458-9245**
Website: **www.acariahealth.com**

Section 12: Definitions

The following terms as used in this Provider Manual shall be construed and/or interpreted as follows. To the extent a definition below conflicts with a definition in the Provider contract, the Provider contract definition governs.

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) and 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 90 calendar days from the date the Health Plan receives a grievance or 30 calendar 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 a Member's request to exercise the right to obtain services outside the network.
- The denial of a Member's request to dispute financial liability.

Agency means state of North Carolina, Department of Health and Human Services.

Appeal means a formal request from a Member to seek a review of an adverse benefit determination taken by WellCare pursuant to 42 CFR 438.400(b).

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

Behavioral Health Home means a Community Mental Health Center has been approved to provide both behavioral health services and primary medical services to Members onsite or in close collaboration. Providers must submit a Readiness Review Tool and be approved by the health plan to become a designated Behavioral Health Home.

Benefit Plan means a schedule of healthcare services to be delivered or other health Covered Service contract or coverage document that is: (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 through 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 radiology, laboratory, dental, or eyeglasses fabrication.

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

Child Health Checkup 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 Department of Health and Human Services (DHHS).

Clean Claim means a claim for Covered Services that is: (a.) received in a timely manner by WellCare; (b.) can be processed without obtaining additional information from the Provider of the service or from a third party; and (c.) not subject to coordination of benefits or subrogation issues. It includes a claim with errors originating in a state's claims system. 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 pursuant to 42 CFR 447.45.

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.

Department of Health and Human Services (DHHS) means State of North Carolina, Department of Health and Human Services.

EPSDT means Early and Periodic Screening, Diagnosis, and Treatment program that provides Medically Necessary healthcare, diagnostic services, preventive services, rehabilitative services, treatment, and other measures described in 42 U.S.C. § 1396d(r)(5) and 42 CFR 440.40(b)(2012) or its successive regulation, to all Members under the age of 21.

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 that the absence of immediate medical attention to result in the following: (1.) placing the health of the individual (or, with respect to a pregnant individual, the health of the individual or her unborn child) in serious jeopardy; (2.) serious impairment to bodily functions; or (3.) serious dysfunction of any bodily organ or part (see 42 USC §1395dd(e)(1) and 42 CFR 438.114).

Emergency Services and Care means medical screening, examination, and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists. If such a condition exists, emergency services and care include the care or treatment necessary to relieve or eliminate the emergency medical condition within the service capability of the facility.

Encounter Data means a record of Covered Services provided to a WellCare Member. An "encounter" is an interaction between a patient and Provider (WellCare, rendering physician, pharmacy, lab, etc.) who delivers services or is professionally responsible for services delivered to a patient.

Expanded Benefits are benefits that the health plan received approval from NCDHHS to provide to Members that are above and beyond the traditional Medicaid services.

Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a Provider or WellCare employee or failure to respect the Member's rights, or a Member dispute of an extension of time proposed by the managed care plan to make an authorization decision.

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

In Lieu of Services means services that the health plan has been approved by NCDHHS to provide to Members in lieu of or in substitution to a traditional Medicaid service.

Ineligible Person means an individual or entity who: (a.) is currently excluded, debarred, suspended, or otherwise ineligible to participate in (1.) Federal Healthcare Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (2.) 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 Healthcare 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.

LTAC means a Long-Term Acute Care hospital.

Medical Necessity (Medically Necessary) means medically necessary Covered Services and supplies as determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. As required by 10A NCAC 25A0201, a medically necessary service may not be experimental in nature.

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

Medically Necessary or Medical Necessity for inpatient hospital services require 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.

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

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

Members/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 that defines age-appropriate services and time frames for screenings within the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) 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 contracted Provider practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, advanced registered nurse practitioner, physician assistant, or other specialty approved by the DHHs who furnishes primary care and patient management services to a Member.

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

Priority Population means populations likely to have care management needs and likely to benefit from care management, including the following:

- Individuals with Long Term Services and Supports (LTSS) needs
- Adults and children with special healthcare needs
- Individuals identified as Rising Risk
- Individuals with high unmet health-related resource needs, as defined at a minimum to include:
    - Members who are homeless, according to the U.S. Department of Housing and Urban Development definition of homelessness
    - Members experiencing or witnessing domestic violence or lack of personal safety
    - Members showing unmet health-related needs in three or more Opportunities for Health domains on the Care Needs Screening
- At-Risk Children (age 0-5)
- High-risk pregnant individuals
- Other Priority Populations as determined by WellCare (i.e., Members with complex conditions such as HIV, Hepatitis C, Asthma or Sickle Cell)

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

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 contract.

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

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

Section 13: WellCare Resources

Important Telephone Numbers	
WellCare Member Services/Provider Service	**1-866-799-5318**
TTY	**711**
24-Hour Nurse Advice Line	**1-800-919-8807**
24-Hour Behavioral Health Crisis Line	**1-833-207-4240**
Fraud, Waste, and Abuse Hotline	**1-866-685-8664**
To report abuse, neglect or exploitation (including elder)	Local County Department of Social Services (DSS) Offices: **www.ncdhhs.gov/divisions/dss/local-county-social-services-offices**

Forms and Documents
www.wellcarenc.com/providers/medicaid/forms

Quick Reference Guide
www.wellcarenc.com/providers/medicaid

Clinical Practice Guidelines and Clinical Coverage Guidelines
www.wellcarenc.com/providers/tools/clinical-guidelines

Job Aids and Resource Guides
www.wellcarenc.com/providers/medicaid

Provider Orientation
https://provider.wellcare.com Provider must be a registered user of WellCare's secure online provider portal to access.

Addendum: Long Term Services and Supports (LTSS)

LTSS Plan Eligibility

A Member is eligible for the LTSS Plan if they are North Carolina Medicaid recipients requiring Medically Necessary LTSS services who have a nursing facility level of care determined by the CARES program. Some services may be subject to additional coverage criteria. WellCare will cover all regions.

WellCare LTSS plan Members are required to participate in case management, so we have designed a plan and person-centered care management to meet our Member's needs.

LTSS Description and Program Goals

Under the Statewide Medicaid Managed Care Long Term Services and Supports program, managed care plans (LTSS plans) are required to provide an array of home and community-based services that enable Members to live in the community and to avoid institutionalization.

Definitions

1. Activities of Daily Living (ADLs) include:
    a. Bathing
    b. Dressing
    c. Eating (oral feeding and fluid intake)
    d. Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control bowel or bladder functions)
    e. Toileting
    f. Transferring

2. Authorized Representative
    a. An individual who has the legal authority to make a decision on behalf of a Member or potential Member.

3. Benefits
    a. A schedule of healthcare and related services to be delivered to Members covered by an LTSS plan.

4. Case Record
    a. A file that includes information regarding the management of services for a Member including the plan of care, comprehensive needs assessment, and documentation of case management activities.

5. Comprehensive Assessment
    a. WellCare will identify Members who may need Long Term Services and Supports (LTSS) through referrals from numerous sources, including the Member's providers, family, self-referral, or other care managers. The Care Management team of WellCare will assess all Members potentially eligible for LTSS. The InterRAI tool will be used, which assesses the Member's physical, intellectual, or developmental disabilities; physical and behavioral

conditions to include dental; immediate care needs; current services; other state or local services currently used; current and past mental health and substance use status and/or disorders; medications, both prescribed and taken; available informal, caregiver, or other social supports, including peer support; unmet health-related resource needs such as housing, food, transportation, and interpersonal safety; any other ongoing special conditions that require a course of treatment or care monitoring; and, as needed, adults only exposure to adverse childhood experiences (ACEs) or other trauma. The care team will also assess any home safety needs for the Member. If the results of the assessment indicate the Member needs LTSS WellCare will initiate the process to obtain the appropriate services.

6. Direct Care
    a. Any LTSS services that are provided through face-to-face contact with a Member including access to the Member's living areas, funds, personal property, or personal identification information.

7. Instrumental Activities of Daily Living (IADLs)
    a. Grocery shopping
    b. Laundry
    c. Light housework
    d. Meal preparation
    e. Medication management
    f. Money management
    g. Personal hygiene
    h. Transportation
    i. Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)

8. LTSS Supplemental Assessment
    a. An evaluation conducted by the LTSS plan of the level of natural support that are available to the Member and to capture additional information regarding the functional needs of the Member.

9. Maintenance Therapy
    a. Therapy that is performed to maintain or to prevent deterioration of a chronic condition. Maintenance therapy is provided when further clinical improvement cannot reasonably be expected from continuous ongoing care, and the treatment becomes supportive rather than correction in nature.

10. Medically Necessary or Medical Necessity
    a. Services that meet either of the following criteria:
        i. Nursing facility services and mixed services must meet Medical Necessity criteria
        ii. All other LTSS supportive services that meet all of the following:
            1. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the patient's needs

2. Be reflective of the level of service that can be safely furnished, and for which not equally effective and more conservative or less costly treatment is available statewide
3. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the Provider

   And one of the following:
1. Enable the Member to maintain or regain functional capacity
2. Enable the Member to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of their choice

11. Natural Supports
    a. Unpaid support that are provided voluntarily to the individual in lieu of home and community-based services and supports.

12. Patient Responsibility
    a. The amount a Member is responsible to pay toward LTSS services, as determined by the Department of Health and Human Services (DHHS). The DHHS determines the amount of patient responsibility for LTSS Members residing in an ALF through the post-eligibility treatment of income process according to the requirements in:
       i. Chapter 65A-1.7141, North Carolina Administrative Code; and
       ii. Title 42 Section 435.725, Code of Federal Regulations

13. Plan of Care
    a. A description of the Member's goals for long-term care, the services and supports needed to meet those goals, and the specific service needs of each Member showing the projected duration, desired frequency, type of provider furnishing each service, and the scope of the services to be provided.

14. Supportive Services
    a. Services that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function

Long Term Services and Supports (LTSS)

In addition to all the benefits and services our Members receive under our Comprehensive Plan, our LTSS Plan Members also have access to the following:

- Additional Expanded Benefits
- Person-centered care management
- Access to an Interdisciplinary Care Team

Covered Services

Our Covered Services meet all of the following:

1. Are determined Medically Necessary
2. Do not duplicate another service
3. Are consistent with the type, amount, duration, frequency, and scope of services specified in the Member's authorized plan of care
4. Are provided in accordance with a goal in the Member's plan of care

5. Are intended to enable the Member to reside in the most appropriate and least restrictive setting

LTSS Program Minimum Covered Services	
Home Health	Personal care
Hospice	Respite care (Relief Camps)

Additional Expanded Benefits:

- Transition Assistance: nursing facility to community setting
- Individual therapy sessions for caregivers

Home and Community Based Supportive Services

Our Long-term Care plans include coverage of the following home and community based supportive services:

1. Personal Care
   a. Personal care services (PCS) include a range of human assistance provided to persons of all ages with disabilities and chronic conditions to enable them to accomplish tasks that they would ordinarily do for themselves if they were not disabled. These PCS are intended to provide person-to-person, hands-on assistance by a PCS direct care worker in the Member's home or residential setting with common activities of daily living (ADLs) that, for this program are eating, dressing, bathing, toileting, and mobility. PCS also include assistance with instrumental activities of daily living (IADLs), such as light housekeeping tasks, when directly related to the approved ADLs and the assistance is specified in the Member's plan of care. PCS is provided by a direct care worker who is employed by a licensed home care agency, or by a residential facility licensed as an adult care home, family care home, supervised living facility, or combination home, and who meets the qualifications specified on Attachment 3.1-A.1, Pages 23-29, section c.

2. Respite Care (Relief Camps)
   a. The provision of services on a short-term basis due to the absence of, or need to relieve, the Member's natural supports on a planned or an emergency basis.

Benefit Exclusions

The LTSS program benefit does not include coverage for Services provided through the Program of All-Inclusive Care for the Elderly (PACE), CAP and CAP-C benefits, nursing facility services longer than 90-120 days, and Members who are dual eligible for Medicare and Medicaid. We will work in partnership with our long-term care Providers to provide training, systems access, and communication to ensure that our Members are provided the coordinated care that they need. The following will be available to assist Providers to coordinate care for our Members:

Provider Web Portal Access

Our **Long-term care Provider web portal** offers a streamlined LTSS Provider experience with access to everything LTSS Providers need to file and submit claims, receive authorizations, and review care plans. This web portal has the ability to notify Providers of the need to take available training and to track the completion of training.

Community Providers Performance Dashboard/Scorecard

Our new Community Providers Performance Dashboard is a new tool that will display performance metrics by Provider. This dashboard allows community Providers to easily track their own performance on key LTSS measures. A locally based LTSS Provider Relations representative will be assigned to each LTSS Provider.

LTSS Provider Advisory Group

WellCare's Provider Advisory Group will be expanded to include a separate LTSS Provider Advisory Group with meetings held quarterly. LTSS Provider Advisory Group participation will help to validate both the adequacy and relevancy of our training.

Critical Incident Reporting

HCBS Providers shall report critical incidents to WellCare immediately upon occurrence and no later than within 24 hours after detection or notification. The Incident Report Form is at **www.wellcarenc.com/providers/medicaid/forms**. WellCare shall ensure suspected cases of abuse, neglect, and/or exploitation are reported to the Local County Department of Social Services (DSS) Offices at **www.ncdhhs.gov/divisions/dss/local-county-social-services-offices**.

WellCare does not require nursing facilities or ALFs to report critical incidents or provide incident reports to WellCare. Critical incidents occurring in nursing facilities and ALFs will be addressed in accordance with North Carolina law.

LTSS plans will use standard Company Contact Information as shown below:

Important Telephone Numbers	
Member Services/Provider Service	**1-866-799-5318**
TTY	**711**
24-Hour Nurse Advice Line	**1-800-919-8807**
24-Hour Behavioral Health Crisis Line	**1-833-207-4240**
Fraud, Waste, and Abuse Hotline	**1-866-685-8664**
To report abuse, neglect or exploitation (including elder)	Local County Department of Social Services (DSS) Offices: **www.ncdhhs.gov/divisions/dss/local-county-social-services-offices**

Forms and Documents
www.wellcarenc.com/providers/medicaid/forms
Quick Reference Guide
www.wellcarenc.com/providers/medicaid

Clinical Practice Guidelines and Clinical Coverage Guidelines
www.wellcarenc.com/providers/tools/clinical-guidelines

Job Aids and Resource Guides
www.wellcarenc.com/providers/medicaid

Provider Orientation
https://provider.wellcare.com Provider must be a registered user of WellCare's secure online provider portal to access.