# 2014 Florida Medicaid and Healthy Kids Provider Manual Table of Contents

## 2014 Florida Medicaid and Healthy Kids Provider Manual Table of Revisions

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Florida Medicaid and Healthy Kids Provider Manual
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Section 1: Welcome to WellCare

Overview
WellCare of Florida, Inc., doing business as Staywell (WellCare), provides managed care services targeted exclusively to government-sponsored health care programs, focused on Medicaid, CHIP and Medicare, including prescription drug plans and health plans for families and children. WellCare's corporate office is located in Tampa, Florida. WellCare serves approximately 2.8 million members. Our experience and commitment to government-sponsored health care programs enables us to serve our members and providers as well as manage our operations effectively and efficiently.

Mission and Vision
WellCare's vision is to be the leader in government-sponsored health care programs in partnership with the members, providers, governments and communities we serve. WellCare will:

- Enhance our members' health and quality of life;
- Partner with providers and governments to provide quality, cost-effective health care solutions; and
- Create a rewarding and enriching environment for our associates.

Our values are:

- Partnership – Members are the reason we are in business; providers are our partners in serving our members; and regulators are the stewards of the public's resources and trust. We will deliver excellent service to our partners.
- Integrity – Our actions must consistently demonstrate a high level of integrity that earns the trust of those we serve.
- Accountability – All associates must be responsible for the commitments we make and the results we deliver.
- Teamwork – With our fellow associates, we can expect – and are expected to demonstrate – a collaborative approach in the way we work.

Purpose of this Provider Manual
This Provider Manual is intended for WellCare-contracted (participating) Medicaid and Healthy Kids providers providing health care service(s) to WellCare members enrolled in a WellCare Managed Care Plan. This manual serves as a guide to the policies and procedures governing the administration of WellCare’s Medicaid and Healthy Kids plans and is an extension of and supplements the Provider Participation Agreement (the Agreement) between WellCare and health care providers, who include, without limitation: primary care providers, hospitals and ancillary providers (collectively, providers).

This manual replaces and supersedes any previous versions dated prior to April 1, 2014, for Regions 2–8 and 10. The manual is available on WellCare’s website at https://florida.wellcare.com/provider/resources. A paper copy may be obtained, at no charge, upon request by contacting Customer Service (Provider Services) or your Provider Relations representative.

See Appendix A for a regional map.
In accordance with the policies and procedures clause of the Agreement, 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 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 a government health insurance program for persons of all ages whose income and resources are insufficient to pay for health care. WellCare is contracted with the Florida Agency for Health Care Administration (Agency) to provide Medicaid managed care services. These products are offered in select markets to allow flexibility and offer a distinct set of benefits to fit member needs in each area. The health plans offered are below.

**Programs**

**Staywell** – Staywell is a plan for people who qualify for Florida Medicaid. Medicaid is a state and federal health care program for those with low incomes. Members who have Medicaid join Staywell. Members who choose Staywell get all of their Medicaid benefits plus the extra benefits offered through the plan.

**MediKids** – is the Florida KidCare Program which offers low-cost health insurance for children ages 1–4. The Agency for Health Care Administration (AHCA) manages the program. The MediKids program is similar to Medicaid. Children enrolled in MediKids receive Medicaid benefits and medical services from Medicaid providers.

**HealthEase Kids and Staywell Kids** – is a Children’s Health Insurance Program (CHIP) managed by Florida Healthy Kids Corporation, that offers health care coverage for as little as $15–$20 per month. There are also low-cost, full-pay options, making Healthy Kids coverage available to every 5–18-year old in Florida.

**Staywell (Medicaid)**
WellCare of Florida, Inc., doing business as Staywell, serves both adults and children eligible to participate in Florida’s Medicaid program. The plan offers members more benefits and coverage than traditional Medicaid at no additional cost. Members may choose their primary care provider (PCP) from a network of participating providers, including family doctors, pediatricians and internists.

**Staywell (Medicaid) Eligibility**
Eligibility is solely determined by the Agency. Three basic groups eligible for Medicaid are:
- Supplemental Security Income (SSI) recipients;
- Children and families, including women; and
- Aged, blind and disabled persons, including those needing institutional care (these programs are also referred to as “SSI-related” Medicaid).

An individual must meet specific eligibility requirements in order to be eligible for Medicaid. Each program has specific income and asset limits that must be met.
The Agency requires that Medicaid recipients must enroll with a managed care plan. Eligible recipients are given 30 days from the date that Medicaid eligibility begins to select a Medicaid managed care option. If recipients do not select an option within 30 days, they are automatically assigned to a managed care plan.

The Florida Legislature created a new program called "Statewide Medicaid Managed Care."

In response, AHCA has changed how some individuals receive health care from Medicaid.

One of the two components that make up Medicaid Managed Care is the Florida Managed Medical Assistance (MMA) program. Starting May 1, 2014, Staywell will offer MMA services, and members will receive the following benefits in Regions 2, 3 and 4; Regions 5, 6 and 8 will start on June 1, 2014; Region 11 will start on July 1, 2014; Region 7 will start on Aug. 1, 2014.

**Staywell (Medicaid) 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 Florida Medicaid members:

- Advanced registered nurse practitioner services
- Ambulatory surgical treatment center services
- Birthing center services
- Chiropractic services
- Dental services
- Early periodic screening diagnosis and treatment services for recipients under age 21
- Emergency services
- Family planning services and supplies
- Healthy Start services, except as provided in 409.975(4)
- Hearing services
- Home health agency services
- Hospice services
- Hospital inpatient services
- Hospital outpatient services
- Laboratory and imaging services
- Medical supplies, equipment, prostheses and orthoses
- Mental health services
- Nursing care
- Optical services and supplies
- Optometrist services
- Physical, occupational, respiratory and speech therapy services
- Physician services, including physician assistant services
- Podiatry services
- Prescription drugs
- Renal dialysis services
- Respiratory equipment and supplies
- Rural health clinic services
- Substance abuse treatment services
- Transplant services
Transportation to covered services

For the most up-to-date information on Covered Services, refer to the Agency’s website at [http://ahca.myflorida.com/](http://ahca.myflorida.com/).

The following expanded benefits* and special programs are available to Staywell members:

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<td>Healthy Rewards Card</td>
<td>Members can earn up to $50 by participating in Staywell's Healthy Rewards Program. The incentive program allows members to be rewarded with a reloadable Visa debit card for completing for specific preventive health, wellness and engagement milestones.</td>
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<td>Co-payment Waiver</td>
<td>Co-payments are waived for nonpregnant adults for all services except nonemergency Emergency Department* and chiropractic services. For each visit to the emergency room for nonemergency services, there is a 5% coinsurance up to the first $300 of Medicaid payment, not to exceed $15.00.</td>
</tr>
<tr>
<td>Enrollee Discount Card</td>
<td>Members will receive monthly discounts from pre-selected retailers. Members can receive the discount card after completion of certain healthy behaviors.</td>
</tr>
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<td>Equine Therapy</td>
<td>SSI children, adults and dually eligible members who meet utilization management criteria for cerebral palsy and autism can receive 10 free riding sessions per year.</td>
</tr>
<tr>
<td>Expanded Adult Dental Benefits</td>
<td>Adults can receive preventive dental care services, including oral exams and cleanings every six months as well as annual X-rays, with no co-pay to members age 21 and older, and pregnant women. Children are covered under a standard benefit package.</td>
</tr>
<tr>
<td>Expanded Vision Benefits</td>
<td>Members age 21 and older can apply a $100 allowance toward any frame, contact lenses or upgrades.</td>
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<tr>
<td>Free Baby Stroller or Playpen</td>
<td>By attending prenatal appointments, members are rewarded with a stroller or portable playpen that is delivered to their home.</td>
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<td>Service Description</td>
<td>Description</td>
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<tr>
<td>Free Cell Phone</td>
<td>Staywell will offer a free cell phone to members who are engaged in care management and do not have a telephone.</td>
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<td>Hypoallergenic Bedding</td>
<td>Members who meet criteria for asthma are offered an allowance to purchase hypoallergenic bedding, including bed linens, cushions, mattress protectors and pillow coverings.</td>
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<td>Lodging and Food for Services Requiring an Overnight Stay</td>
<td>Costs of lodging and food associated with a nonemergent medical procedure, specialist visit or hospitalization, where overnight travel is required, will be covered.</td>
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<td>Meals Program</td>
<td>SSI and dually eligible members discharged within two weeks from an inpatient facility can receive 10 meals for post-acute nutritional support.</td>
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<td>Smoking Cessation</td>
<td>Members will be offered a health coach who will provide telephonic outreach and support. Support can also include nicotine replacement therapy, multimodal communication and other resources.</td>
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<td>Over-the-Counter (OTC) Benefit</td>
<td>Staywell will offer a $25 OTC medication allowance per household each month.</td>
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<td>Art Therapy</td>
<td>Provides therapy coverage for SSI children, adults, and dually eligible enrollees who are identified by care management criteria for cancer treatment, emotional abuse, post-traumatic stress disorders (PTSD) and other chronic conditions based on medical necessity.</td>
</tr>
<tr>
<td>Pet Therapy</td>
<td>Provides therapy coverage for SSI children, adults, and dually eligible enrollees who are identified by utilization management criteria for cancer treatment, emotional abuse, cerebral palsy, autism and other chronic conditions based on medical necessity.</td>
</tr>
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<td>Physician Home Visit</td>
<td>Staywell covers services provided by physicians and advanced practice nurse practitioners evaluating and treating acute and chronic medical problems in the home setting. In-home care services provided for persons who are frail, homebound and unable to travel to a physician’s office.</td>
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<tr>
<td>Service</td>
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<tr>
<td>Evaluation and coordination of home health, therapy and other services as needed.</td>
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<td>Pneumonia Vaccine</td>
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<td>Shingles Vaccine</td>
<td>Staywell covers vaccination of shingles for members age 60 and older. Coverage includes one vaccination every six years. Not covered for the following individuals:</td>
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<td>- A person who has ever had a life-threatening or severe allergic reaction to gelatin, the antibiotic neomycin or any other component of shingles vaccine. Tell your doctor if you have any severe allergies.</td>
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<td>- A person who has a weakened immune system because of:</td>
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<td>- HIV/AIDS or another disease that affects the immune system</td>
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<td></td>
<td>- Treatment with drugs that affect the immune system, such as steroids</td>
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<td></td>
<td>- Cancer treatment such as radiation or chemotherapy</td>
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<td>- Cancer affecting the bone marrow or lymphatic system, such as leukemia or lymphoma</td>
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<td></td>
<td>- Women who are or might be pregnant</td>
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<tr>
<td>Unlimited Primary Care Provider Visits</td>
<td>To support our quality initiatives, Staywell promotes the use of preventive care including well-child visits and checkups, and enhances overall access to care. Staywell will provide all enrollees with unlimited visits to their primary care provider (PCP). We believe that this is essential to our enrollees receiving the services they need, and demonstrates our commitment to ongoing quality improvement.</td>
</tr>
<tr>
<td>Nutritional counseling</td>
<td>Coverage includes assessment, hands-on care and guidance to caregivers and enrollees with respect to nutrition. This service teaches caregivers and enrollees to follow dietary specifications that are essential to enrollees’ health and physical functioning, and to prepare and eat nutritionally appropriate meals. The service promotes better health through improved nutrition. This service may include instructions on shopping for quality food and</td>
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<td>Service</td>
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<td><strong>Outpatient Hospital</strong></td>
<td>Outpatient hospital services are preventive, diagnostic, therapeutic or palliative care, and service items provided in an outpatient setting. The services must be provided under the direction of a licensed physician or dentist. Medicaid reimburses licensed, Medicaid-participating hospitals for outpatient services. Medicaid reimbursement includes medical supplies, nursing care, therapeutic services and pharmacy services. Primary care services provided in an outpatient hospital setting, hospital-owned clinic or satellite facility are not considered outpatient hospital services and are not reimbursable under the Florida Medicaid (Title XIX) Outpatient Hospital Reimbursement Plan.</td>
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</tbody>
</table>
| **Prenatal and Perinatal Visits**   | Staywell reimburses for prenatal and perinatal services rendered by licensed, Medicaid-participating doctors of allopathic or osteopathic medicine. Services may be rendered as necessary to support the health and well-being of a woman and her child during pregnancy and in the period immediately after birth.  
- Unlimited prenatal visits  
- Unlimited postpartum visits in the four-week postpartum period  
- Medicaid currently offers 10 prenatal visits per recipient, per pregnancy  
- Four additional visits may be reimbursed for high-risk pregnancies  
- Two medically necessary postpartum visits per recipient, per pregnancy |
| **Hearing Services**                | Staywell will provide coverage for one hearing evaluation for the purpose of determining hearing aid candidacy, per eligible, every two years from the date of the last evaluation.                                                                 |
| **Influenza Vaccine**               | All persons age 6 months and older are covered for an annual vaccination. When vaccine supply is limited, vaccination efforts should focus on delivering vaccination to the following persons (no hierarchy is implied by order of listing):  
- Are age 6 months through 4 years (59 |
- Are age 50 years and older
- Have chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, neurologic, hematologic or metabolic disorders (including diabetes mellitus)
- Are immunosuppressed (including immunosuppression caused by medications or by human immunodeficiency virus)
- Are or will be pregnant during the influenza season
- Are age 6 months through 18 years and receiving long-term aspirin therapy and who therefore might be at risk for experiencing Reye’s syndrome after influenza virus infection
- Are residents of nursing homes and other chronic-care facilities
- Are American Indians/Alaska Natives
- Are morbidly obese (body mass index is 40 or greater)
- Are caregivers of children younger than 5 years and/or adults age 50 years and older, with particular emphasis on vaccinating contacts of children younger than 6 months
- Are caregivers of persons with medical conditions that put them at higher risk for severe complications from influenza

### Home Health Visits for Nonpregnant Adults
Members may receive four (4) personal care home health visits from nurses and/or aides per day, per member. Personal care home health visits provide medically necessary assistance with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) that enable recipients to accomplish tasks that they would normally be able to do for themselves if they did not have medical conditions or disabilities.

Skilled interventions that may be performed only by a licensed health professional are not considered personal care services.

### Circumcisions
To be eligible for coverage, the male patient must be age 0–3 months.
HealthEase Kids and Staywell Kids
Healthy Kids is designed to provide quality, affordable health insurance for families not eligible for Medicaid. HealthEase Kids and Staywell Kids provide affordable health coverage to children in communities across the state and are a part of the Florida Healthy Kids program. Florida Healthy Kids is a public/private partnership that provides comprehensive health insurance for school-age children ages 5–18 in the state of Florida.

HealthEase Kids and Staywell Kids Eligibility
Eligibility for the Healthy Kids program is solely determined by the Florida Healthy Kids Corporation. Most Florida Healthy Kids families pay just $15 or $20 per month. Monthly premiums depend on household size and income. Other criteria’s include:

- Be 5–18 years of age
- Be uninsured
- Be a U.S. citizen or a qualified alien
- Not be the dependent of a state employee
- Applicant child:
  - May not have access to employer sponsored insurance; or if such access exists, the cost exceeds 5 percent of the family’s income;
  - Has not voluntarily lost employer coverage within six months of application; and
  - Is ineligible for Medicaid or the Children’s Medical Services Network (CMSN) as defined by the Florida KidCare Act, Florida Statutes 409.810-409.820).

HealthEase Kids and Staywell Kids 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 Florida HealthEase Kids and Staywell Kids members:

<table>
<thead>
<tr>
<th>Service</th>
<th>Important Notes</th>
<th>Co-Payment (due at time of service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortions</td>
<td>Covered only:</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>- If the pregnancy is the result of an act of rape or incest; or</td>
<td></td>
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<tr>
<td></td>
<td>- When a primary care provider has found that the abortion is needed to save the</td>
<td></td>
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<tr>
<td></td>
<td>life of the mother</td>
<td></td>
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<tr>
<td>Ambulatory surgery center services</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Service</td>
<td>Important Notes</td>
<td>Co-Payment (due at time of service)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------</td>
</tr>
</tbody>
</table>
| Child health checkups   | For children who are 5–18 years of age Screening services include:  
  • A comprehensive physical examination  
  • A comprehensive health and developmental history  
  • Developmental appraisal (including mental, emotional and behavioral)  
  • Anticipatory guidance and health education  
  • Measurements  
  • Dental/oral health assessment  
  • Vision and hearing tests  
  • Certain laboratory procedures  
  • Lead risk assessment  
  • Immunizations, as needed, to be given at the time of screening services  
  
  Checkup schedule: 5–18 years of age – one exam each year  
  
  Covered Services include evaluation and treatment done on one or more areas of the body.  
  
  Treatment consists of manual manipulation or adjustment with application of controlled force to reestablish normal function (mobility and range of motion to the spine).  
  
  Limited to 24 visits a year  
  
  Manual manipulation done on patients who don’t have back issues is not covered. | $0                                                                                   |
| Chiropractic services   |                                                                                                                                                                                                               | $5                                  |
| Cosmetic procedures     | Not covered                                                                                                                                                                                                     | Not covered                         |
| Dental services         | Talk with child’s PCP to coordinate care  
  Pre-authorization required |
<table>
<thead>
<tr>
<th>Service</th>
<th>Important Notes</th>
<th>Co-Payment (due at time of service)</th>
</tr>
</thead>
</table>
| Durable medical equipment (DME)      | Includes, but not limited to, items such as:  
  - Medical supplies (such as colostomy, ureterostomy, gastrostomy or surgical dressings)  
  - Diabetic supplies (lancets, glucose testing strips), nebulizers, infusion pumps, wheelchairs and hospital beds  
  
  Members 5–18 years of age with a physical or mental condition that results in chronic incontinence, diapers, briefs, protective underwear, pull-ons, liners, shields, guards, pads and undergarments may be reimbursed up to a combined total of $200 per calendar month.  
  
  Devices and equipment that are primarily and customarily used for nonmedical purposes are not covered; some items include comfort or convenience items, physical fitness equipment, incontinence items, and safety alarms and alert systems.  
  
  Pre-authorization required                                                                                                      | $0                                  |
| Emergency room (ER) services         | Covered Services include:  
  - Visits to an emergency room or other licensed facility if needed immediately due to an injury or illness, and delay means risk of permanent damage to the member’s health  | $10 per visit (not collected if admitted or approved by the child’s PCP) |
| Experimental and investigational procedures | Not covered                                                                                                                                  | Not covered                         |
| Family planning services             | Covered Services include:  
  - Planning and referral  
  - Education and counseling  
  - Initial examination  
  - Diagnostic procedures and routine laboratory studies  
  - Contraceptive drugs (such as IUD, Depo-Provera, Lunelle and cervical caps) and supplies  
  
  Family planning is limited to one annual visit and one supply visit each 90 days.                                                                 | $0                                  |
<table>
<thead>
<tr>
<th>Service</th>
<th>Important Notes</th>
<th>Co-Payment (due at time of service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing services</td>
<td>Routine hearing screenings must be provided by the child’s PCP.</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Hearing aids are covered only when needed to help treat a medical condition.</td>
<td></td>
</tr>
<tr>
<td>Home health care services</td>
<td>Covered Services include:</td>
<td>$5 per visit</td>
</tr>
<tr>
<td></td>
<td>- Prescribed visits by both registered and licensed practical nurses to provide skilled nursing services on a part-time, intermittent basis</td>
<td></td>
</tr>
<tr>
<td>Hospice care</td>
<td>Covered Services include:</td>
<td>$5 per visit</td>
</tr>
<tr>
<td></td>
<td>- Reasonable and necessary services to manage terminal illness</td>
<td></td>
</tr>
<tr>
<td>Inpatient mental health and substance abuse services</td>
<td>Covered mental health services include:</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>- Care for psychological or psychiatric evaluation and treatment by a licensed mental health professional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance abuse services include:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Coverage for care for drug and alcohol abuse, including counseling and placement assistance</td>
<td></td>
</tr>
<tr>
<td>Inpatient services</td>
<td>Pre-authorization required</td>
<td>$0</td>
</tr>
<tr>
<td>Maternity services and newborn care</td>
<td>Covered Services include:</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>- Maternity care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Newborn care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Prenatal and postnatal care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Initial inpatient care of adolescent participants, including nursery charges and initial pediatric or neonatal examination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Infant is covered for up to three days following birth or until infant is transferred to another medical facility, whichever comes first.</td>
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</tr>
<tr>
<td>Nursing facility services</td>
<td>Coverage includes:</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>- Regular nursing services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Rehabilitation services</td>
<td></td>
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<tr>
<td></td>
<td>- Drugs and biologicals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Medical supplies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Use of appliances and equipment furnished by the facility</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Limited to no more than 100 days in a contract (October–October) year</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Pre-authorization required</td>
<td></td>
</tr>
<tr>
<td>Outpatient hospital services</td>
<td>Pre-authorization required</td>
<td>$0</td>
</tr>
<tr>
<td>Service</td>
<td>Important Notes</td>
<td>Co-Payment (due at time of service)</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------</td>
</tr>
</tbody>
</table>
| Outpatient mental and substance abuse services      | Covered mental health services include:  
- Care for psychological or psychiatric evaluation and treatment by a licensed mental health professional  
Substance abuse services include:  
- Coverage for care for drug and alcohol abuse, including counseling and placement assistance  
Outpatient services include evaluation and treatment by a licensed practitioner | $0                                  |
| Podiatry (foot) services                            | Covered Services include:  
- Diagnosis, medical, surgical, mechanical, manipulative and electrical treatment services limited to ailments of the human foot or leg  
- Limited to one visit a day, totaling two visits a month | $5 per visit                        |
| Physical, occupational and speech therapies (done in an office or a hospital) | Covered Services include:  
- Physical, occupational, respiratory and speech therapies for short-term rehabilitation where significant improvement in the member’s condition will result  
- Limited to up to 24 treatment sessions within a 60-day period per episode or injury, with the 60-day period beginning with the first treatment  
- Pre-authorization required | $5 per visit                        |
| Prescriptions                                       | Generic prescriptions (31-day supply)  
Brand-name prescriptions (available only if no generic is available or if the brand-name prescription is considered medically necessary) | $5 per prescription                 |
| Primary Care Provider (PCP) services                 | Covered Services include:  
- Office visits  
- Medical and surgical care and consultation  
- Diagnosis  
- Treatment | $5 per prescription                  |
| Prosthetic and orthotic devices                     | Includes, but not limited to, items such as:  
- Leg, arm and neck braces  
- Diabetic and custom-molded shoes  
- Artificial limbs  
- Breast prostheses  
- Prosthetic eyes | $0                                  |
<table>
<thead>
<tr>
<th>Service</th>
<th>Important Notes</th>
<th>Co-Payment (due at time of service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist services</td>
<td>Covered Services include:</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>• Office visits</td>
<td></td>
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<tr>
<td></td>
<td>• Medical and surgical care and consultation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Diagnosis</td>
<td></td>
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<tr>
<td></td>
<td>• Treatment</td>
<td></td>
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<tr>
<td></td>
<td>• PCP must refer</td>
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<tr>
<td>Sterilization</td>
<td>Not covered:</td>
<td>$5 per visit</td>
</tr>
<tr>
<td></td>
<td>• Tubal ligation</td>
<td></td>
</tr>
<tr>
<td>Transplant services</td>
<td>Organ transplantation services include:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pre-transplant, transplant and post discharge services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Treatment of complications after transplant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Coverage is available for transplants and medically related services if deemed</td>
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</tr>
<tr>
<td></td>
<td>necessary and appropriate within the guidelines set by the Organ Transplant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Advisory Council or the Bone Marrow Transplant Advisory Council.</td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>Emergency ambulance transportation:</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>• Emergency transportation as determined to be medically necessary in response to</td>
<td></td>
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<tr>
<td></td>
<td>an emergency situation</td>
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<tr>
<td></td>
<td>• Emergency air ambulance transportation</td>
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<tr>
<td></td>
<td>• Services are covered when the transport is a critical emergency situation in</td>
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<td></td>
<td>which loss of life or limb or essential body or organ function is jeopardized,</td>
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<tr>
<td></td>
<td>and time constraints make the use of land ambulance impractical.</td>
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<tr>
<td></td>
<td>Not covered:</td>
<td></td>
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<tr>
<td></td>
<td>• Nonemergency transportation</td>
<td></td>
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<tr>
<td>Vision services</td>
<td>Child must have failed a vision screening by his or her PCP.</td>
<td>$10 per service</td>
</tr>
<tr>
<td></td>
<td>Limited to:</td>
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<td></td>
<td>• One pair of glasses (Medicaid frames with plastic or SYL nontinted lenses)</td>
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<tr>
<td></td>
<td>every two years unless head size or prescription changes</td>
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</tbody>
</table>

For the most up-to-date information on Covered Services, refer to the Florida Health Kids Corporation website at [https://www.healthykids.org/](https://www.healthykids.org/).
Extra Benefits for HealthEase Kids and Staywell Kids Members
In addition to the Covered Services itemized above, eligible HealthEase Kids and Staywell Kids members have access to the following benefits:

- No co-payment for primary care physician visits
- No co-payment for urgent care visits
- Members ages 6–18 can receive an annual membership to a Boys & Girls Club at no cost (where clubs are available and only during the school year).
- Qualified members can receive up to $100 in hypoallergenic bedding to avoid asthma triggers (for more information, see Section 4: Utilization Management, Case Management and Disease Management).
- Members can receive an allowance of $15 for over-the-counter (OTC) drugs per household per month.

HealthEase Kids and Staywell Kids Immunizations Bonus Program
This program is designed to ensure that members receive necessary vaccinations in a timely fashion. Under this program, qualifying providers will receive a $10 increase in reimbursement for the administration costs of a vaccine. To receive the reimbursement, HealthEase Kids and Staywell Kids providers should bill WellCare.

Special Provisions for HealthEase Kids and Staywell Kids Primary Care Providers
Primary care providers who have recently completed a National Board for Certification of Training Administrators of Graduate Medical Education Programs-approved residency program in pediatrics or family practice and are eligible for board certification but have not yet achieved board certification may participate as providers in the HealthEase Kids and Staywell Kids program. If the non-board-certified primary care provider does not achieve board certification within the first three years of initial credentialing, the provider will be removed from the HealthEase Kids and Staywell Kids panel and members will be reassigned.

Additionally, all primary care physicians must provide all covered immunizations to members and be enrolled with the Florida State Health Online Tracking System (SHOTS), Florida’s statewide online immunization registry.

Provider Services
Providers may contact the appropriate departments at WellCare by referring to the Quick Reference Guide which may be found on WellCare’s website at https://florida.wellcare.com/provider/resources. Provider Relations representatives are available to assist in many requests for participating WellCare providers.

Website Resources
WellCare’s website, https://florida.wellcare.com, offers a variety of tools to assist providers and their staff.

Available resources include:
- Provider Manual
- Quick Reference Guide
- Clinical Practice Guidelines
- Clinical Coverage Guidelines
- Forms and documents
- Pharmacy and provider look-up (directories);
- Authorization look-up tool
- Training materials and guides
Secure Provider Portal – Benefits of Registering
Our secure online Provider Portal offers immediate access to an assortment of useful tools. Providers can create unlimited individual sub-accounts for staff members, allowing for separate billing and medical accounts.

All providers who create a user name and password using your WellCare Provider Identification (Provider ID) number have access to the following features:

- **Claims submission status and inquiry:** Submit a new claim, check the status of an existing claim, and customize and download reports.
- **Member eligibility and co-payment information:** Verify member eligibility and obtain specific co-payment information.
- **Authorization requests:** Submit authorization requests, attach clinical documentation and check authorization status. You can also print and/or save authorization forms.
- **Pharmacy services and utilization:** View and download a copy of WellCare’s Preferred Drug List (PDL), see drug recalls, access pharmacy utilization reports and obtain information about WellCare pharmacy services.
- **Training:** Take required training courses and complete attestations online.
- **Reports:** Access reports such as active members, authorization status, claims status, eligibility status, pharmacy utilization and more.
- **Provider news:** View the latest important announcements and updates.
- **Personal inbox:** Receive notices and key reports regarding your claims, eligibility inquiries and authorization requests.

How to Register

After registering on WellCare's website, providers should retain and password information for future reference.

For more information about WellCare’s Web capabilities, please contact Provider Services or your Provider Relations representative.

Additional Resources
The WellCare Provider Resource Guide contains information about our secure online Provider Portal, member eligibility, authorizations, filing paper and electronic claims, appeals and more. It can be found on our website at
Another valuable resource is the *Quick Reference Guide*, which contains important addresses, phone/fax numbers and authorization requirements. You can find the *Quick Reference Guide* at [https://florida.wellcare.com/provider/resources](https://florida.wellcare.com/provider/resources).
Section 2: Provider and Member Administrative Guidelines

Provider Administrative Overview
This section is an overview of guidelines for which all participating WellCare Medicaid and Healthy Kids Managed Care providers are accountable. Please refer to the Provider Participation Agreement (the Agreement) or contact your 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 with its Medicaid and Healthy Kids contract(s) approved AHCA and Florida Healthy Kids Corporation (FHKC) rules and regulations, and assist us in complying with corrective action plans necessary for us to comply with such rules and regulations;
- Retain all agreements, books, documents, papers and medical records related to the provision of services to WellCare members as required by state and federal laws;
- Provide Covered Services in a manner consistent with professionally recognized standards of health care [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 the approved AHCA, FHKC 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 title (examples: MD, DO, ARNP, PA) to members and to other health care professionals;
- Honor at all times any member request to be seen by a physician rather than a physician extender;
- Administer, within the scope of practice, treatment for any member in need of health care services;
- Maintain the confidentiality of member information and records;
- Allow WellCare to use provider performance data;
- Respond promptly to WellCare’s request(s) for medical records in order to comply with regulatory requirements;
- Maintain accurate medical records and adhere to all WellCare’s policies governing content and confidentiality of medical records as outlined in Section 3: Quality Improvement and Section 8: Compliance;
- Ensure that:
  - All employed physicians and other health care practitioners and providers comply with the terms and conditions of the Agreement between provider and WellCare;
To the extent physician maintains written agreements with employed physicians and other health care practitioners and providers, such agreements contain similar provisions to the Agreement; and

- Physician maintains written agreements with all contracted physicians or other health care practitioners and providers, which agreements contain similar provisions to the Agreement;

- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene;

- Communicate timely clinical information between providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to WellCare, the member or the requesting party at no charge, unless otherwise agreed;

- 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;

- Ensure that the hours of operation offered to WellCare members is no less than those offered to commercial members or comparable Medicaid fee-for-service recipients if provider serves only Medicaid recipients;

- Not deny, limit or condition the furnishing of treatment to any WellCare member on the basis of any factor that is related to health status, including, but not limited to, the following:
  - Medical condition, including mental as well as physical illness;
  - Claims experience;
  - Receipt of health care;
  - 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 that are in need of services related to children’s health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation, substance abuse or other behavioral health issues. If indicated, providers must refer members to WellCare-sponsored or community-based programs;

- Must document the referral to WellCare-sponsored or community-based programs in the member’s medical record and provide the appropriate follow-up to ensure the member accessed the services.
**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 Medicaid fee-for-service system, and for which WellCare is not financially responsible. These services may be paid for by the Agency 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(s) is (are) excluded, you must submit reimbursement for services directly to the Agency. In the event the service(s) is(are) prohibited, neither WellCare nor the Agency is financially responsible. For more information on prohibited services, refer to the Agency’s website at [http://ahca.myflorida.com/](http://ahca.myflorida.com/).

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

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

Suspected cases of abuse, neglect and/or exploitation must be reported to the state’s Adult Protective Services Unit. Adult Protective Services (APS) are services designed to protect elders and vulnerable adults from abuse, neglect or exploitation. The Department of Elder Affairs (DOEA) and the Florida Department of Children and Families (DCF) have defined processes for ensuring elderly victims of abuse, neglect or exploitation in need of home and community-based services are referred to the aging network, tracked and served in a timely manner. Requirements for serving elderly victims of abuse, neglect and exploitation can be found in s. 430.205 (5)(a), F.S.

Providers may be asked to cooperate with WellCare to provide services or arrange for the member to change locations. Training regarding abuse, neglect and exploitation is on our website at [https://florida.wellcare.com/provider/Provider_Training_and_Education](https://florida.wellcare.com/provider/Provider_Training_and_Education).

To report suspected abuse, neglect or exploitation of children or vulnerable adults, providers should call the Florida Abuse Hotline at **1-800-96-ABUSE (1-800-962-2873)** (TDD **1-800-453-5145**). The toll-free number is available 24 hours a day. If you see a child or vulnerable adult in immediate danger, call **911**.

**Access Standards**

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

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

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent</td>
<td>Within one (1) day of the request</td>
</tr>
<tr>
<td>Sick</td>
<td>Within one (1) week of the request</td>
</tr>
<tr>
<td>WellCare Visit</td>
<td>Within one (1) month of the request</td>
</tr>
</tbody>
</table>

In-office waiting times for primary care visits, specialty and urgent care, optometry services, and lab and X-ray services shall not exceed 30 minutes.

PCPs must provide or arrange for coverage of services, consultation or approval for referrals 24 hours a day, seven days a week. To ensure accessibility and availability, PCPs must provide one of the following:
- A 24-hour answering service that connects the member to someone who can render a clinical decision or reach the PCP;
- An answering system with the option to page the physician for a return call within a maximum of 30 minutes; or
- An advice nurse with access to the PCP or on-call physician within a maximum of 30 minutes.

See Section 10: Behavioral Health for mental health and substance use 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 Agreement, not replace them. In the event of a conflict between this Provider Manual and the Agreement, the Agreement shall govern.

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

Providers who are not already enrolled with the Florida Medicaid program, and who perform services for WellCare’s Medicaid members, must also obtain a Florida Medicaid provider ID. WellCare will register its providers with the Florida Medicaid program to ensure each provider obtains a provider ID. The provider ID is used to submit encounter data for the services rendered under the health plan.

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

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

Information regarding living will and advance directives should be made available in
provider offices and discussed with the members. Completed forms should be
documented and filed in members’ medical records.

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

**Provider Billing and Address Changes**
Prior notice to your 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 Agreement, you must
adhere to the following terms:
- Any contracted provider must give at least 90 days prior written notice to
WellCare before terminating your relationship with WellCare “without cause,”
unless otherwise agreed to in writing. This ensures that adequate notice may be
given to WellCare members regarding your participation status with WellCare.
Please refer to your Agreement for the details regarding the specific required
days for providing termination notice, as you may be required by contract to give
more notice than listed above;
- Unless otherwise provided in the termination notice, the effective date of a
termination will be on the last day of the month; and
- 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, not to exceed six months after the provider termination.
For pregnant members who have initiated a course of general care, regardless of
the trimester in which care was initiated, continuation shall be provided until the
completion of postpartum care.

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

Please note that WellCare will notify in writing all appropriate agencies and/or members
prior to the termination effective date of a participating primary care physician
(PCP), hospital, specialist or significant ancillary provider within the service area as
required by Florida Medicaid program requirements and/or regulations and statutes.

**Out-of-Area Member Transfers**
Providers should assist WellCare in arranging and accepting the transfer of members
receiving care out of the service area if the transfer is considered medically acceptable
by the WellCare provider and the out-of-network attending physician/provider.
Members with Special Health Care Needs
Members with special health care needs include members with the following conditions:

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

The following is a summary of responsibilities specific to providers who render services to WellCare members who have been identified with special health care needs:

- Assess members and develop plans of care for those members determined to need courses of treatment or regular care;
- Coordinate treatment plans with members, family and/or specialists caring for members;
- Plan of care should adhere to community standards and any applicable sponsoring government agency quality assurance and utilization review standards;
- Allow members needing courses of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as appropriate for the members’ conditions or needs;
- Coordinate with WellCare, if appropriate, to ensure that each member has an ongoing source of primary care appropriate to his or her needs, and a person or entity formally designated as primarily responsible for coordinating the health care 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; and
- Ensure the member’s privacy is protected as appropriate during the coordination process.

For more information on Utilization Management for members with special health care needs, refer to Section 4: Utilization Management, Case 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 Agreement, not replace them.

- Coordinate, monitor and supervise the delivery of primary care services to each member;
- See members for an initial office visit and assessment within the first ninety (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 under the age of 21;
• Maintain a ratio of members to full-time equivalent (FTE) physicians as follows:
  o One physician FTE per 1,500 Medicaid or Healthy Kids members;
  o One advanced registered nurse practitioner (ARNP) FTE for every 750 Medicaid or Healthy Kids members above 1,500; and
  o One physician assistant (PA) FTE for every 750 Medicaid or Healthy Kids members above 1,500.
• Provide appropriate referrals of potentially eligible women, infants and children to the Women, Infants, and Children (WIC) program for nutritional assistance;
• Assure 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;
• Ensure members utilize network providers. If unable to locate a participating WellCare Medicaid provider for services required, contact Health Services for assistance. Refer to the Quick Reference Guide on WellCare’s website at https://florida.wellcare.com/provider/resources; and
• Comply with and participate in corrective action and performance improvement plan(s).

**Vaccines for Children Program**
Providers must participate in the Vaccines for Children Program (VFC). The VFC is administered by the Department of Health, Bureau of Immunizations. The VFC provides vaccines at no charge to physicians and eliminates the need to refer children to county health departments (CHDs) for immunizations. Title XXI MediKids members do not qualify for the VFC program. Providers should bill Medicaid fee-for-service directly for immunizations provided to Title XXI MediKids participants. WellCare covers and reimburses participating providers for immunizations covered by Medicaid, but not provided through VFC. Providers who are directly enrolled in the VFC program must maintain adequate vaccine supplies.

Florida Healthy Kids members do not qualify for the VFC program. Providers should bill WellCare (Staywell/HealthEase) for the costs of immunizations provided to Florida Healthy Kids members.

**Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**
Any provider, including physicians, nurse practitioners, registered nurses, physician assistants and medical residents who provide Early and Periodic Screening, Diagnostic and Treatment (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 the Agency’s approved Medicaid administrative regulation Sect III C.9.b and the periodicity schedule provided by the American Academy of Pediatrics (AAP);
• Referring the member to an out-of-network provider for treatment if the service is not available within WellCare’s network;
• Providing vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines;
• Providing vaccinations in conjunction with EPSDT/Well-child visits. Providers are required to use vaccines available without charge under the Vaccines for Children (VFC) Program for Medicaid children 18-years-old and younger;
• Addressing unresolved problems, referrals and results from diagnostic tests including results from previous EPSDT visits;
• Requesting prior authorization for medically necessary EPSDT special services in the event other health care, diagnostic, preventive or rehabilitative services, treatment or other measures described in 42 U.S.C. 1396d(a) are not otherwise covered under the Florida Medicaid Program;
• Monitoring, tracking and following up with members:
  o Who have not had a health assessment screening; and
  o Who miss appointments to assist them in obtaining an appointment.
• 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; and
• Assisting members with transition to other appropriate care for children who age-out of EPSDT services.

Providers will be sent a monthly membership list which specifies the health assessment eligible children who have not had an encounter within 120 days of joining WellCare or are not in compliance with the EPSDT Program.

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

For more information on EPSDT Covered Services, refer to Section 1: Welcome to WellCare. For more information on the Florida Medicaid EPSDT periodicity schedule refer to the Agency’s website at http://ahca.myflorida.com. For more information on the periodicity schedule based on the American Academy of Pediatrics guidelines, refer to the AAP website at http://www2.aap.org/immunization/IZSchedule.html.

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, Health Services and Marketing and Sales departments, as well as the tools and resources available on WellCare’s website at https://florida.wellcare.com/provider; and
• Information on WellCare network providers for the purposes of referral management and discharge planning.

Closing of Physician Panel
When requesting closure of your panel to new and/or transferring WellCare members, PCPs must:
• Submit the request in writing at least 60 days (or such other period of time provided in the Agreement) prior to the effective date of closing the panel;
- Maintain the panel to all WellCare members who were provided services before the closing of the panel; and
- Submit written notice of the reopening of the panel, including a specific effective date.

**Covering Physicians/Providers**

In the event that 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, unless there is an emergency.

Covering physicians should be credentialed by WellCare, and are required to sign an agreement accepting the negotiated rate and agreeing to not balance bill WellCare members. For additional information, please refer to Section 6: Credentialing.

In nonemergency cases, should you have a covering physician/provider who is not contracted and credentialed with WellCare, contact WellCare for approval. For more information, refer to the *Quick Reference Guide* on WellCare’s website at https://florida.wellcare.com/provider/resources.

**Termination of a Member**

A WellCare provider may not seek or request to terminate his/her relationship with a member, or transfer a member to another provider of care, based 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 his/her efforts to develop and maintain a satisfactory provider and member relationship. If a satisfactory relationship cannot be established or maintained, the provider shall continue to provide medical care for the WellCare member until such time that written notification is received from WellCare stating that the member has been transferred from the provider’s practice, and such transfer has occurred.

In the event that a participating provider desires to terminate his/her relationship with a WellCare member, the provider should submit adequate documentation to support that although they have attempted to maintain a satisfactory provider and member relationship, the member’s noncompliance with treatment or uncooperative behavior is impairing the ability to care for and treat the member effectively.

The provider should complete a “PCP Request for Transfer of Member Form”, attach supporting documentation and fax the form to WellCare’s Customer Service Department. A copy of the form is available on WellCare’s website at https://florida.wellcare.com/provider/forms_and_documents.

**Health Information Exchange**

WellCare is dedicated to improving the health and quality of life of our members and actively supports the statewide implementation of the Florida Health Information Exchange (HIE). The HIE means the secure electronic information infrastructure created by the state of Florida for sharing health information among health care organizations and offering health care providers the functionality to support meaningful use and a high level of patient-centered care. WellCare’s goal is to support providers in connecting with
the Florida HIE. The HIE is a secure, interoperable network in which participating providers with certified electronic health record (EHR) technology can use to locate and share needed patient information and send Direct Secure Messages (DSMs) between each other which results in improved coordination of care among physician practices, hospitals and labs, and across the various health systems.

Please visit https://www.florida-hie.net to obtain more information on this program and guidance on how you can make the HIE connection.

**Domestic Violence and Substance Abuse Screening**
PCPs should identify indicators of substance abuse or domestic violence and offer referral services to applicable community agencies. Sample screening tools for domestic violence and substance abuse are located on WellCare’s website at https://www.wellcare.com/provider/CCGs.

**Healthy Rewards Program**
Staywell believes that healthy behaviors lead to effective medical care for enrollees of all eligibility types. We encourage our enrollees to make healthy choices by rewarding their efforts to manage health needs, improve habits that impact their health status, and take advantage of preventive screenings. In support of these goals, Staywell will offer programs to members who want to stop smoking, lose weight or address drug abuse problems. Staywell will reward members who join these programs and meet certain goals. These programs will start on Oct. 1, 2014. Program details are forthcoming.

**Smoking Cessation**
PCPs should direct members who smoke and wish to quit smoking to call WellCare’s Customer Service Department and ask to be directed to the Smoking Cessation Program. A health coach will work with members through tailored interactions based on their individual needs and health objectives associated with smoking cessation.

PCPs can also reference the Agency for Health Care and Research & Quality’s Smoking Cessation Quick Reference Guide, which is available on WellCare’s website at https://florida.wellcare.com/provider/job_aids_and_resource_guides or by contacting your Provider Relations representative.

**Weight Loss**
Providers should direct members with a high body mass index (BMI) and who wish to achieve a healthy weight to call WellCare’s Customer Service Department and ask to be directed to the Medically Directed Healthy Weight program. A health coach will work with members through tailored interactions based on their individual needs and health objectives associated with weight loss.

**Adult Health Screening**
An adult health screening should be performed by a physician to assess the health status of all WellCare adult members. The adult member should receive an appropriate assessment and intervention as indicated or upon request.

**Cultural Competency Program and Plan**

**Overview**
The purpose of the Cultural Competency Program is to ensure that WellCare meets the unique, diverse needs of all members, to provide that the associates of WellCare value
diversity within the organization, and to see that members in need of linguistic services have adequate communication support. In addition, WellCare is committed to having our 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 that have potential cultural or linguistic barriers for which alternative communication methods are needed;
- Utilize culturally sensitive and appropriate educational materials based on the member's race, ethnicity and primary language spoken;
- Make resources available to meet 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; and
- Decrease health care disparities in the minority populations we serve.

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

The components of WellCare’s Cultural Competency Program include:
- **Data Analysis**
  - Analysis of claims and encounter data to identify the health care needs of the population; and
  - Collection of member data on race, ethnicity and language spoken.
- **Community-Based Support**
  - Outreach to community-based organizations which support minorities and the disabled in ensuring that the existing resources for members are being utilized to their full potential.
- **Diversity and Language Abilities of Health Plan Staff**
  - Nondiscrimination – WellCare may not discriminate with regard to race, religion or ethnic background when hiring associates;
  - Recruiting – WellCare recruits diverse talented associates in all levels of management; and
  - Multilingual – WellCare recruits bilingual associates for areas that have direct contact with members to meet the needs identified, and encourages providers to do the same.
- **Diversity of Provider Network**
  - Providers are inventoried for their language abilities, and this information is made available in the Provider Directory so that members can choose a provider that speaks their primary language; and
  - Providers are recruited to ensure a diverse selection of providers to care for the population served.
- **Linguistic Services**
  - Providers will identify members that 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 Customer Service Department; Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency, and sign language for the hearing impaired. These services will be provided by vendors with such expertise and are coordinated by WellCare’s Customer Service Department; and 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/TDD line for hearing impaired services. WellCare’s Customer Service Department is responsible for any necessary follow-up calls to the member. The toll-free TTY/TDD number can be found on the member identification card.

**Provider Education**
- WellCare’s Cultural Competency Program provides a Cultural Competency Checklist to assess the provider office’s cultural competency;
- For more information on the Cultural Competency Program, registered Provider Portal users may access the Cultural Competency Training on WellCare’s website at [https://florida.wellcare.com/provider/Provider_Training_and_Education](https://florida.wellcare.com/provider/Provider_Training_and_Education). A paper copy, at no charge, may be obtained upon request by contacting Provider Services or your Provider Relations representative; and
- Providers must adhere to the Cultural Competency Program as set forth above.

**Cultural Competency Survey**
You may access the Cultural Competency Survey on WellCare’s website at [https://florida.wellcare.com/provider/Provider_Training_and_Education](https://florida.wellcare.com/provider/Provider_Training_and_Education) under the Provider Training and Education link.

**Member Administrative Guidelines**

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

**Member Handbook**
All newly enrolled members will receive a Member Handbook within five calendar days of receiving the notice of enrollment from WellCare. WellCare will mail all enrolled members a Member Handbook.

**Enrollment**
WellCare must obey laws that protect from discrimination or unfair treatment. WellCare does not discriminate based on a person’s race, disability, religion, sex, health, ethnicity, creed, age or national origin.
Upon enrollment in WellCare, members are provided with the following:

- Terms and conditions of enrollment;
- Description of covered services in network and out of network (if applicable);
- Information about PCPs, such as location, telephone number and office hours;
- Information regarding out-of-network emergency services;
- Grievance and disenrollment procedures; and
- Brochures describing certain benefits not traditionally covered by Medicaid or Healthy Kids 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 health care 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, health plan contact information and claims filing address. Possession of the member identification card does not guarantee eligibility or coverage. Providers are responsible for ascertaining the current eligibility of the card holder.

**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 [https://florida.wellcare.com](https://florida.wellcare.com);
- Access WellCare’s interactive voice response (IVR) system; and/or
- Contact Provider Services.

You will need your 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 your Agreement for additional details.

**Member Engagement**

WellCare utilizes a number of engagement strategies to establish a relationship with our members. Engagement begins with notification of member enrollment. Notice of enrollment triggers an attempt to reach the member by phone to complete the Health Risk Assessment (HRA) and to familiarize the member with his or her plan benefits. A total of 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. Our telephonic team and CHWs are trained in behavioral interviewing techniques which promote maximum engagement of the member.

**Assessments for Members**
A Health Risk Assessment is completed with the member within the first 90 days of enrollment. Members have several options for completing the HRA. A paper version is mailed to the member with his or her enrollment materials. The member can alternatively choose to take the HRA online via the member portal. In addition, WellCare makes eight attempts to contact the member telephonically to complete an HRA. If the telephonic attempts are not successful, members are referred to our community health workers, who are assigned by ZIP Code, for completion of the HRA. Community health workers utilize every method at their disposal to make contact with a member and to conduct a face-to-face interview to complete the HRA.

In the event that the HRA identifies a member who requires a more comprehensive assessment, the member is electronically referred to our Case Management Program for completion of a more comprehensive assessment. Case managers are either licensed registered nurses or social workers. Upon completion of the more comprehensive assessment, a care plan is developed with input from the member, the provider and the case manager. The care plan is available for providers to view via the provider portal. Case managers collaborate with the provider to ensure the most successful care plan is developed and implemented to effect positive outcomes for the member.

**Staywell (Medicaid) Member Rights and Responsibilities**

Staywell (Medicaid) members have the right:

- To get details about what the plan covers and how to use its services and plan providers;
- To have their privacy protected;
- To know the names and titles of doctors and others who treat them;
- To talk openly about care needed for their health, no matter the cost or benefit coverage;
- To freely talk about care options and risks involved;
- To have this information shared in a way they understand;
- To know what to do for their health after they leave the hospital or provider office;
- To refuse to take part in research;
- To create an advance directive;
- To suggest ways the plan can improve;
- To file complaints or appeals about the plan or the care it provides;
- To have a say in the plan’s member rights;
- To have all these rights apply to the person who can legally make health care decisions for them;
- To have all health plan staff members observe their rights;
- To use these rights no matter what their sex, age, race, ethnic, economic, educational or religious background;
- To receive information about Staywell, its services, its practitioners and providers, and members rights and responsibilities;
- To participate with practitioners in making decisions about their health care;
- To a candid discussion of appropriate or medical necessary treatment options for their conditions, regardless of cost or benefit coverage;
- To make recommendations regarding member rights and responsibilities;
• To be treated with respect and with due consideration for dignity and privacy;
• To receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand;
• To participate in decisions regarding health care, including the right to refuse treatment;
• To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation; and
• To ask for and receive a copy of medical records, and ask that they be amended or corrected:
  o Requests must be received in writing from the member or the person chosen to represent him or her;
  o The records will be provided at no cost; and
  o The records will be sent within 14 days of receipt of the request

To be furnished health care services in accordance with federal and state regulations the state must make sure a member is:
• Free to exercise their rights, and
• The exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat the member.

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

HealthEase Kids and Staywell Kids Member Rights and Responsibilities
HealthEase Kids and Staywell Kids members have the right to:
• Timely and appropriate care;
• Receive information about the organization, its services, its practitioners and providers, and member rights and responsibilities;
• Participate with practitioners in making decisions about their health care;
• A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage;
• Make recommendations regarding the organization’s’ member rights and responsibilities;
• Be treated with courtesy and respect, with appreciation of individual dignity, and protection of privacy;
• A prompt and reasonable response to questions and requests;
• Know who is providing medical services and who is responsible for their care;
• Know what patient support services are available, including whether an interpreter is available if the member does not speak English;
• Know what rules and regulations apply to their conduct;
• Get information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis; and the plan cannot keep the health care provider from giving the information to the member;
• Refuse any treatment; except as otherwise provided by law;
• Not be responsible for the plan’s debts in the event of bankruptcy;
• Not be held liable for covered services for which the plan does not pay the provider, and the provider cannot hold the member responsible for any unpaid amounts due to the provider other than a co-payment;
• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
• Timely problem resolution;
• Make complaints and appeals without discrimination and expect problems to be fairly examined and appropriately addressed;
• Responsiveness to reasonable requests made for services;
• Confidentiality;
• Review and comment about their personal health information and review medical records and/or changes to personally identifiable health information;
• Protection against unauthorized disclosure of their personal health information;
• Approve the release of any information beyond Staywell Kids or HealthEase Kids;
• Have information used for research or performance measurement limited in that all data will be combined; and
• Authorize the use of their individually identifiable health information for any purpose including:
  o The collection, use and sharing of data, unless the release of the information is required by law;
  o General consent is given when the enrollment application is submitted:
    ▪ This authorizes the use of identifiable information that is needed for treatment, coordination of care, conducting quality assessment, utilization review, fraud detection and specific and known oversight reviews (such as state or accreditation organizations);
- This consent covers future, known or routine needs for the use of the member’s health information;
  - Other consents, or special consents, will be obtained if specific member-identifiable information is requested and is to be shared with another organization or agency.
- To be furnished health care services in accordance with federal and state regulations, the state must make sure a member is:
- Free to exercise their rights, and
- The exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat the member.

HealthEase Kids and Staywell Kids members have the responsibility to:
- Follow plans and instructions for care that they have agreed to with their practitioners;
- Understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible;
- Keep appointments and, when unable to do so, to notify their health care provider or the health care facility;
- Provide to the health care provider accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to health to the best of their knowledge;
- Report unexpected changes in their condition to the health care provider;
- Follow the treatment plan recommended by the health care provider;
- Report to the health provider whether they understand a course of treatment and what is expected of them;
- Be responsible for their actions if they refuse treatment or do not follow the health care provider’s instructions;
- Ensure that co-pays are paid as promptly as possible; and
- Follow health care facility rules and regulations affecting patient care and conduct.

**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 health care needs from providing primary care services to coordinating referrals to specialists and providers of ancillary or hospital services.

**Changing Primary Care Providers**
Members may change their PCP selection at any time by calling Customer Service. The requested change will be effective the first day of the following month of the request if the request is received after the tenth day of the current month.

**Women’s Health Specialists**
PCPs may also provide routine and preventive health care services that are specific to female members. If a female member selects a PCP who does not provide these services, she has the right to direct in-network access to a women’s health specialist for covered services related to this type of routine and preventive care.

**Hearing-Impaired, Interpreter and Sign Language Services**
Hearing-impaired, interpreter and sign language services are available to WellCare members through WellCare’s Customer Service Department. PCPs should coordinate these services for WellCare members and contact Customer Service if assistance is needed. For Provider Services telephone numbers, please refer to the Quick Reference Guide WellCare’s website at https://florida.wellcare.com/provider/resources.
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 health care 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 health care settings/services;
- Cultural competency;
- Quality of care/service;
- Preventive health;
- Service utilization;
- Complaints/grievances;
- Network adequacy;
- Appropriate service utilization;
- Disease and Case Management;
- Member and provider satisfaction;
- Components of operational service; and
- Regulatory/federal/state/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, and/or medical record audits. The organization’s Board of Directors has delegated authority to the Quality Improvement Committee to approve 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 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, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals’ findings, appointment records, 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 service(s).

Confidentiality of member information must be maintained at all times. Records are to be stored securely with access granted to authorized personnel only. Access to records should be granted to WellCare or its representatives without a fee to the extent permitted by state and federal law. Providers should have procedures in place to permit the timely access and submission of medical records to WellCare upon request. WellCare follows state and federal law regarding the retention of records remaining under the care, custody and control of the physician or health care provider. Information from the medical records review may be used in the re-credentialing process as well as quality activities.
For more information regarding confidentiality of member information and release of records, refer to Section 8: Compliance.

The member’s medical record is the property of the provider who generates the record. However, each member or his or her representative is entitled to one free copy of his or her 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 which contains sufficient medical information from all providers involved in the member’s care to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:

- Member/patient identification information on each page;
- Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers of emergency contacts (if no phone, contact name), consent forms, identify language spoken, and guardianship information;
- Date of data entry and date of encounter;
- Late entries should include date and time of occurrence and date and time of documentation;
- Provider identification by name and profession of the rendering provider (e.g., M.D., D.O., O.D.);
- Allergies and/or adverse reactions to drugs shall be noted in a prominent location;
- Past medical history, including serious accidents, operations and illnesses. For children, past medical history includes prenatal care and birth information, operations and childhood illnesses (i.e., documentation of chicken pox);
- Identification of current problems;
- The consultation, laboratory and radiology reports filed in the medical record shall contain the ordering provider’s initials or other documentation indicating review;
- A current list of immunizations pursuant to 42 CFR 456;
- Identification and history of nicotine, alcohol use or substance abuse;
- Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department of Public Health pursuant to 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 under the age of 13;
- 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 their 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; and
A review of telemedicine should be included in the plan’s fraud and abuse detection activities; and

- Record is legible to at least a peer of the writer and written in standard English. Any record judged illegible by one reviewer shall be evaluated by another reviewer.

A member’s medical record shall include the following minimal detail for individual clinical encounters:

- History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient’s medical/behavioral health, including mental health and substance abuse status;
- Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening (EPSDT) services are addressed from previous visits; and
- Plan of treatment including:
  - Medication history, current medications prescribed, including the strength, amount and directions for use and refills;
  - Therapies and other prescribed regimen; and
- Follow-up plans including consultation and referrals and directions, including time to return; and
- Education and instructions whether verbal, written or via telephone.

**OB/GYN Medical Records**

Medical records requirements and guidelines:

- Pre-term delivery risk assessment is rendered by the twenty-eighth week;
- The member will be seen by an obstetrician **within the first trimester** of the pregnancy with the following assessments performed and documented:
  - Weight;
  - Blood pressure;
  - Fetal heart tones;
  - Hemoglobin and hematocrit (H&H);
  - Urinalysis;
  - Blood typing and anti-body screening;
  - Rubella antibody titer;
  - Syphilis screening;
  - HBsAg screening;
  - Pap smear; and
  - Nutrition assessment.
- The member will be seen **once every month in the second trimester** of pregnancy with the following assessments performed and documented:
  - Weight;
  - Blood pressure;
  - Fetal heart tones;
  - Hemoglobin and hematocrit (H&H);
  - Urinalysis;
  - Alpha-fetoprotein (between 15 and 20 weeks);
  - Diabetes screening/GTT (between 24 and 28 weeks);
  - Repeat antibody test for unsensitized RH negative patients (28 weeks); and
  - Prophylactic administration of Rho(D) immune globulin (28 weeks), if indicated.
- The member will be seen **twice every month in the third trimester** of pregnancy and **one visit per week in the ninth month** with the following assessments performed and documented:
- Weight;
- Blood pressure;
- Fetal heart tones;
- Hemoglobin and hematocrit (H&H);
- Urinalysis;
- Testing for sexually transmitted diseases (STDs) /sexually transmitted infections (STIs) and HBsAg for high-risk members; and
- Group B strep screening for high-risk members (between 35 and 37 weeks).

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;
- 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;
  - Providing individual diet counseling and a nutrition care plan by a public health nutritionist;
  - A nurse or physician following the nutrition assessment; and
  - Ensuring documentation of the nutrition care plan in the medical record by the person providing counseling.
- Member education (childbirth/maternal care);
- Postpartum care – at least one complication-free visit, or appropriate follow-up if complications exist;
- Family planning counseling and services for all pregnant women and mothers;
- HIV testing/counseling is offered at the initial prenatal care visit and again at 28 weeks and 32 weeks:
  - The provider will attempt to obtain a signed objection if a pregnant woman declines an HIV test and keeps this signed objection in the medical record; and
  - All HIV infected women are counseled about and offered the latest antiretroviral regimen recommended by the U.S. Department of Health & Human Services (Public Health Service Task Force Report entitled, Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States).
- Screening for Hepatitis B:
  - Providers must screen all pregnant members during their first prenatal visit for Hepatitis B and again between 28 and 32 weeks for members who test negative and are considered high-risk for Hepatitis B;
  - All HBsAg-positive women shall be reported to WellCare, the local county health department and to Healthy Start, regardless of their Healthy Start screening score.
    - The report should be made on the Department of Health Practitioner Disease Report Form (DH 2136). This form is available on WellCare’s website at [https://florida.wellcare.com/provider/forms_and_documents](https://florida.wellcare.com/provider/forms_and_documents).
    - For more information, refer to the Required Screenings and Assessments for Pregnant Members job aid on WellCare’s website at [https://florida.wellcare.com/provider/job_aids_and_resource_guides](https://florida.wellcare.com/provider/job_aids_and_resource_guides).

- Healthy Start – Pregnant women will receive a prenatal risk screening as part of their first prenatal visit. Provider will complete the Department of Health (DOH) Prenatal Risk Form (DH 3134), retain a copy in the member's medical record, forward a copy within 10
business days to the county health department where the screening was performed, and provide a copy to the member. Providers will maintain documentation of Healthy Start screenings, assessments, findings and referrals in the member’s medical record;

- Florida hospitals contracting with WellCare must electronically file the Florida Healthy Start Infant (Postnatal) Risk Screening Instrument (DH Form 3135) and the Certificate of Live Birth with the CHD in the county where the infant was born within five business days of the birth. Birthing facilities not participating in the Department of Health electronic birth registration system must file the required birth information with the CHD within five business days of the birth, keep a copy of the completed DH Form 3135 in the member’s medical record, and mail a copy to the member;

- Pregnant members or infants who do not score high enough to be eligible for Healthy Start care coordination may be referred for services, regardless of their score on the Healthy Start screen, in the following ways:
  o If the referral is to be made at the same time the Healthy Start risk screen is administered, the provider may indicate on the risk screening form that the member or infant is invited to participate based on factors other than score; or
  o If the determination is made subsequent to risk screening, the provider may refer the member or infant directly to the Healthy Start care coordinator based on the assessment of actual or potential factors associated with high risk, such as HIV, Hepatitis B, substance abuse or domestic violence.

- Providers refer all pregnant, breastfeeding and postpartum women to the local Women, Infants, and Children (WIC) office:
  o Providers provide a completed Florida WIC program medical referral form with the current height or length and weight (taken within 60 calendar days of the WIC appointment);
  o Hemoglobin or hematocrit (H&H);
  o Any identified medical/nutritional problems;
  o Give a copy of the completed form to the member; and
  o Retain a copy of the completed form in the member’s medical record.

**Provider Participation in the Quality Improvement Program**

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

Information regarding the QI Program, available upon request, includes a description of the QI Program and a report assessing the progress in meeting goals. WellCare evaluates the effectiveness of the QI Program on an annual basis. An annual report is summarized detailing 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 which are recommended or in progress, and any modifications to the program. This report is available as a written document.

**Member Satisfaction**

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

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

Programs promoting patient safety are a public expectation, a legal and professional standard and an effective risk-management tool. As an integral component of health care 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 health care 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.

**Risk Management/Patient Safety**

The program includes, at a minimum, patient safety and risk mitigation practices and is designed to identify, investigate, analyze, evaluate and prevent incidents that pose health and safety risk in accordance with Section 641.55, Chapter 59A-12 of F.A.C. (Florida Administrative Code). The program relies on an incident reporting system to identify potential and/or actual quality of care events, adverse events and/or critical incidents that occur throughout the Plan’s health care delivery system 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 the Plan to report injuries and adverse events.

All potential quality of care events, adverse incidents and critical incidents shall be reported by the provider and/or provider staff, at the first awareness, to the licensed health care risk manager (LHRM) within the Quality Improvement (QI) Department on the *Incident Report Form* located on WellCare’s website at [https://florida.wellcare.com/Provider/Forms_and_Documents](https://florida.wellcare.com/Provider/Forms_and_Documents).

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:

- Death or serious disability;
- Delay or omission of care;
- Medication issue;
- Patient safety;
- Post-op complications; or
- Procedural issue.
Adverse incidents are events involving situations where health care personnel could have exercised control and there is an association, in whole or in part, with a medical intervention, rather than the condition for which such intervention occurred and results in one of the following injuries:

- Death;
- Brain or spinal damage;
- Performance of a surgical procedure on the wrong patient;
- Performance of a wrong surgical procedure;
- Performance of a wrong-site surgical procedure;
- Performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient’s diagnosis or medical condition;
- Surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk and disclosed to the patient;
- Performance of a procedure to remove unplanned foreign objects remaining from a surgical procedure;
- Permanent disfigurement;
- Fracture or dislocation of bones or joints;
- A resulting limitation of neurological, physical or sensory function which continues after discharge from the facility;
- Any condition that required specialized medical attention or surgical intervention resulting from nonemergency medical intervention, other than an emergency medical condition, to which the patient has not given his or her informed consent; and/or
- Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient’s condition prior the adverse incident.

Critical incidents are behavioral health events where there is:

- Death of a member while the member is in a facility operated or contracted by the health plan or in an acute care facility due to one of the following:
  1. Suicide;
  2. Homicide;
  3. Abuse;
  4. Neglect; or
  5. An accident or other incident that occurs while the member is in a facility operated or contracted by the health plan or in an acute care facility.

- Member injury or illness – A medical condition that requires medical treatment by a licensed health care 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 operated or contracted by the health plan or while the member is in an acute care facility.

- Sexual battery while the member is in a facility operated or contracted by the health plan or in an acute care facility; 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 the health plan, a provider or a subcontractor, a member; and/or
  3. A member on an employee of the health plan, a provider or a subcontractor.

- The health plan shall report if one or more of the following events occur:
  1. Medication errors in an acute care setting; and/or
  2. Medication errors involving children/adolescents in the care or custody of DCF.
• Member suicide attempt – An act which clearly reflects an attempt by a member to cause his or her own death while a member is in a facility operated or contracted by the health plan or while the member is in an acute care facility, which results in bodily injury requiring medical treatment by a licensed health care 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 operated or contracted by the health plan or while the member is in an acute care facility.
• Member escape – To leave a locked or secured facility operated or contracted by the health
• Member elopement – To leave a facility operated or contracted by the health plan, 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 women;
• Well-baby care;
• Immunizations for children, adolescents and adults; and
• Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, tests for sexually transmitted diseases, Pap smears and mammograms.

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

Clinical Practice Guidelines
WellCare adopts validated evidence-based Clinical Practice Guidelines and 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 and are relevant to the population served. Approval of the Clinical Practice Guidelines occurs through the Quality Improvement Committee. Clinical Practice Guidelines, to include preventive health guidelines, may be found on WellCare’s website at [http://www.wellcare.com/provider/CPGs](http://www.wellcare.com/provider/CPGs).
Staywell (Medicaid) Patient-Centered Medical Home and Incentives
Staywell supports the efforts of providers as they transition into patient-centered medical homes (PCMH). A determination is made as to the level of proficiency of the provider in the practice of patient-centered medical homes. Practices at all levels are supported by Staywell through a variety of tools dependent on the need of the practice. Those practices identified as proficient in the delivery of PCMH are rewarded based on a quality matrix. Those practices identified as “needs improvement” may be supported by Staywell with a focus on closing gaps of performance in the migration to a PCMH. Interventions may include IT support or embedded case management support depending upon the identified need. Incentives are provided to practices based on their levels of performance on the spectrum of proficiency from novice to advanced.

Quality Enhancements and Benefits
It is the policy of WellCare to promote positive health outcomes by offering quality and benefit enhancements/services. The following services are available to our members and may be accessed by providers:

1. **Children's Programs**: WellCare will provide regular general wellness programs targeted specifically toward members from birth to age 5, or WellCare will make a good faith effort to involve members in existing community children’s programs.
   a. Children’s programs will promote increased utilization of prevention and early intervention services for at-risk members with children/adolescents in the target population. WellCare will approve claims for services recommended by the Early Intervention Program when they are covered services and medically necessary.
   b. WellCare will offer annual training to providers that promote proper nutrition, breast-feeding, immunizations, Child Health Check-Ups Program (CHCUP), wellness, prevention and early intervention services.

2. **Domestic Violence**: WellCare will ensure that PCPs screen members for signs of domestic violence and will offer referral services to applicable domestic violence prevention community agencies.

3. **Pregnancy Prevention**: WellCare will conduct regularly scheduled pregnancy prevention programs, or will make a good faith effort to involve members in existing community pregnancy prevention programs, such as the Abstinence Education Program. The programs will be targeted towards teen members, but will be open to all members, regardless of age, gender, pregnancy status or parental consent.

4. **Prenatal/Postpartum Pregnancy Programs**: WellCare will provide regular home visits, conducted by a home health nurse or aide, and counseling and educational materials to pregnant members and postpartum members who are not in compliance with WellCare’s prenatal and postpartum programs. WellCare will coordinate its efforts with the Healthy Start care coordinator to prevent duplication of services.

5. **Behavioral Health Programs**: WellCare will provide outreach to homeless and other populations of members at risk of justice system involvement, as well as those members currently involved in this system, to assure that services are accessible and provided when necessary. This activity will be oriented toward preventive measures to assess behavioral health needs and provide services that can potentially prevent the need for future inpatient services or possible deeper involvement in the forensic or justice system.

6. **Other Programs and Services**: WellCare will actively collaborate with community agencies and organizations, including county health departments, local Early Intervention Programs and local school districts in offering these services.
**HEDIS®**
The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service. The tool comprises 75 measures across eight domains of care, including:

- Effectiveness of care;
- Access and availability of care;
- Satisfaction with the care experience;
- Use of services;
- Cost of care;
- Health plan descriptive information;
- Health plan stability; and
- Informal health care choices.

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

**Web Resources**
WellCare periodically updates clinical, coverage, and preventive guidelines as well as other resource documents posted on the WellCare website. Please check WellCare’s website frequently for the latest news and updated documents at https://florida.wellcare.com/provider.
Section 4: Utilization Management (UM), Case Management (CM) and Disease Management (DM)

Utilization Management

Overview
WellCare’s Utilization Management (UM) Program is designed to meet contractual requirements with federal regulations, while providing members access to high-quality, cost-effective medically necessary care. For purposes of this section, terms and definitions may be contained within this section, within Section 13: Definitions of this manual, or both.

The focus of the UM program is on:
- Evaluating requests for services by determining the medical necessity, efficiency, appropriateness and consistency with the member’s diagnosis and level of care required;
- Providing access to medically appropriate, cost effective health care 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 health care behaviors and member partnership;
- Facilitating communication and partnerships among members, families, providers, delegated entities and the plan in an effort to enhance cooperation and appropriate utilization of health care services;
- Reviewing, revising and developing medical coverage policies to ensure members have appropriate access to new and emerging technology; and
- Enhancing the coordination and minimizing barriers in the delivery of behavioral and medical health care services.

Medically Necessary Services
The determination of whether a covered benefit or service is medically necessary complies with the requirements established in Florida Administrative Code, Chapter 59G-1.010. To be medically necessary or a medical necessity, a covered benefit shall:

(a) Meet the following conditions:
- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific, and consistent with symptoms or confirm diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
- Be consistent with generally accepted professional medical standards as determined by the program, and not be experimental or investigational;
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
- Be furnished in a manner not primarily intended for the convenience of the recipient,
the recipient's caretaker or the provider.

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

(c) 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.

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, prospective, concurrent and retrospective review activities. Each component is designed to provide for the evaluation of health care 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 Florida and professional knowledge and/or clinical expertise in the related health care 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
- State Provider Handbooks, as appropriate
- Local and federal statutes and laws
- Medicaid and Medicare guidelines
- Hayes Health Technology Assessment

The clinical reviewer and/or Medical Director involved in the UM process apply medical necessity criteria in context with the member’s individual circumstance and the capacity of the local provider delivery system. When the above criteria do not address the individual member’s needs or unique circumstance, the Medical Director will use clinical judgment in making the determination.

The review criteria and guidelines are available to the providers upon request. Providers may request a copy of the criteria used for specific determination of medical necessity by contacting the Utilization Management Department via Provider Services. The phone number is listed on
the Quick Reference Guide which may be found on WellCare’s website at https://florida.wellcare.com/provider/resources.

**Utilization Management Process**
The UM process is comprehensive and includes the following review processes:

- Notifications;
- Referrals;
- Prior authorizations;
- Concurrent review; and/or
- 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 on WellCare’s website at https://florida.wellcare.com/provider/forms_and_documents.

**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 case management and claims reimbursement; and
- 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.

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

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

Reasons for requiring prior authorization may include:

- Review for medical necessity;
- Appropriateness of rendering provider;
- Appropriateness of setting; and/or
- Case and disease management considerations.

Prior Authorization is **required** for select elective or nonemergency services as designated by WellCare. Guidelines for prior authorization requirements by service type may be found in the Quick Reference Guide on WellCare’s website at
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.

The attending physician or designee is responsible for obtaining the prior authorization of the elective or nonurgent admission. Refer to the Quick Reference Guide which may be found on WellCare’s website at https://florida.wellcare.com/provider/resources for a list of services requiring prior authorization.

**Oncology Pre-authorization**

WellCare has contracted with eviti, Inc., an independent third party expert with nearly a decade of experience supporting oncology treatment decisions, to give our providers access to a comprehensive knowledge base of evidence-based cancer treatment guidelines, called eviti|Connect.

The eviti platform empowers providers with advanced oncology decision support and allows for instant access to thousands of evidence-based treatment regimens. eviti|Connect will also provide a streamlined, web-based process for the pre-authorization of oncology chemotherapy and radiation therapy treatment plans for WellCare members. A provider must register in eviti prior to being able to create a treatment plan. Please refer to the Register section in the eviti Provider User Guide, the “Register as a Provider” and “Register as a Provider’s Administrative Staff Member” videos, or call Provider Services for more information.

**Concurrent Review**

Concurrent review activities involve the evaluation of a continued hospital, Long-Term Acute Care (LTAC) hospital, skilled nursing or acute rehabilitation stay for medical appropriateness, utilizing appropriate criteria. The concurrent review nurse follows the clinical status of the member through telephonic or on-site chart review and communication with the attending physician, hospital UM, case 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 InterQual™ criteria for appropriateness of continued stay to:

- Ensure that services are provided in a timely and efficient manner;
- Make certain that established standards of quality care are met;
- Implement timely and efficient transfer to lower level of care when clinically indicated and appropriate;
- Complete timely and effective discharge planning; and
- Identify cases appropriate for case management.
The concurrent review process incorporates the use of InterQual™ criteria to assess quality and appropriate level of care for continued medical treatment. Reviews are performed by licensed nurses under the direction of the WellCare Medical Director.

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

**Discharge Planning**
Discharge planning begins upon admission and is designed for early identification of medical and/or psychosocial issues that will need post-hospital intervention. The concurrent review nurse works with the attending physician, hospital discharge planner, ancillary providers and/or community resources to coordinate care and post-discharge services to facilitate a smooth transfer of the member to the appropriate level of care. An inpatient review nurse may refer an inpatient member with identified complex discharge needs to 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 is 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 case management to meet immediate needs that allows the member to remain at home and reduce avoidable readmissions.

The care manager’s work includes, but is not limited to: (a) screening for member needs; (b) education; (c) care coordination; (d) medication reconciliation; and (e) referrals to community-based services. Timely follow up is critical to quickly identify and alleviate any care gaps or barriers to care.

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 Case Management Program or Disease Management Program.

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

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

- Retrospective review initiated by providers
  - WellCare will review post-service requests for authorization of inpatient admissions or outpatient services. 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 your state-specific Quick Reference Guide which may be found on WellCare’s website at https://florida.wellcare.com/provider/resources.

Peer-to-Peer Reconsideration of Adverse Determination
In the event of an adverse determination following a medical necessity review, peer-to-peer reconsideration is offered to the attending or ordering physician via fax notification. The attending or ordering physician is 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 reconsideration is offered within three business days from the decision date.

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

Services Requiring No Authorization
WellCare has determined that many routine procedures and diagnostic tests are allowable without medical review to facilitate timely and effective treatment of members including:

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

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

WellCare Proposed Actions
A proposed action is an action taken by WellCare to deny a request for services. In the event of a proposed action, WellCare will notify the member and the requesting provider in writing of the proposed action. The notice will contain the following:

- The action WellCare has taken or intends to take;
• The reason(s) for the action;
• The member’s right to 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; and
• 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 health care 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 health care
professional within network, or a non-participating provider if there is not a participating provider
with the expertise required for the condition.

In accordance with Florida Statute 641.51, the member may elect to have a second opinion
provided by a non-contracted provider located in the same geographical service area of
WellCare. WellCare will pay the amount of all charges which are usual, reasonable and
customary in the community for second opinion services performed by a physician not under
contract with WellCare, but may require the member to be responsible for up to 40 percent of
such amount. WellCare may require that any tests deemed necessary by a non-contracted
provider be conducted by a participating WellCare provider.

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

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:
  o To obtain a standing authorization, the provider should complete the **Outpatient
Authorization Request Form** and document the need for a standing authorization
request under the pertinent clinical summary area of the form.
  o The authorization request should outline the plan of care including the frequency,
total number of visits and the expected duration of care.
• Coordinate with WellCare to ensure that each member has an ongoing source of primary
care appropriate to his or her needs and a person
or entity formally designated as primarily responsible for coordinating the health care services furnished to the member; and

- Ensure that members requiring specialized medical care over a prolonged period of time have access to a specialty care provider.
  - Members will have access to a specialty care provider through standing authorization requests, if appropriate.

### Service Authorization Decisions

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Extension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Pre-service</td>
<td>7 calendar days</td>
<td>7 calendar days</td>
</tr>
<tr>
<td>Expedited Pre-service</td>
<td>48 hours</td>
<td>48 hours</td>
</tr>
<tr>
<td>Urgent Concurrent</td>
<td>24 hours</td>
<td>48 hours</td>
</tr>
<tr>
<td>Post-service</td>
<td>30 calendar days</td>
<td>15 calendar days</td>
</tr>
</tbody>
</table>

### 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 seven 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 seven calendar days if the member or the provider requests an extension, or if WellCare justifies a need for additional information and the extension is in the member’s best interest.

### Expedited Service Authorization

In the event the provider indicates, or WellCare determines, that following the standard time frame could seriously jeopardize the member’s life or health, WellCare will make an expedited authorization determination and provide notice within **48 hours** of the request. An extension may be granted for an additional 48 hours 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 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 on WellCare’s website at [https://florida.wellcare.com/provider/resources](https://florida.wellcare.com/provider/resources).

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 13: Definitions** for definitions of “emergency” and “urgent”.

Post-stabilization services are services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or improve, or resolve the member’s condition. Post-stabilization services are covered without prior authorization up to the point WellCare is notified that the member’s condition has stabilized.
**Continuity of Care**
WellCare will allow members in active treatment to continue care with a terminated treating provider, when such care is medically necessary, through completion of treatment of a condition for which the member was receiving care at the time of the termination, until the member selects another treating provider, or during the next open enrollment period. None of the above may exceed six months after the termination of the provider's contract.

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**
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.

When relinquishing members, WellCare will cooperate with the receiving health plan regarding the course of on-going care with a specialist or other provider.

When WellCare becomes aware that a covered Medicaid member will be disenrolled from WellCare and will transition to a 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 which may be found on WellCare’s website at https://florida.wellcare.com/provider/resources.

**Authorization Request Forms**
WellCare requests providers use our standardized authorization request forms to ensure receipt of all pertinent information and enable a timely response to your request, including:

- *Inpatient Authorization Request Form* is used for services such as planned elective/non-urgent inpatient, observation, and skilled nursing facility and inpatient rehabilitation authorizations.
- *Outpatient Authorization Request Form* is used for services such as follow-up consultations, consultations with treatment, diagnostic testing, office procedures, ambulatory surgery, radiation therapy, out-of-network services and
Ancillary Authorization Request Form is used for services such as Durable Medical Equipment (DME), dialysis, home care services, and outpatient therapies including Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST). All Ancillary 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; and
- 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 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 enables WellCare to identify members for inclusion into the Prenatal Program and/or members who might benefit from WellCare’s High Risk Pregnancy Program, and for reporting pregnancies to DCF.

All forms are located on WellCare’s website at https://florida.wellcare.com/provider/forms_and_documents. All forms 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 Florida Medicaid Handbooks.

Special Requirements for Payment of Services
The following services have special requirements from the state of Florida:

Abortion
Prior authorization is required for the administration of an abortion to validate medical necessity per federal regulations. The consent form does not need to be submitted with the request for authorization.

Abortions are covered for eligible WellCare members if the provider certifies that the pregnancy is a result of rape or incest or that the woman is in danger of death unless an abortion is performed.

An Abortion Certification Form 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 he/she signs the consent;
- Is not mentally competent; and/or
- Is institutionalized in a correctional facility, mental hospital or other rehabilitation facility.

The required MAP 250 Consent Form 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 required for the administration of a hysterectomy to validate medical necessity. WellCare reimburses providers for hysterectomy procedures only when the following requirements are met:

- The provider ensured that the individual was informed, verbally and in writing, prior to the hysterectomy that she would be permanently incapable of reproducing (this does not apply if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy);
- Prior to the hysterectomy, the member/individual and the attending physician must sign and date the Hysterectomy Acknowledgement Form;
- In the case of prior sterility or emergency hysterectomy, a member is not required to sign the consent form; and
- The provider submits the properly executed Patient's Acknowledgement of Prior Receipt of Hysterectomy Information Form 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 which 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 on WellCare’s website at https://florida.wellcare.com/provider/forms_and_documents.

**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 and 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 AHCA and FHKC, 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; and
- 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.

**Case Management Program**

Staywell (Medicaid) offers comprehensive case management services to facilitate health status assessment, care planning and advocacy to improve health outcomes for our members. The Staywell (Medicaid) Case Management Program is built around every member’s unique healthcare needs. We refer to our Case Management program as iREACH to demonstrate our commitment to identify our members with needs in the community, reach them where they live, understand how they prefer to engage with the health care system, assess their needs, facilitate their access to care, and help them when they need us:

- Identify
- Reach
- Engage
- Assess
- Care
- Help

We understand that case management must complement primary care, behavioral health services, ancillary services, outpatient and inpatient services. Our care management services are specifically designed to:

- Foster the relationship between an member and his or her 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
Assist members with understanding and accessing their benefits to improve member outcomes

Staywell (Medicaid) multidisciplinary case 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 case managers share the care plans and work collaboratively with providers 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. Staywell (Medicaid) requests that providers participate as active members of the inter-disciplinary care team for those members that are engaged in case and disease management programs.

Members commonly identified Case Management Program includes:
- **Catastrophic** – Traumatic injuries, i.e., amputations, blunt trauma, spinal cord injuries, head injuries, burns and multiple traumas;
- **Multiple Chronic Conditions** – Multiple co-morbidities such as diabetes, COPD and hypertension, or multiple intricate barriers to quality health care, i.e., AIDS;
- **Transplantation** – Organ failure, donor matching, post-transplant follow-up; and
- **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.; and
- **Special Health Care Needs** – Children and adults who have serious medical or chronic conditions with severe chronic illnesses, physical, mental and developmental disabilities.

**Disease Management Program**

Disease management is a component of Staywell’s iREACH Case Management Program. Clinically trained disease managers support members with targeted chronic conditions. At Staywell (Medicaid) our primary role is to give our members the education and the tools that they need to take control of their health. To accomplish this, we identify members with chronic diseases and provide 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, Staywell will provide the disease management plan of care through our Provider Portal. The Plan’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 Disease Management Program targets the following conditions:
- Asthma
- Cancer
- Coronary artery disease (CAD)/hypertension
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
Staywell (Medicaid) disease management process will consist of five phases:

- **Phase 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).

- **Phase 2: Stratification:** Assign a level and a case manager to each member identified with chronic conditions. Introduce member to the disease management program and invite them to participate.

- **Phase 3: Assessment and Plan:** Assessment completed and individualized disease management plan of care developed.

- **Phase 4: Education and Support:** Develop a disease management focused care plan in collaboration with the member and guide them through the disease management milestones.

- **Phase 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 Staywell (Medicaid) may be found on our website at [http://www.wellcare.com/provider/CPGs](http://www.wellcare.com/provider/CPGs). 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 attain goals.

Staywell (Medicaid) disease management offerings employ innovative biometric monitoring solutions for high risk members diagnosed with CHF, COPD, CAD and diabetes. This biometric measurement device provides 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.

Staywell (Medicaid) makes education available to providers and members regarding their health conditions on both the Member and Provider Portals which can be accessed through the web site at [https://florida.wellcare.com/](https://florida.wellcare.com/).
Case and Disease Management Referrals
Members may be identified for case and disease management in several ways, including:

- Referral from their primary care provider or specialist;
- Self-referral;
- Referral from a family member;
- Referral after a hospital discharge;
- Triggers after completing a Health Risk Assessment (HRA); and
- Data mining for members with healthcare risks or identified care needs.

If you would like to refer a Staywell (Medicaid) member as a potential candidate to the Case Management Program or Disease Management Program, or would like more information about one of the programs, you may call the Staywell Case Management Referral Line at the number listed on the Quick Reference Guide on our website at https://florida.wellcare.com/provider/resources.

For more information on the Case Management Referral Line, refer to the Quick Reference Guide on our website at https://florida.wellcare.com/provider/resources.
Section 5: Claims

Overview
The focus of WellCare’s/Staywell’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 our Customer Service Department. For more information, refer to the Quick Reference Guide, which may be found on WellCare’s website at https://florida.wellcare.com/provider/resources.

For providers who are unaccustomed to submitting claims, WellCare provides detailed claims’ submission procedures on its website. The Florida Medicaid Provider Resource Guide on WellCare’s website at https://florida.wellcare.com/provider/job_aids_and_resource_guides 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 are located on the Quick Reference Guide which can be accessed on WellCare’s website at https://florida.wellcare.com/provider/resources.

Additional information regarding reimbursement policies and Claims Companion Guides are located on WellCare’s website at https://florida.wellcare.com/provider/claims_updates.

Timely Claims Submission
Unless otherwise stated in the Provider Participation Agreement (the Agreement), provider must submit claims (initial, corrected and voided) within six months from the Medicaid or primary insurance payment date, whichever is later, from the date of service for outpatient services and the date of discharge for inpatient services (Hospital Services Manual Section IX Transmittal #17 page 9.3). Unless prohibited by federal law or 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 Agreement for filing Clean Claims.

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; and
- A provider’s electronic submission sheet with all the following identifiers, including patient name, provider name, date of service to match Explanation of Benefits (EOB)/claim(s) in question, prior submission bill dates; and WellCare product name or line of business.

The following items are not acceptable as evidence of timely submission:
- Strategic National Implementation Process (SNIP) Rejection Letter; and
- 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 on the CMS website at www.cms.hhs.gov.
**Taxonomy**
Providers are encouraged to submit claims with the correct taxonomy code consistent with provider’s specialty and services being rendered in order to increase appropriate adjudication. WellCare may reject the claim or pay it at the lower reimbursement rate if the taxonomy code is incorrect or omitted.

**Preauthorization number**
If a preauthorization number was obtained, 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, the rejected claim should be resubmitted within timely filing limits.

**Claims Submission Requirements**
When presenting a claim for payment to WellCare, the provider is indicating an understanding that:

- The provider has an affirmative duty to supervise the provision of, and be responsible for, the Covered Services claimed to have been provided;
- To supervise and be responsible for preparation and submission of the claim; and
- To present a claim that is true and accurate and that is for health plan Covered Services that:
  - Have actually been furnished to the member by the provider prior to submitting the claims; and
  - 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 WellCare’s website at [https://florida.wellcare.com/provider/resources](https://florida.wellcare.com/provider/resources). For more information on Covered Services under WellCare’s Florida Medicaid plans, refer to WellCare’s website at [https://florida.wellcare.com/member/default](https://florida.wellcare.com/member/default). For more information on claims submission requirements, refer to Florida Statute 641.3154.
**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* which may be found on WellCare’s website at [https://florida.wellcare.com/provider/claims_updates](https://florida.wellcare.com/provider/claims_updates).

Because 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 our website at [https://florida.wellcare.com/provider/job_aids_and_resource_guides](https://florida.wellcare.com/provider/job_aids_and_resource_guides).

**HIPAA Electronic Transactions and Code Sets**
*HIPAA Electronic Transactions and Code Sets* is a federal mandate that requires health care 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* on WellCare’s website at [https://florida.wellcare.com/provider/claims_updates](https://florida.wellcare.com/provider/claims_updates).

**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 Agreement. For assistance in creating an EDI process, contact WellCare’s EDI team by referring to the *Quick Reference Guide* on WellCare’s website at [https://florida.wellcare.com/provider/resources](https://florida.wellcare.com/provider/resources).

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

- Paper claims must only be submitted on an original (red ink on white paper) claim forms.
- Any missing, illegible, incomplete, or invalid information in any field will cause the claim to be rejected or processed incorrectly.
- 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 forms;
    - Typed. Do not print, handwrite, or stamp any extraneous data on the form.
    - In black ink;
    - In large, dark font such as, PICA, ARIAL 10-, 11- or 12-point type; and
Claims Processing

Readmission
WellCare may choose to review claims if data analysis deems it appropriate. WellCare may review hospital admissions on a specific member if it appears that two or more admissions are related based on the data analysis. Based upon the claim review (including a review of medical records if requested from the provider) WellCare will make all necessary adjustments to the claim, including recovery of payments which are not supported by the medical record. 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.

48-Hour Rule
WellCare follows the CMS guidelines for Outpatient Services Treated as Inpatient Services (including but not necessarily limited to: Outpatient Services Followed by Admission Before Midnight of the Following Day, Preadmission Diagnostic Services, and Other Preadmission Services). Please refer to the CMS Claims Processing Manual for additional information or the Florida Medicaid Hospital Services and Coverage Limitations Handbook located at: http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/42/Default.aspx.

Disclosure of Coding Edits
WellCare uses claims editing software programs to assist in determining proper coding for provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule Database, the American Medical Association (AMA) and Specialty Society correct coding guidelines, and regulations. These software programs may result in claim edits for specific procedure code combinations. These claims editing software programs may result in an adjustment of the payment to the provider for the services or in a request, prior to payment, for the submission for review of medical records that relate to the claim. Providers may request reconsideration of any adjustments produced by these claims editing software programs by submitting a timely request for reconsideration to WellCare. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.
**Prompt Payment**  
Refer to your Agreement and/refer to Florida Statute 641.3155.

**Coordination of Benefits (COB)**  
WellCare shall coordinate payment for Covered Services in accordance with the terms of a member’s benefit plan, applicable state and federal laws and CMS guidance. Providers shall bill primary insurers for items and services they provide to a member before they submit claims for the same items or services to WellCare. Any balance due after receipt of payment from the primary payer should be submitted to WellCare for consideration and the claim must include information verifying the payment amount received from the primary plan 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 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.

**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. If encounter data does not meet the Service Level Agreements (SLA) for timeliness of submission, completeness or accuracy, the Agency 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 Agreement, delegated vendors and capitated providers should submit complete and accurate encounter files to WellCare as follows:

- For initial submission, encounters will be submitted within 60 days from 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 Health Plan has delegated activities to the provider pursuant to a separate delegation addendum: Provider shall reimburse Health Plan for any fines, penalties or costs of corrective actions required of the health plan by governmental authorities cause by the provider’s failure to comply with laws or program requirements, including failure to submit accurate encounters on a timely basis or to properly perform delegated functions.
Accurate Encounters Submission
All encounter transactions submitted via DDE or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines as per the state requirements. SNIP Levels 1 through 5 shall be maintained. Once WellCare receives a delegated vendor or provider encounter, the encounter is loaded into WellCare’s Encounters System and processed. The encounter is subjected to a series of SNIP editing to ensure that the encounter has all the required information and that the information is accurate.

For more information on submitting encounters electronically, refer to the WellCare Companion Guides which may be found on WellCare’s website at https://florida.wellcare.com/provider/claims_updates.

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 Health Care Claim / Encounter Institutional, Professional and Dental Guides for detailed instructions on how to submit encounters electronically using SFTP. For more information on EDI implementation with WellCare, refer to WellCare’s website at https://florida.wellcare.com/provider/claims_updates.

Submitting Encounters Using Direct Data Entry (DDE)
Delegated vendors and providers may submit their encounter information directly to WellCare using WellCare’s Direct Data Entry (DDE) portal. The DDE tool can be found on the secure, online Provider Portal at https://florida.wellcare.com/. For more information on free DDE options, refer to the Florida Medicaid Provider Resource Guide on WellCare’s website at https://florida.wellcare.com/provider/job_aids_and_resource_guides.

Encounters Data Types
There are four (4) 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 Health Care Claim / Encounter Institutional, Professional and, Dental Guides.
Encounters submitted to WellCare from a delegated vendor or provider can be a new, voided or a replaced / overlaid encounter. The definitions of the types of encounters are as follows:

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

**Balance Billing**

Providers shall accept payment from WellCare for Covered Services provided to WellCare members in accordance with the reimbursement terms outlined in the Agreement. Payment made to providers constitutes payment in full by WellCare for covered benefits, with the exception of member expenses. For Covered Services, providers shall not balance bill members any amount in excess of the contracted amount in the Agreement. An adjustment in payment as a result of WellCare’s claims policies and/or procedures does not indicate that the service provided is a non-Covered Service, and members are to be held harmless for Covered Services. For more information on balance billing, refer to the Florida 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 Florida 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 Florida Medicaid. Providers shall accept WellCare’s payment as payment in full or will bill Florida Medicaid if WellCare has not assumed the Agency’s financial responsibility under an agreement between WellCare and the Agency.

**Claims Appeals**

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

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

To initiate the process, please mail to the address, or fax to the fax number, listed in your Quick Reference Guide located on WellCare’s website at https://florida.wellcare.com/provider/resources.

**Provider Solution Resolution**

Staywell educates our providers regarding our provider resolution process, which includes:

- Dedicated Provider Solutions unit representatives for providers to contact via telephone, electronic mail, regular mail, or in person, to ask questions, file a complaint or resolve problems. Providers will be directed to use the regular Customer Service number and the dedicated number for resolutions (PRT) prior to contacting Provider Solutions.
• Dedicated personnel to receive and process provider complaints. The Provider Solutions team will work closely with Customer Service and Provider Resolution staff to quickly address issues.
• Our policy allows providers 45 calendar days to file a written complaint for issues that are not claims-related.
• Staywell will notify the provider (verbally or in writing) within three business days of receipt of a complaint that the complaint has been received and the expected date of resolution.
• A process to thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying Staywell’s written policies and procedures.
• Our policy is to document why a complaint is unresolved within 15 calendar days of receipt and to provide written notice of the status to the provider every 15 calendar days thereafter.
• Staywell will resolve all complaints within 90 calendar days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three business days of resolution.
• Staywell executives who have the authority to require corrective action are involved in the provider complaint process.

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

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

To submit a Corrected or Voided Claim electronically:
• For Institutional claims, provider must include the original WellCare claim number for the claim adjusting or voiding in the REF*F8 (loop and segment) for any 7 (Replacement for prior claim) or 8 (Void/cancel of prior claim) in the standard 837 layout.
• For Professional claims, provider must have the Frequency Code marked appropriately as 7 (Replacement for prior claim) or 8 (Void/cancel of prior claim) in the standard 837 layout.

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

To submit a **Corrected or Voided Claim via paper:**
• For Institutional claims, provider must include the original WellCare claim number and bill frequency code per industry standards.

**Example:**
Box 4 – Type of Bill: the third character represents the “Frequency Code”

<table>
<thead>
<tr>
<th>Type of Bill</th>
<th>Frequency Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 or 8</td>
<td>7 or 8</td>
</tr>
</tbody>
</table>

Box 64 – Place the Claim number of the Prior Claim in Box 64
• For Professional claims, provider must include the original WellCare claim number and bill frequency code per industry standards. When submitting a Corrected or Voided claim, enter the appropriate bill frequency code left justified in the left-hand side of Box 22.

Example:

<table>
<thead>
<tr>
<th>22. MEDICAID RESUBMISSION CODE</th>
<th>ORIGINAL REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 OR 8</td>
<td>123456789012A33456</td>
</tr>
</tbody>
</table>

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

*Please Note: If you handwrite, stamp, or type “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 co-pay, coinsurance or deductible) – and noted “Payment lost/voided/missed.” This process will deduct the payment for this claim, or zero net amount if applicable.
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).

**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 secondary surgical procedure; and
- 25 percent of maximum allowable fee for all other surgical procedures.

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


**Assistant Surgeon**

Assistant Surgeons (AS) are reimbursed 16 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; and
- 16 percent of 25 percent of the maximum allowable fee for all other surgical procedures.

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


**Co-Surgeon**

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

For more information, refer to the Florida Medicaid Hospital Services and Coverage Limitations Handbook located at
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 Florida Medicaid website specific to payment for non-physician practitioners or Allied Health Professionals, WellCare follows CMS reimbursement guidelines regarding Allied Health Professionals.

Overpayment Recovery
WellCare strives for 100 percent payment quality but recognizes that a small percentage of financial overpayments will occur while processing claims. An overpayment can occur due to reasons such as retroactive member 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 12 months from the payment date for professional claims (CMS-1500 or its successor) and 30 months from the payment date for institutional claims (UB-04 or its successor), with the exception for retrospective disenrollment, where institutional claims are also limited to 12 months from the 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 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 timeframe will constitute acceptance of the terms in the letter and will result in offsets to future payments. The provider will receive an EOP indicating if the balance has been satisfied. In situations where the overpaid balance has aged more than three months and no refund has been received, the provider may be contacted by WellCare, or its designee, to arrange payment.

If the provider independently identifies an overpayment it can either a) send a corrected claim (refer to the corrected claim section of the manual), b) contact WellCare Customer Service to arrange an off-set against future payments or c) send a refund and explanation of the overpayment to:
For more information on contacting Provider Services, refer to the *Quick Reference Guide*.

**Benefits During Disaster and Catastrophic Events**
Refer to your Agreement.
Section 6: Credentialing

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

This review includes (as applicable to practitioner type):
- Background;
- Education;
- Postgraduate training;
- Certification(s);
- Experience;
- Work history and demonstrated ability;
- Patient admitting capabilities;
- Licensure, regulatory compliance and health status which may affect a practitioner’s ability to provide health care; and
- Accreditation status, as applicable to non-individuals.

Practitioners are required to be credentialed prior to being listed as participating network providers of care or services to WellCare members. Staywell will only register a participating provider with AHCA after a background screening has been completed.

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

Please take note of the following credentialing process highlights:

Primary source verifications are obtained in accordance with state and federal regulatory agencies, accreditation and WellCare policy and procedure requirements, and include a query to the National Practitioner Data Bank.

Physicians, allied health professionals and ancillary facilities/health care delivery organizations are required to be credentialed in order to be network providers of services to WellCare members.

Satisfactory site inspection evaluations are required to be performed in accordance with state, federal, state and accreditation requirements.
After the credentialing process has been completed, a timely notification of the credentialing decision is forwarded to the provider.

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

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

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

**Practitioner’s Right to Be Informed of Credentialing/Re-Credentialing Application Status**
Upon receipt of a written request, WellCare will provide written information to the practitioner on the status of the credentialing/re-credentialing application, generally within 15 business days. The information provided will advise of any items pending verification, needing to be verified, any non-response in obtaining verifications and any discrepancies in verification information received compared with the information provided by the practitioner.

**Practitioner’s Right to Review Information Submitted in Support of Credentialing/ Re-Credentialing Application**
The practitioner may review documentation submitted by him/her in support of the application/re-credentialing application, together with any discrepant information received from professional liability insurance carriers, State licensing agencies and certification boards, subject to any WellCare restrictions. WellCare or its designee will review the corrected information and explanation at the time of considering the practitioner’s credentials for provider network participation or re-credentialing.

The provider may not review peer review information obtained by WellCare.

**Right to Correct Erroneous Information and Receive Notification of the Process and Time Frame**
In the event the credentials verification process reveals information submitted by the practitioner that differs from the verification information obtained by WellCare, the practitioner has the right to review the information that was submitted in support of his/her application, and has the right to correct the erroneous information. WellCare will provide written notification to the practitioner of the discrepant information.

WellCare’s written notification to the practitioner includes:
- The nature of the discrepant information;
- The process for correcting the erroneous information submitted by another source;
- The format for submitting corrections;
- The time frame for submitting the corrections;
- The addressee in Credentialing to whom corrections must be sent;
• WellCare’s documentation process for receiving the correction information from the provider; and
• WellCare’s review process.

Baseline Criteria
Baseline criteria for practitioners to qualify for provider network participation:

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

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

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

Board Certification – Physicians (M.D., D.O., D.P.M.) must maintain Board Certification in the specialty being practiced as a provider for WellCare or must have verifiable educational/training from an accredited training program in the specialty requested. PCPs for Healthy Kids must be Board certified in either Family Practice or Pediatrics.

Special Provisions for HealthEase Kids and Staywell Kids Primary Care Providers –
Primary care providers who have recently completed a National Board for Certification of Training Administrators of Graduate Medical Education Programs-approved residency program in pediatrics or family practice and are eligible for board certification but have not yet achieved board certification may participate as providers in the HealthEase Kids and Staywell Kids program. If the non-board certified primary care provider does not achieve board certification within the first three (3) years of initial credentialing, the provider will be removed from the HealthEase Kids and Staywell Kids panel and members will be reassigned.

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

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

New Providers – A provider is required to have a Florida Medicaid provider number as well as a National Provider Identifier (NPI) to participate in WellCare’s network. Healthy Kids providers are not required to have a Florida Medicaid provider number.

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

**Liability Insurance**
WellCare requires individual providers to meet professional liability insurance in accordance with Florida Statute Chapter 438 section 32:

- $250,000 per occurrence, $750,000 aggregate, if provider has hospital privileges;
- $100,000 per occurrence, $300,000 aggregate, if individual has no hospital privileges; or
- Physicians practicing in County Public Health Departments or Federally Qualified Health Centers may submit evidence of coverage under Sovereign Immunity; or
- An active practicing provider may opt to carry no medical malpractice insurance if they meet the following criteria:
  1. The provider has held an active license in any state for more than 15 years.
  2. The provider has either retired from the practice of medicine or maintains a part-time practice of no more than 1,000 patient contact hours per year.
  3. The provider has had no more than two medical malpractice resulting in an indemnity exceeding $25,000 within the previous five-year period.
  4. The provider has not been convicted of, or pled guilty or nolo contendere to, any criminal violation specified in Florida Statute Chapter 438.
  5. The provider has not been subject within the last 10 years of practice to license revocation or suspension for any period of time; probation for a period of 3 years or longer; or a fine of $500 or more for a violation of this chapter or the medical practice act of another jurisdiction.
  6. The provider must post notice in the form of a sign prominently displayed in the reception area and clearly noticeable to all patients or provide a written statement to any person to whom medical services are being supplied that he/she has decided not to carry medical malpractice insurance, pursuant to Florida law.

Atypical facilities and providers contracted for the Nursing Home Diversion line of business are required to be licensed, bonded and insured according to minimum industry standards of the field in which they are operating.

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

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

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

SIEs are conducted for:
- Unaccredited facilities;
- State-specific initial credentialing requirements;
• State-specific re-credentialing requirements; and
• When complaint is received relative to office site criteria.

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

Covering Physicians
Primary care physicians in solo practice must have a covering physician who also participates with or is credentialed with WellCare.

Attestation to Active Patient Load
An attestation that the total active patient load (all populations with Medicaid FFS, Children’s Medical Services Network, HMO, PSN, Medicare and commercial coverage) is no more than 3,000 patients per PCP is required. An active patient is one that is seen by the provider a minimum of three times per year.

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

Dependent AHPs include the following, and are required to provide collaborative practice information to WellCare:
• Advanced registered nurse practitioners (ARNPs);
• Certified nurse midwives (CNMs);
• Physician assistants (PAs); and
• Osteopathic assistant (OAs).

Independent AHPs include, but are not limited to the following:
• Licensed clinical social workers;
• Licensed mental health counselors;
• Licensed marriage and family therapists;
• Physical therapists;
• Occupational therapists;
• Audiologists; and
• Speech/language therapists/pathologists.

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

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

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

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

**Eligibility in the Medicaid Program**
All providers must be eligible for participation in the Medicaid program. If a provider is currently suspended or involuntarily terminated from the Florida Medicaid program whether by contract or sanction, other than for purposes of inactivity, that provider is not considered an eligible Medicaid provider. Suspension and termination are described further in Rule 59G-9.070, F.A.C. If a provider is found to be ineligible for participation in the Medicaid program, the provider is subject to immediate termination from WellCare.

**Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials**
On a regular and ongoing basis, WellCare or its designee contacts state licensure agencies to obtain the most current available information on sanctioned providers. This information is cross-checked against the network of WellCare providers. If a network provider is identified as being currently under sanction, appropriate action is taken in accordance with WellCare policy and procedure. If the sanction imposed is revocation of license, the provider is subject to immediate termination. Notifications of termination are given in accordance with contract and WellCare policies and procedures.

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

**Participating Provider Appeal through the Dispute Resolution Peer Review Process**
WellCare may immediately suspend, pending investigation, the participation status of a participating provider who, in the opinion of the Medical Director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of members. In such instances, the Medical Director investigates on an expedited basis.

WellCare has a Participating Provider Dispute Resolution Peer Review Panel process in the event WellCare chooses to alter the conditions of participation of a provider based on issues of quality of care, conduct or service, and if such process is implemented, may result in reporting to regulatory agencies.

The Provider Dispute Resolution Peer Review process has two levels. All disputes in connection with the actions listed below are referred to as a first level Peer Review Panel consisting of at least three (3) qualified individuals of whom at least one is a participating provider and a clinical peer of the practitioner that filed the dispute.
The practitioner also has the right to consideration by a second-level Peer Review Panel consisting of at least three qualified individuals, of whom at least one is a participating provider and a clinical peer of the practitioner that filed the dispute. The second-level panel is comprised of individuals who were not involved in earlier decisions.

The following actions by WellCare entitle the practitioner affected thereby to the Provider Dispute Resolution Peer Review Panel Process:

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

Notification of the adverse recommendation, together with reasons for the action, and the practitioner's rights and process for obtaining the first and/or second-level Dispute Resolution Peer Review Panel processes, are provided to the practitioner. Notification to the practitioner will be mailed by overnight, recorded or certified return-receipt mail.

The practitioner has a period of up to 30 days in which to file a written request via recorded or certified return receipt mail to access the Dispute Resolution Peer Review Panel process.

Upon timely receipt of the request, the Medical Director or his or her designee shall notify the practitioner of the date, time and telephone access number for the Panel hearing. WellCare then notifies the practitioner of the schedule for the Review Panel hearing.

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

The Dispute Resolution Peer Review Panel shall consider and decide the case objectively and in good faith. The Medical Director, within five (5) business days after final adjournment of the Dispute Resolution Peer Review Panel hearing, shall notify the practitioner of the results of the first-level Panel hearing. In the event the findings are positive for the practitioner, the second-level review shall be waived.

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

Within 10 calendar days of the request for a second-level Peer Review Panel hearing, the Medical Director or his or her designee shall notify the practitioner of the date, time and access number for the second-level Peer Review Panel hearing.

The second-level Dispute Resolution Peer Review Panel shall consider and decide the case objectively and in good faith. The Medical Director, within five (5) business days after final adjournment of the second-level Dispute Resolution Peer Review Panel hearing, shall notify the
practitioner of the results of the second-level Panel hearing via certified or overnight recorded delivery mail. In the event the findings of the second-level Peer Review Panel result in an adverse determination for the practitioner, the findings of the second-level Peer Review Panel shall be final.

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

**Delegated Entities**

All participating providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a monthly/quarterly basis and formal audits are conducted annually. Please refer to Section 9: *Delegated Entities* section in this manual for further details.
Section 7: Appeals and Grievances

Appeals Process

Provider

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

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

WellCare has 60 calendar days to review the case for medical necessity and conformity to WellCare guidelines.

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 re-open the case. Records and documents received after that timeframe 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 on Behalf of Self Appeals
If all of the relevant information is received, WellCare will make a determination within 60 calendar days. If it is determined during the review that the provider has complied with WellCare protocols and that the appealed services were medically necessary, the denial will be overturned. The provider will be notified of this decision in writing.

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

Affirmation of Denial of Provider on Behalf of Self Appeals
If it is determined during the review that the provider did not comply with WellCare protocols and or medical necessity was not established, the denial will be upheld. The provider will be notified of this decision in writing.

For denials based on medical necessity, the criteria used to make the decision may be provided. The provider may also request a copy of the clinical 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 Customer Service 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 30 calendar days of the date of receipt of the notice of action. WellCare shall acknowledge in writing within five business days of receipt of appeal except in the case of an expedited request.

The member should send the appeal request to:

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

Fax: **1-866-201-0657**  
Telephone: **1-866-334-7927**  
Hours of Operation: Monday–Friday, from 8 a.m. to 7 p.m.

If an appeal is filed verbally via WellCare’s Customer Service, the request must be followed up with a written, signed appeal request to WellCare within 10 calendar days of the verbal filing, except when an expedited resolution has been requested. For verbal filings, the time frames for resolution begin on the date the verbal filing was received by WellCare.

If the member’s request for appeal is submitted after 30 calendar days of receipt of the notice of action, 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 action or received the notice late;
- The member was seriously ill, which prevented a timely appeal;
- There was a death or serious illness in the member’s immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limits; and/or
- The member had incorrect or incomplete information concerning the appeal process.

If the member wishes to use a representative, he or she must submit a signed statement naming the person he or she wishes to represent him or her. For the member’s convenience, WellCare has an Appointment of Representative (AOR) statement form that can be used. The member and the person who will be representing the member must sign the AOR statement. The form is located on WellCare’s website at [https://florida.wellcare.com/provider/forms_and_documents](https://florida.wellcare.com/provider/forms_and_documents). 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/TDD 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. The request can come from the provider or office staff working on behalf of the provider. Only a provider can request a standard retrospective appeal on his or her own behalf.

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

Examples of 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 the Agency;
- 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 his or her 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. When deciding any of the following: (a) an appeal of a denial based on lack of medical necessity; (b) a grievance regarding denial of expedited resolution of an appeal; or (c) a grievance or appeal involving clinical issues. The appeal reviewers will be health care professionals with clinical expertise in treating the member's condition/disease or have sought advice from providers with expertise in the field of medicine related to the request.

WellCare must make a determination from the receipt of the request on a member appeal and notify the appropriate party within the following time frames:
- Expeditied 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 provide the member with written notice of the reason for the delay within five (5) business days of the decision to extend the timeframe. The plan 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.

Members who verbally request an expedited appeal are not required to submit a written appeal request as outlined in the Appeals Member section.
A request for payment of a service already provided to a member is not eligible to be reviewed as an expedited appeal.

**Denial of an Expedited Request**
WellCare will provide the member 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 (2) 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 she or he disagrees with the organization’s decision not to expedite the appeal and provide instructions about the expedited grievance process and its time frames; and
- The member’s right to resubmit a request for an expedited appeal and that if the member gets any provider’s support indicating that applying the standard time frame for making a determination could seriously jeopardize the member’s life, health or ability to regain maximum function, the request will be expedited automatically.

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

**Reversal of Denial of an Expedited Appeal**
If WellCare overturns its initial action and/or the denial, it will issue authorization to cover the requested service and notify the member verbally 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 Action to the member and/or appellant;
- Include in the Notice the specific reason for the appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based;
- Inform the member:
  - Of their right to request a Medicaid Fair Hearing within 90 calendar days and how to do so;
  - Of their right to file a Beneficiary Assistance Panel/Subscriber Assistance Panel hearing within one year of WellCare’s notice of resolution;
  - 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 Pre-Service Appeals Process**
A member, a member’s representative or a provider on behalf of a member with the member’s written consent, may file a standard pre-service appeal request either verbally or in writing within 30 calendar days of the date of receipt of the notice of action.

If an appeal is filed verbally through Customer Service, the request must be followed up with a written, signed appeal to WellCare within 10 calendar days of the verbal filing. For verbal filings, the timeframes for resolution begin on the date the verbal filing was received.

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

**Reversal of Denial of a Standard Pre-Service Appeal**
If upon standard appeal, WellCare overturns its adverse organization determination denying a member’s request for a service (pre-service request), then WellCare will issue an authorization for the pre-service request.

WellCare will issue an authorization for the disputed services within 72 hours of the decision, if the services were not furnished while the appeal was pending and the decision is to reverse a decision to deny, limit or delay services. WellCare will also pay for the disputed services if the services were furnished while the appeal was pending and the disposition reverses a decision to deny, limit or delay services.

**Affirmation of Denial of a Standard Pre-Service Appeal**
If WellCare affirms its initial action and/or denial (in whole or in part), it will:
- Issue a Notice of Adverse Action to the member and/or appellant;
- Include in the Notice the specific reason for the appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, as well as informs the member:
  o Of their right to request a Medicaid Fair Hearing within 90 calendar days and how to do so;
  o Of their right to file a Beneficiary Assistance Panel/Subscriber Assistance Panel hearing within one year of WellCare’s notice of resolution;
  o Of their right to representation;
  o Of their right to continue to receive benefits pending a Medicaid Fair Hearing; and
  o That they may be liable for the cost of any continued benefits if WellCare’s action is upheld.

**Standard Retrospective Appeals Process**
Post-service appeals are typically requests for payment for care or services that the member has already received. Accordingly, a post-service appeal would never result in the need for an expedited review.

A member, or a member’s representative, may file a standard retrospective appeal request either verbally or in writing within 30 calendar days of receipt of the notice of action. Members are also provided reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing.

For more information on Appointment of Representative (AOR) statements and verbal filings requirements, see Appeals Member section.
Reversal of Denial of Standard Retrospective Appeal
If, upon appeal, WellCare overturns its adverse organization determination denying a member’s request for payment, then WellCare will issue its reconsidered determination and send payment for the service.

WellCare will also pay for appealed 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 Retrospective Appeal
If WellCare affirms its initial action and/or denial (in whole or in part), it will:
- Issue a Notice of Adverse Action to the member and/or appellant;
- Include in the Notice the specific reason for the appeal decision in an easily understandable language with reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, as well as informs the member:
  - Of their right to request a Medicaid Fair Hearing within 90 calendar days and how to do so;
  - Of their right to file a Beneficiary Assistance Panel/Subscriber Assistance Panel hearing within one year of WellCare’s notice of resolution;
  - 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.

Medicaid Fair Hearing for Medicaid Members
A Medicaid member has the right to request a Medicaid Fair Hearing, in addition to, and at the same time as, pursuing resolution through WellCare’s Grievance and Appeal processes. A provider must have a member's written consent before requesting a Medicaid Fair Hearing on behalf of a member. The parties to a Medicaid Fair Hearing include WellCare, as well as the member, his or her representative or the representative of a deceased member's estate and the state. This process does not apply to Florida Health Kids members. Requests should be sent to:

Office of Appeal Hearings
1317 Winewood Boulevard, Building 5 Room 255
Tallahassee, FL 32399-0700

Telephone: 1-850-488-1429
Fax: 1-850-487-0662
Email: Appeal_Hearings@dcf.state.fl.us
Web: www.mytfamilies.com/about-us/office-inspector-general/investigation-reports/appeal-hearings

Beneficiary Assistance Program (BAP) or Subscriber Assistance Program (SAP)
Medicaid and Healthy Kids recipients have a right to request a hearing from the BAP or SAP. The BAP process applies to HealthEase and Staywell. The SAP process applies to HealthEase Kids and Staywell Kids.
Members are notified in the Adverse Determination letter, Member Handbook, and Appeal Decision letter of their right to request a hearing before the BAP or SAP. The member must complete WellCare's entire appeals process available before filing a hearing request with the BAP or SAP.

A member may submit a request for review of their action and appeal to the BAP or SAP. In order for the member to qualify for review, the following criteria must be met:

- The submission of the appeal to the BAP or SAP must be done within one year after the receipt of the final decision letter from the plan;
- If it concerns:
  - The availability of health care services or the coverage of benefits, or an adverse determination about benefits made pursuant to Utilization Management (UM); or
  - Claims payment, handling, or reimbursement for benefits.
- If the Medicaid member has taken the appeal to a Medicaid Fair Hearing, the member cannot submit the appeal to the BAP.

BAP requests should be sent to:

Agency for Health Care Administration
Beneficiary Assistance Program (BAP)
Building 3 MS #26
2727 Mahan Drive
Tallahassee, Florida 32308

Telephone: 1-850-412-4502
Toll-free: 1-888-419-3456

SAP requests should be sent to:

Agency for Health Care Administration
Subscriber Assistance Program (SAP)
Building 3, MS #26
2727 Mahan Drive
Tallahassee, Florida 32308

Telephone: 1-850-412-4502
Toll-free: 1-888-419-3456

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

As used in this section, “timely” means filing on or before the later of the following:

- Within 10 business days of WellCare mailing the Notice of Adverse Action; or
- Within 10 business days after the intended effective date of WellCare’s Proposed Action, whichever is later.

WellCare will continue the member’s benefits if: (a) the member, or the member’s Authorized Representative files the appeal timely; (b) the appeal involves the termination, suspension or reduction of a previously authorized course of treatment; (c) the services were ordered by an authorized provider; (d) the original period covered by the original authorization has not expired; and (e) the member requests extension of the benefits.
If, at the member’s request, WellCare continues or reinstates the member’s benefit while the Appeal or Medicaid Fair Hearing is pending, the benefits will be continued until one of the following occurs:

- The member withdraws the appeal or request for the Medicaid Fair Hearing;
- 10 business days pass after WellCare mails the Notice of Adverse Action, unless the member, within 10 business days, has requested a Medicaid Fair Hearing with continuation of benefits until a Medicaid Fair Hearing decision is reached;
- A Medicaid Fair Hearing officer issues a hearing decision adverse to the member;
- The time period or service limits of a previously authorized service has been met; or
- 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.

**Grievance Process**

**Provider Complaints**

Providers have the right to file a written complaint for issues that are non-claims related no later than 45 calendar days from the date the provider becomes aware of the issue generating the complaint. Written resolution will be provided by WellCare to the provider within 45 calendar days from the date the complaint is received by WellCare. Providers with complaints unresolved during Provider Service Resolution (PSR) process, or if the provider makes his request known, may request to file a provider complaint.

**Provider Complaints (Medicaid):**

A verbal or written notice will be sent to the provider filing the grievance within 3 business days; acknowledging receipt of the complaint and the expected date of resolution.

All complaints shall be resolved within ninety (90) calendar days of receipt and provide a written notice of the disposition and the basis of the resolution to the provider within 3 business days of resolution. If the complaint is unresolved after fifteen (15) calendar days of receiving the complaint, documentation explaining why and a written notice of the status to the provider every fifteen (15) calendar days thereafter.

A written notice of the disposition and basis of the resolution will be mailed to the provider within:

- Three business days of the resolution

A written provider grievance shall be mailed directly to WellCare’s Grievance Department.

For more information on how to contact the Grievance Department, refer to the Quick Reference Guide which may be found on WellCare’s website at [https://florida.wellcare.com/provider/resources](https://florida.wellcare.com/provider/resources).

A provider may not file a grievance on behalf of the member without written consent from the member, as the member’s representative.

WellCare will give all providers written notice of the provider grievance procedures at the time they enter into contract.
For more information, see the *Grievance Submission* section.

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

- **Provider Service including, 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); and/or
  - Office conditions.

- **Services provided by WellCare including, but not limited to:**
  - Hold time on telephone;
  - Rudeness of staff;
  - Involuntary disenrollment from WellCare; and/or
  - Unfulfilled requests.

- **Access availability including, but not limited to:**
  - Difficulty getting an appointment;
  - Wait time in excess of one hour; and/or
  - Handicap accessibility.

A member, a member’s representative or any provider acting on behalf of the member with written consent, may file a standard and/or expedited grievance within one year of the incident, or when the member was made aware of the incident.

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

If the member wishes to use a representative, then he or she must submit a signed statement naming the person he or she wishes to represent him or her. For the member’s convenience, WellCare has an Appointment of Representative (AOR) statement form that can be used. The member and the person who will be representing the member must sign the AOR statement. The form is located on WellCare’s website at [https://florida.wellcare.com/provider/forms_and_documents](https://florida.wellcare.com/provider/forms_and_documents). 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/TDD capability.
Grievance Submission
A verbal grievance request can be filed, toll-free, with WellCare Customer Service. 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/Staywell Grievances
P.O. Box 31384
Tampa, FL 33631-3384

Fax: 1-866-388-1769
Telephone: 1-866-334-7927
Hours of Operation: Monday–Friday, from 8 a.m. to 7 p.m.

Grievance Resolution
WellCare will acknowledge the member’s standard grievance in writing within 10 business days from the date the grievance is received by WellCare. Upon the grievance resolution, a letter will be mailed to the member: (a) within 60 calendar days from the date the standard grievance is received by WellCare; or (b) within a maximum of 90 calendar days, if the grievance involves the collection of information outside the service area. This resolution letter may not take the place of the acknowledgment letter, unless a decision is reached before the written acknowledgement is sent, then one letter shall be sent which includes the acknowledgement and the decision of the grievance.

The acknowledgement letter includes:
- Name and telephone number of the Grievance Coordinator; and
- 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; and
- Member rights on Medicaid Fair Hearing.

The plan shall notify members in their primary language of grievance resolutions.

Medicaid Fair Hearing for Medicaid Members
If a Medicaid member is dissatisfied with the grievance decision reached by WellCare, the member may request a Medicaid Fair Hearing within 90 calendar days of receiving the grievance resolution letter. This process does not apply to Florida Healthy Kids Members.
Section 8: Compliance

WellCare’s Compliance Program

Overview
WellCare maintains a Corporate Compliance Program (Compliance Program) that promotes ethical conduct in all aspects of the company’s operations, and ensures compliance with WellCare policies, and applicable federal and state regulations. The Compliance Program includes information regarding WellCare’s policies and procedures related to fraud, waste and abuse, and provides guidance and oversight as to the performance of work by WellCare, WellCare employees, contractors (including delegated entities) and business partners in an ethical and legal manner. All providers, including provider employees and provider sub-contractors and their employees, are required to comply with WellCare 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; and
  - 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; and
    - 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 sub-contractors and their employees to have appropriate policies and procedures to address fraud, waste, and abuse;
    - Process for reporting suspected fraud, waste and abuse;
    - Protections for employees and subcontractors who report suspected fraud, waste and abuse; and
    - Types of fraud, waste and abuse that can occur.

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

Details of the corporate ethics and compliance program may be found on WellCare’s website at [https://www.wellcare.com/AboutUs/default](https://www.wellcare.com/AboutUs/default).

**Provider Education and Outreach**

Providers may:
- Display state-approved health-plan specific materials in-office;
- Announce a new affiliation with a health plan;
- Make available and/or distribute marketing materials as long as the provider and/or the facility distributes, or makes available, marketing materials for all Managed Care Plans with which the provider participates; and
- 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 providers networks among health plans, other than to confirm their participation in a health plan’s network;
- Furnishing lists of their Medicaid patients to any health plan with which they contract, or any other entity;
- Furnishing health plans’ membership lists to the health plan, such as WellCare, or any other entity; and
- Assisting with health plan enrollment or disenrollment.

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

**Provider-Based Marketing Activities**

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

Providers must comply with the following:
- To the extent that a provider can assist a recipient in an objective assessment of his/her needs and potential options to meet those needs, the provider may do so.
- May engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.

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

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

Provider Affiliation Information:
• Providers may announce new or continuing affiliations with the Managed Care Plan through general advertising (e.g., radio, television, websites).
• Providers may make new affiliation announcements within the first thirty (30) calendar days of the new Provider Agreement.
• Providers may make one announcement to patients of a new affiliation that names only the Managed Care Plan when such announcement is conveyed through direct mail, email, or phone.
• Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all Managed Care Plans with which the provider 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 printed information provided by the Managed Care Plan to their patients comparing the benefits of all of the different Managed Care Plans with which the providers contract. The Managed Care Plan shall ensure that:
  (i) Materials do not “rank order” or highlight specific Managed Care Plans and include only objective information.
  (ii) Such materials have the concurrence of all Managed Care Plans involved in the comparison and are approved by the Agency prior to distribution.
  (iii) The Managed Care Plans identify a lead Managed Care Plan to coordinate submission of the materials.

Code of Conduct and Business Ethics
Overview
WellCare has established a Code of Conduct and Business Ethics that outlines ethical principles to ensure that all business is conducted in a manner that reflects an unwavering allegiance to ethics and compliance. WellCare’s Code of Conduct and Business Ethics policy can be found at https://www.wellcare.com/AboutUs/default.

The Code of Conduct and Business Ethics (the Code) is the foundation of iCare, WellCare's Corporate Ethics and Compliance Program. It describes WellCare's firm commitment to operate in accordance with the laws and regulations governing our 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 encouraged to report compliance concerns and any suspected or actual misconduct. Report suspected Fraud, Waste and Abuse by calling the WellCare FWA Hotline at 1-866-678-8355.

Fraud, Waste and Abuse
WellCare is committed to the prevention, detection and reporting of health care 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 health care service use, including over-utilization, unbundling, up-coding, misuse of modifiers and other common schemes.

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

Our goal is to process claims consistently and in accordance with best practice standards. If a claim coding is identified as contrary to AMA, CMS, FDA and State Medicaid guidelines, the provider will be notified of the same, and WellCare will seek to remedy the issue. Providers will receive notification that claim coding error was detected based on edits that include, but are not limited to, AMA, CMS, FDA and state Medicaid guidelines. That includes high dollar claims, unbundled procedures, modifiers, Correct Coding Initiatives edits, duplicates, maximum units, multiple surgeries, and bilateral procedures, all of which WellCare actively monitors for FWA. Federal and state regulatory agencies, law enforcement, and WellCare vigorously investigate incidents of suspected fraud and abuse. Providers are cautioned that unbundling, fragmenting, up-coding and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD), Physicians’ Current Procedural Terminology (CPT), the Healthcare Common Procedure Coding System (HCPCS), and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

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

Participating providers must be in compliance with all CMS rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicaid managed care organization meet annual compliance and education training requirements with respect to
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 on WellCare’s website at [https://florida.wellcare.com/provider/resources](https://florida.wellcare.com/provider/resources) or call our confidential and toll-free WellCare compliance hotline. Details of the corporate ethics and compliance program, and how to contact the WellCare fraud hotline, are on WellCare’s website at [https://www.wellcare.com/AboutUs/default](https://www.wellcare.com/AboutUs/default).

To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at [1-888-419-3456](tel:1-888-419-3456) or complete a Medicaid Fraud and Abuse Complaint Form which is available online at [https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx](https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx).

If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program. Call toll-free at [1-866-966-7226](tel:1-866-966-7226) or [1-850-414-3990](tel:1-850-414-3990). The reward may be up to 25 percent of the amount recovered, or a maximum of $500,000 per case (Florida Statutes Chapter 409.9203). You can talk to the Attorney General’s Office about keeping your identity confidential and protected.

### Confidentiality of Member Information and Release of Records

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

Every provider practice is required to provide members with information regarding their privacy practices and to the extent required by law, with their Notice of Privacy Practices (NPP). The NPP advises members how the provider practice may use and share a member's PHI and how a member can exercise his or her health privacy rights. HIPAA provides for the release of member medical records to WellCare for payment purposes and/or health plan operations. HIPAA regulations require each covered entity, such as health care 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 mental care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number (SSN), etc.;
• Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem; and
• Any communicable disease, such as Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) testing that is protected under federal or state law.

Refer to Section 3: Quality Improvement for guidance in responding to WellCare’s requests for member health records for the purposes of treatment, payment and health care 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 Customer Service 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* on WellCare’s website at [https://florida.wellcare.com/provider/resources](https://florida.wellcare.com/provider/resources).
Section 9: Delegated Entities

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

Compliance
WellCare's compliance responsibilities extend to delegated entities, including, without limitation:
- Compliance Plan;
- HIPAA Privacy and Security;
- Fraud, Waste and Abuse Training;
- Cultural Competency Plan; and
- Disaster Recovery and Business Continuity.

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

WellCare ensures compliance through the delegation oversight process and the Delegation Oversight Committee (DOC). The DOC and its committee representatives:
- Ensure that all delegated entities are eligible for participation in the Medicaid and Medicare programs;
- Ensure that WellCare has written agreements with each delegated entity that specifies the responsibilities of the delegated entity and WellCare, reporting requirements and delegated activities in a clear and understandable manner;
- Ensure that the appropriate WellCare associates have properly evaluated the entity's ability to perform the delegated activities prior to delegation;
- Provide formal, ongoing monitoring of the entity’s performance at least annually, including monitoring to ensure quality of care and quality of service is not compromised by financial incentives;
- Impose sanctions up to and including the revocation and/or termination of delegation if the delegated entity’s performance is inadequate;
- Assure the delegated entity is in compliance with the requirement in 42 CFR 438;
- Assure that each delegated subcontract:
  - Identifies the population covered by the delegated subcontract;
  - Specifies the amount, duration and scope of services to be provided by the delegated subcontractor;
  - Specifies the term and the procedures and criteria for termination;
  - Specifies that delegated subcontractors use only Agency-participating Medicaid providers in accordance with the Florida Contract;
  - Makes full disclosure of the method and amount of compensation or other consideration to be received from WellCare;
  - Provides for monitoring by WellCare of the quality of services rendered to members, in accordance with the Florida Contract;
  - Provides that the Agency and Department of Health and Human Services (DHHS) may evaluate through inspection or other means the quality, appropriateness and timeliness of services performed;
o Provide for inspections of any records pertinent to the Florida Contract by the Agency and DHHS;

o Requires that records be maintained for a minimum of no less than 10 years from the close of the Florida Contract and after final payment is made under the Florida contract. If an audit, litigation or other action involving the records is started before the end of the 10 year period, the records must be retained until all issues arising out of the action are resolved; (Prior approval for the disposition of records must be requested and approved by WellCare if the subcontract is continuous);

o Where the delegated subcontractor agrees to provide Covered Services, contain no provision that provides incentives, monetary or otherwise, for the withholding from members of medically necessary Covered Services;

o Contains a prohibition on assignment, or on any further subcontracting, without the prior written consent of the subcontractor;

o Specifies that delegated subcontractor agrees to submit encounter records in the format specified by the Agency so that WellCare can meet the Agency's specifications required by the Florida Contract;

o Incorporates all the provisions of the Florida Contract to the fullest extent applicable to the service or activity delegated pursuant to the delegated subcontract, including without limitation, the obligation to comply with all applicable federal and Agency laws and regulations;

o Provides for WellCare to monitor the delegated subcontractor's performance on an ongoing basis, including those with accreditation; the frequency and method of reporting to WellCare, the process by which WellCare evaluates the delegated subcontractor’s performance; and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually;

o Specifies that a delegated subcontractor with NCQA®, URAC or other national accreditation shall provide WellCare with a copy of its current certificate of accreditation together with a copy of the survey report;

o Provides a process for the delegated subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action;

o Specifies the remedies, up to and including revocation of the delegated subcontract available to WellCare if the delegated subcontractor does not fulfill its obligations; and

o Contains provisions that require suspected fraud and abuse be reported to WellCare.
Section 10: Behavioral Health

Overview
WellCare provides a behavioral health benefit for Medicaid and Healthy Kids 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 uses InterQual criteria for mental health and American Society for Addiction Medicine (ASAM) criteria, for substance abuse. Both criteria are well-known and nationally accepted guideline for assessing level of care criteria for behavioral health.

For complete information regarding benefits and exclusions, or in the event you need to contact WellCare’s Customer Service for a referral to a behavioral health provider, refer to the Quick Reference Guide, which may be found on WellCare’s website at https://florida.wellcare.com/provider/resources.

Behavioral Health Program
WellCare does not require prior authorization for standard outpatient services. We encourage community-based services and member treatment at the least restrictive level of care, whenever possible.

Prior authorization is required for psychological testing, intensive outpatient, partial hospital programs, residential treatment programs and inpatient hospital services. Prior authorization 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 on our website at https://florida.wellcare.com/provider/behavioral_health.

Continuity and Coordination of Care between Medical Care and Behavioral Health Care
PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. Conversely, behavioral health providers may provide physical health care services if and when they are licensed to do so within the scope of their practice. Behavioral providers are required to use the DSM-IV multi-axial classification when assessing the member for behavioral health services and document the DSM-IV 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. The Plan encourages behavioral health providers to pay particular attention to communicating with PCPs at the time of discharge from an inpatient hospitalization (the Plan recommends faxing the discharge instruction sheet, or a letter summarizing the hospital stay, to the PCP). Please send this communication, with the properly signed consent, to the members identified PCP noting any changes in the treatment plan on the day of discharge.
We strongly encourage open communication between PCPs and behavioral health providers. If a member’s medical or behavioral condition changes, WellCare expects that both PCPs and behavioral health providers will communicate those changes to each other, especially if there are any changes in medications that need to be discussed and coordinated between providers.

To maintain continuity of care, patient safety and member well-being, communication between behavioral health care providers and medical care providers is critical, especially for members with co-morbidities receiving pharmacological therapy. Fostering a culture of collaboration and cooperation will help sustain a seamless continuum of care between medical and behavioral health and thus impact member outcomes.

**Responsibilities of Behavioral Health Providers**

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

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH Provider – Urgent</td>
<td>Within one (1) day of the request</td>
</tr>
<tr>
<td>BH Provider – Sick Care</td>
<td>Within one (1) week of the request</td>
</tr>
<tr>
<td>BH Provider – Well Care Visit</td>
<td>Within one (1) month of the request</td>
</tr>
</tbody>
</table>

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

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

Behavioral health providers are expected to 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 our website.

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 (Staywell’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 our 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;
- Network Improvement Program (NIP); and
- Exactus™ Pharmacy Solutions.

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

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

To contact WellCare’s Pharmacy department, please refer to the *Quick Reference Guide* which may be found on WellCare’s website at [https://florida.wellcare.com/provider/resources](https://florida.wellcare.com/provider/resources).

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

The PDL is a published prescribing reference and clinical guide of prescription drug products selected by the Pharmacy and Therapeutics Committee (P&T Committee). MMA Managed Care Plans and Comprehensive Managed Care Plans shall provide all prescription drugs listed in the Agency’s Medicaid Preferred Drug List (PDL). The Managed Care Plan shall participate in the Agency’s Pharmaceutical and Therapeutics Committee, as requested by the Agency. The PDL denotes any of the pharmacy utilization management tools that apply to a particular pharmaceutical.

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).
Both the Staywell and HealthEase/Staywell Healthy Kids PDLs can be found on our website at https://florida.wellcare.com/provider/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; and/or
- Pharmacy and provider communication that detail any major changes to a particular therapy or therapeutic class.

**Additions to the Preferred Drug List**

To request consideration for the addition of a drug to WellCare’s PDL, providers may write or fax WellCare explaining the medical justification. For contact information, refer to the Quick Reference Guide on WellCare’s website at https://florida.wellcare.com/provider/resources.

For more information on requesting exceptions, refer to the Coverage Determination Review Process below.

**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 Agency’s PDL or on WellCare’s PDL have been evaluated through the use of clinical literature and are approved by the corresponding P&T Committee.

Medications requiring step therapy are identified on the PDL.
**Quantity Limits**

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

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

**Age Limits**

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

Medications with age limits are identified on the PDL.

**Injectable and Infusion Services**

Select self-injectable and infusion drugs are covered under the outpatient pharmacy benefit. Some self-injectable products and infusion drugs listed on the PDL and all non-PDL injectables will require a Coverage Determination Request Review using the Injectable Infusion Form.

Approved self-injectable and infusion drugs are covered when supplied by retail pharmacies and infusion vendors contracted with WellCare. Please contact the Pharmacy department regarding criteria related to specific drugs. The specific J-codes of any self-injectable products that do not require authorization when administered in a doctor's office are included on the No Authorization Required Medical Injectable List.

Refer to WellCare's website at [https://florida.wellcare.com/provider/pharmacy](https://florida.wellcare.com/provider/pharmacy) for more information. You may access the No Authorization Required Medical Injectable List under the Pharmacy tab on the provider page, and access the Injectable Infusion Form in the Forms and Documents section on the Provider Resources page.

**Coverage Limitations**

WellCare covers all drug categories currently available through the Florida 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;
- Agents used for cosmetic purposes or hair growth;
- Cough and cold combination medications for members 21 years of age and older;
- 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; and
- Agents prescribed for any indication that is not medically accepted.

WellCare will not reimburse for prescriptions for early refills, duplicate therapy or excessively high dosages for the member.

**Smoking Cessation therapy**

WellCare will provide members who want to quit smoking with nicotine replacement therapy for no more than 24 weeks, or the manufacturer's recommended duration, per year. Covered therapies include transdermal nicotine patches, gum or lozenges containing nicotine, bupropion tablets and Chantix tablets.
Hemophilia Medications

Staywell and HealthEase Healthy Kids benefits cover hemophilia factor-related medications. For Staywell members, hemophilia factor-related medications are identified by the Agency for distribution through the Comprehensive Hemophilia Disease Management Program. WellCare shall coordinate the care of its members with the Agency-approved organizations, but is not responsible for the distribution of hemophilia-related drugs.

Informed Consent for Psychotropic Medications

All prescriptions for psychotropic medications prescribed for a child under the age of 13 must be accompanied by the express, written and informed consent of the child’s parent or legal guardian. Psychotropic (psychotherapeutic) medications include antipsychotics, antidepressants, antianxiety medications, and mood stabilizers. Anticonvulsants and attention-deficit/hyperactivity disorder (ADHD) medications (stimulants and non-stimulants) are not included at this time. For purposes of this Manual, and pursuant to Florida statute 394.492(3), “child” means a person from birth until the person’s thirteenth birthday.

The prescriber must document the consent in the child’s medical record and provide the pharmacy with a signed attestation of the consent with the prescription. The prescriber must ensure completion of an appropriate attestation form.

The completed form must be filed with the prescription (hardcopy or imaged) in the pharmacy and held for audit purposes for a minimum of six years. Pharmacies may not add refills to old prescriptions to circumvent the need for an updated informed consent form. Every new prescription will require a new informed consent form. The informed consent forms do not replace prior authorization requirements for non-PDL medications or prior authorized antipsychotics for children and adolescents from birth through age 17.

The consent/attestation form is located on WellCare’s website at https://florida.wellcare.com/provider/forms_and_documents.

For the full Agency Health Care Alert and Provider Message, including a list of Psychotropic (Psychotherapeutic) Medications, step-by-step instructions and a variety of consent forms, refer to the Agency’s website at http://ahca.myflorida.com/Medicaid/Prescribed_Drug/med_resource.shtml.

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. Examples of OTC items listed on the PDL include:

- Multivitamins / multivitamins with iron;
- Iron;
- Non-sedating antihistamines;
- Enteric coated aspirin;
- Diphenydramine;
- Insulin & insulin syringes;
- Topical antifungals;
- Ibuprofen;
- Permethrin;
- Meclizine;
• Urine test strips; and
• H-2 receptor antagonists.

For a complete listing of covered OTC medications, please refer to the PDL on our website at 

**Pharmacy Lock-In Program**

Members identified as over-utilizing drugs in certain therapeutic classes, receiving duplicative therapy from multiple physicians, or frequently visiting the Emergency Room seeking pain medication will be placed in Pharmacy Lock-in (Lock-in) status for a minimum of one year. While in Lock-in, the member will be restricted to one pharmacy to obtain their medications. Claims submitted by other pharmacies will not be paid for the member. Members identified will also be referred to Case Management.

Members in the Lock-in program will be reviewed annually by the P&T Committee who shall determine the need for further lock-in according to established procedures and federal regulations regarding such action.

**Member Co-Payments**

• $0 co-payment for Staywell members; and
• $5 co-payment for HealthEase and Staywell Healthy Kids members.

**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; and
• Drugs that have a step therapy edit and the first-line therapy is inappropriate.

Providers may request an exception to WellCare’s PDL verbally or in writing. For written requests, providers should complete a Coverage Determination Request Form, supplying pertinent member medical history and information. A Coverage Determination Request form may be accessed on WellCare’s website at https://florida.wellcare.com/provider/forms_and_documents.

To submit a request, orally, refer to the contact information listed on your Quick Reference Guide on WellCare’s website at https://florida.wellcare.com/provider/resources.

Upon receipt of the Coverage Determination Request, a decision is completed within 72 hours for a standard request and 24 hours for an expedited request. If authorization cannot be approved or denied, and the drug is medically necessary, up to a seven day emergency supply of the non-preferred drug can be supplied to the member.

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For WellCare, a decision is completed within 24 hours for both standard and expedited requests.

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, mail, in person or phone. The *Medication Appeals Form* is located on the website at [https://florida.wellcare.com/provider/resources](https://florida.wellcare.com/provider/resources).

For contact information, refer to the *Quick Reference Guide* on WellCare’s website at [https://florida.wellcare.com/provider/resources](https://florida.wellcare.com/provider/resources).

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 - Network Improvement Program (NIP)**
The Pharmacy Network Improvement Program (NIP) is designed to provide physicians with quarterly utilization reports to identify over-utilization and under-utilization 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 Catamaran for information on how to access pharmacy services. Contact information is located on the *Quick Reference Guide* on WellCare’s website at [https://florida.wellcare.com/provider/resources](https://florida.wellcare.com/provider/resources).

**Exactus Pharmacy Solutions**
WellCare offers specialty pharmacy services to members who are taking medications to treat long-term, life-threatening or rare conditions. The Exactus Pharmacy Solutions team has expertise in the special handling, storage and administration that injectables, infusibles, orals and other medications require. This team knows the insurance process and the member's plan benefits. This means less chance of delays in a member receiving their needed medication(s). Prescription orders generally ship directly to the member’s home, provider’s office, or alternative address provided by the member, within 24 to 48 hours after contacting an Exactus Pharmacy Solutions representative. The actual ship date depends on whether or not provider discussion is needed about the prescription.

To learn more about the conditions covered under Exactus Pharmacy Solutions, or how to contact them, refer to the Exactus Pharmacy Solutions website at [https://www.wellcare.com/provider/ExactusPharmacySolutions](https://www.wellcare.com/provider/ExactusPharmacySolutions).
Section 12: Definitions

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

**Action** means, pursuant to 42 CFR 438.400(b), the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the state; or the failure of WellCare to act within ninety (90) days from the date WellCare receives a grievance, or forty-five (45) days from the date WellCare receives an appeal. For a resident of a rural area with only one (1) managed care entity, the denial of an enrollee's request to exercise the right to obtain services outside the network.

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

**Agency** means state of Florida, Agency for Health Care Administration.

**Appeal** means a formal request from an enrollee to seek a review of an action 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.

**Benefit Plan** means a schedule of health care services to be delivered or other health covered service contract or coverage document (a) issued by WellCare or (b) administered by WellCare pursuant to a Government Contract. Benefit Plans and their designs are subject to change periodically.

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

**Calendar Days** means all seven days of the week.

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

**Centers for Medicare & Medicaid Services (CMS)** means the agency within the United States 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 Check-Up-Program (CHCUP)** means a set of comprehensive and preventive health examinations provided on a periodic basis to identify and correct medical conditions in children/adolescents. Refer to the “EPSDT” definition for more information.

**Children/Adolescents** means members under the age of twenty-one (21). For purposes of the provision of Behavioral Health services, means members under the age of eighteen (18) as defined by the Department of Children and Families (DCF).

**Clean Claim** means a claim for Covered Services that a) is received timely by WellCare, b) can be processed without obtaining additional information from the provider of the service or from a third party and, c) is 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 Children and Families (DCF)** means state of Florida, Department of Children and Families.

**EPSDT** means Early and Periodic Screening, Diagnosis and Treatment program that provides medically necessary health care, diagnostic services, preventive services, rehabilitative services, treatment and other measures described in 42 USC Section 1396d(a), to all members under the age of 21.

**Emergency Medical Condition** means (a) a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in any of the following: (1) serious jeopardy to the health of a patient, including a pregnant woman or fetus; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part. (b) With respect to a pregnant woman: (1) that there is inadequate time to effect safe transfer to another hospital prior to delivery; (2) that a transfer may pose a threat to the health and safety of the patient or fetus; (3) that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes (see Section 395.002, F.S.).

**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.

**Grievance** means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or WellCare employee or failure to respect the enrollee's rights.

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

**LTAC** means a Long-Term Acute Care hospital.

**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 Health Care 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 our Plan.

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

**Periodicity Schedule** means the schedule which defines age-appropriate services and timeframes 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 WellCare staff or contracted physician practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, advanced registered nurse practitioner, physician assistant or other specialty approved by the Agency, who furnishes primary care and patient management services to an enrollee.

**Prior Authorization** means the act of authorizing specific services before they are rendered.
**Provider** means a person or entity eligible to provide Medicaid services and that has a contractual agreement with WellCare to provide services. PSN fee-for-service providers must have an active Medicaid provider agreement. All other providers must be eligible for a Medicaid provider agreement.

**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 an enrollee's physical or mental condition to determine evidence or indications of problems and need for further evaluation.

**Service** means health care, treatment, a procedure, supply, item or equipment.

**Service Location** means any location at which a member may obtain any health care 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 an enrollee's activity (e.g., infectious illnesses, flu, respiratory ailments, etc.).

**WellCare Companion Guide** means the transaction guide that sets forth data requirements and electronic transaction requirements for Clean Claims and Encounter Data submitted to WellCare or its Affiliates, as amended from time to time. The WellCare Claims/Encounter Companion Guides are part of the Provider Manual.
## Section 13: WellCare/Staywell Resources

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<td>Staywell Customer Service/Provider Service</td>
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<td>TTY/TDD</td>
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<tr>
<td>24-Hour Nurse Advice Line</td>
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<tr>
<td>24-Hour Mental Health Crisis Line</td>
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<tr>
<td>Fraud, Waste and Abuse Hotline</td>
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</table>

To report abuse, neglect or exploitation (including elder)

Florida Abuse Hotline: 1-800-96-ABUSE (1-800-962-2873)
(TTY/TDD 1-800-453-5145)

You can also report abuse through the DCF website:
http://www.dcf.state.fl.us/abuse/report/

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Forms and Documents
https://florida.wellcare.com/provider/forms_and_documents

Quick Reference Guide
https://florida.wellcare.com/provider/resources

Clinical Practice Guidelines
http://www.wellcare.com/provider/cpgs

Clinical Coverage Guidelines
https://www.wellcare.com/provider/ccgs

Job Aids and Resource Guides
https://florida.wellcare.com/provider/job_aids_and_resource_guides

Provider Orientation
https://florida.wellcare.com
You must be a registered user of WellCare’s secure online Provider Portal to access.
Appendix A: FL Medicaid and Healthy Kids Regional Map

Region 1: Escambia, Okaloosa, Santa Rosa, and Walton
Region 2: Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington
Region 3: Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Palm Beach, Sumter, Suwannee, and Union
Region 4: Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia
Region 5: Pasco and Pinellas
Region 6: Hernando, Highlands, Hillsborough, Manatee, and Polk
Region 7: Brevard, Orange, Osceola, and Seminole
Region 8: Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota
Region 9: Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie
Region 10: Broward
Region 11: Miami-Dade and Monroe