WellCare proudly serves the Georgia Medicaid and PeachCare for Kids® members enrolled in the Georgia Families® program and women enrolled in the Planning for Healthy Babies® program.
Dear Provider Partner:

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

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

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

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

Thank you again for being a trusted WellCare provider partner!

Sincerely,

Dr. Clarence Davis
Medical Director – Georgia,
WellCare Health Plans

---

### Quality Highlights

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Quality care is a team effort. Thank you for playing a starring role!
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<td>01/23/2019</td>
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<td>03/13/2019</td>
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<td>Amended: Pharmacy Lock-In Program</td>
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<td>03/13/2019</td>
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<td>134</td>
<td>Edited the guidelines WellCare uses for BH services</td>
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Section 1: Overview

About WellCare
WellCare Health Plans, Inc., (WellCare), doing business as WellCare of Georgia, provides managed care services targeted exclusively to government-sponsored health care programs, focused on Medicaid and Medicare, including prescription drug plans, health plans for families, and the aged, blind and disabled. WellCare’s corporate office is located in Tampa, Florida. Our company serves approximately 4.4 million Members. WellCare’s experience and commitment to government-sponsored healthcare programs enable WellCare to serve its Members and Providers as well as manage its operations effectively and efficiently.

WellCare of Georgia is accredited by the National Committee for Quality Assurance (NCQA), a private nonprofit organization dedicated to improving healthcare quality.

Mission and Vision
WellCare Health Plans, Inc.’s vision is to be the leader in government-sponsored healthcare programs in partnership with the Members, Providers, governments and communities it serves. WellCare will:

- Enhance its 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 its associates.

Our company’s Values are:

- Partnership – Members are the reason WellCare is in business; Providers are WellCare’s partners in serving its Members; and regulators are the stewards of the public’s resources and trust. WellCare will deliver excellent service to its partners.
- Integrity – WellCare’s actions must consistently demonstrate a high level of integrity that earns the trust of those it serves.
- Accountability – All associates must be responsible for the commitments WellCare makes and the results it delivers.
- One Team – WellCare and its associates can expect – and are expected to demonstrate – a collaborative approach in the way they work.

Purpose of this Handbook
This Provider Handbook is intended for WellCare-contracted (participating) Medicaid Providers providing healthcare service(s) to its Members enrolled in a WellCare Medicaid Managed Care Plan. This Handbook serves as a guide to the policies and procedures governing the administration of WellCare’s Medicaid plans and is an extension of and supplements the Provider Participation Agreement (Agreement) between WellCare and its healthcare Providers including, without limitation, physicians, hospitals and ancillary Providers (collectively, Providers). This Handbook replaces and supersedes any previous versions dated prior to March 13, 2019 and is available on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid. A paper
copy, at no charge, may be obtained upon request by contacting Customer Service (Provider Services) or a Provider Relations representative.

In accordance with the policies and procedures clause of the Agreement, participating WellCare Medicaid Providers must abide by all applicable provisions contained in this Handbook. Revisions to this Handbook reflect changes made to WellCare’s policies and procedures. Revisions shall become binding thirty (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 this Handbook. A paper copy, at no charge, may be obtained upon request by contacting Customer Service (Provider Services) or a Provider Relations representative. Provider Bulletins that are state-specific may override the policies and procedures in this Handbook. Providers are encouraged to periodically check the Provider Portal on the WellCare website for updates and bulletins.

WellCare provides additional information online via the Quick Reference Guide. The Quick Reference Guide is a document that lists important addresses, phone and fax numbers, and authorization requirements. The Georgia Quick Reference Guide is available on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid.

DCH Fiscal Agent
Georgia Department of Community Health (DCH) is the state agency responsible for the administration of the Georgia Medicaid program for adults and children (i.e., Georgia Families®) and the State Children’s Health Insurance Program (S-CHIP), also known as PeachCare for Kids®. The mission of the Department of Community Health is to provide Georgians with access to affordable, quality healthcare through effective planning, purchasing, and oversight.

The Georgia Medicaid Management Information System (GAMMIS) serves as the primary web portal for Medicaid, PeachCare for Kids® and all related waiver programs administered by DCH’s Medical Assistance Plans Division. The GAMMIS portal provides timely communications, data exchange and self-service tools for Members and Providers with both secure and public access areas. Since 2010, DXC Technology serves as the fiscal agent for Medicaid and PeachCare for Kids® which includes providing site updates and maintenance to the GAMMIS portal.

As Georgia Medicaid’s fiscal agent, HPES maintains and operates the GAMMIS. Major operational functions include Provider enrollment, claims processing/resolution, Provider payment, and state and federal reporting. HPES works closely with the DCH to implement Medicaid and PeachCare for Kids® policy changes and other enhancements in the system brought about through legislative healthcare initiatives. Additional information can be found on the DCH website at: dch.georgia.gov/
WellCare’s Medicaid Programs
WellCare has contracted with the Georgia Department of Community Health (DCH) to provide Medicaid services for members enrolled in the Georgia Families® program. These products are offered to allow flexibility and offer a distinct set of benefits to fit Members or enrollee needs in each area.

WellCare serves both adults and children eligible to participate in Georgia’s Medicaid program. This program offer 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.

DCH will provide healthcare benefits to certain eligible populations through the Georgia Families® program, a full-risk, and capitated care management system.

According to DCH, the Georgia Families® program is designed to:

• Improve the healthcare status of the Member population;
• Establish a “Provider home” for Members through its use of assigned Primary Care Providers;
• Establish a climate of contractual accountability among the state, the care management organizations and the healthcare Providers;
• Slow the rate of expenditure growth in the Medicaid program; and
• Expand and strengthen a sense of Member responsibility that leads to more appropriate utilization of the healthcare system.

Certain populations will be enrolled in the Georgia Families® program (hereinafter referred to as “GF”):

Georgia Families®

• Low Income Families – Adults and children who meet the standards of the former AFDC (Aid to Families with Dependent Children) program.

• Transitional Medicaid – Former Low-Income Medicaid (LIM) families who are no longer eligible for LIM because their earned income exceeds the income limit.

• Pregnant Women (Right from the Start Medicaid – RSM) – Pregnant women with family income at or below two hundred twenty percent (220%) of the federal poverty level who receive Medicaid through the RSM program.

• Children (Right from the Start Medicaid – RSM) – Children less than nineteen (19) years of age whose family income is at or below the appropriate percentage of the federal poverty level for their age and family.

• Children (newborn) – A child born to a woman who is eligible for Medicaid on the day the child is born.
• Women Eligible Due to Breast and Cervical Cancer – Women younger than sixty-five (65) years of age who have been screened through Title XV Centers for Disease Control and Prevention (CDC) screening and have been diagnosed with breast or cervical cancer.

• Refugees – Individuals, as defined under O.C.G.A. § 38-3-3, including, but not limited to, those who have the required Immigration and Naturalization Service (INS) documentation showing they meet a status of asylees, Cuban parolees/Haitian entrants, Amerasians or human trafficking victims.

PeachCare for Kids® – The Children’s Health Insurance Program (CHIP) in Georgia.

• Children younger than nineteen (19) years of age:
  o Who have family income that is less than two hundred forty-seven percent (247%) of the federal poverty level;
  o Who are not eligible for Medicaid, or any other health insurance program; and
  o Who cannot be covered by the State Health Benefit Plan.

Planning for Healthy Babies® (otherwise known as P4HB Enrollees) – This program includes three distinct groups:

• Women ages eighteen (18) through forty-four (44) who are otherwise uninsured with family income at or below two hundred eleven percent (211%) of the federal poverty level and are eligible for family planning only services;

• Women ages eighteen (18) through forty-four (44) who are otherwise uninsured with family income at or below two hundred eleven percent (211%) of the federal poverty level who have delivered a very low birth weight infant and are eligible for Family Planning Services and Interpregnancy care services; and

• Women ages eighteen (18) through forty-four (44) who are current Medicaid recipients, have delivered a very low birth weight infant and are eligible for Resource Mother services only.
## Covered Services and Benefits for Georgia Medicaid and PeachCare for Kids® Members

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<tr>
<th>Benefits</th>
<th>Limits</th>
<th>Georgia Medicaid Co-payments</th>
<th>PeachCare for Kids® Co-payments for children at least 6 years old, but under 19 years.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory surgical services</td>
<td>$3</td>
<td>$3</td>
<td></td>
</tr>
<tr>
<td>Childbirth education services</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Dental services (preventive, diagnostic and treatment)</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Dental emergency services</td>
<td>Ages 21 and older</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Durable medical equipment (DME)</td>
<td>Devices and equipment that are primarily and customarily used for non-medical purposes are not covered. Some items include: comfort or convenience items, physical fitness equipment, incontinence items, and safety alarms and alert systems. For children under the age of 21, when Medically Necessary, these items will be covered under the EPSDT benefit.</td>
<td>$0</td>
<td>$2</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services</td>
<td>Georgia Medicaid – ages 0 up to 21 PeachCare for Kids® – ages 0 up to 19</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Emergency transportation services</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Emergency services</td>
<td>$0 (if an emergency)</td>
<td>$0 (if an emergency)</td>
<td>$3 (if not an emergency)</td>
</tr>
<tr>
<td>Family planning services and supplies</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>Limits</td>
<td>Georgia Medicaid Co-payments</td>
<td>PeachCare for Kids® Co-payments for children at least 6 years old, but under 19 years.*</td>
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<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Federally Qualified Health Center (FQHC) services</td>
<td></td>
<td>$2</td>
<td>$2</td>
</tr>
</tbody>
</table>
| WellChild Visit | • Medicaid: ages 0 to 21  
• PeachCare for Kids®: ages 0 to 19 | $0 | $0 |
<p>| Hearing services | Ages younger than 21: available under EPSDT as part of a written service plan | $0 | $0 |
| Home health services | Social, chore and hearing services, and Meals-on-Wheels are not covered | $0 | $3 |
| Hospice services | Available to Members certified as being terminally ill and having a medical prognosis of life expectancy of 6 months or less | $0 | $0 |
| IDEA (Individuals With Disabilities Education Act – Part C) | Ages 0 to 2, as Medically Necessary | $0 | $0 |
| Inpatient hospital services | Covered when Medically Necessary | $12.50 (unless admitted from an emergency room or transferred from another health facility) | $12.50 (unless admitted from an emergency room or transferred from another health facility) |
| Laboratory and radiological services | | $0 | $0 |</p>
<table>
<thead>
<tr>
<th>Benefits</th>
<th>Limits</th>
<th>Georgia Medicaid Co-payments</th>
<th>PeachCare for Kids® Co-payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health services</td>
<td>• Members older than 21: up to 30 inpatient days are covered</td>
<td>$12.50 per admission for members over age 21 (unless admitted from an emergency room or transferred to another health facility)</td>
<td>$12.50 (unless admitted from an emergency room or transferred from another health facility)</td>
</tr>
<tr>
<td></td>
<td>• Services in a state-operated mental hospital or institution for mental diseases are not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Members 21 and younger: no day limit if Medically Necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse midwife services</td>
<td></td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Nurse practitioner services</td>
<td></td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Nursing facility services</td>
<td>Long-term nursing facility stays (more than 30 days) are not covered for Members over the age of 21.</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Obstetrical services</td>
<td></td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Occupational therapy services</td>
<td>• Members younger than 21: as Medically Necessary</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>• Members 21 and older: as Medically Necessary for short-term rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthotic and prosthetic services</td>
<td>Arm, neck and head braces, artificial limbs, artificial eyes, custom-molded shoes and diabetic shoes only</td>
<td>$0</td>
<td>$3</td>
</tr>
<tr>
<td>Oral surgery</td>
<td></td>
<td>Co-pay is based on cost of services and ranges from $.50 to $3</td>
<td>Co-pay is based on cost of services and ranges from $.50 to $3</td>
</tr>
<tr>
<td>Benefits</td>
<td>Limits</td>
<td>Georgia Medicaid Co-payments</td>
<td>PeachCare for Kids® Co-payments for children at least 6 years old, but under 19 years.*</td>
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<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Outpatient hospital services</td>
<td>Non-emergency hospital services</td>
<td>$3 (non-emergency hospital services)</td>
<td>$3 (non-emergency hospital services)</td>
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</tbody>
</table>
| Physical therapy services             | • Members younger than 21: as Medically Necessary  
• Members 21 and older: as Medically Necessary for short-term rehabilitation | $0                                                               | $0                                                                                       |
<p>| Physician services (PCP visits and specialists) | Co-pay is based on cost of services and ranges from $.50 to $3 | Co-pay is based on cost of services and ranges from $.50 to $3 | Co-pay is based on cost of services and ranges from $.50 to $3 |
| Podiatry services                     | Services for flatfoot, subluxation, routine foot care, supportive devices and vitamin B-12 injections are not covered | $0                                                               | Co-pay is based on cost of services and ranges from $.50 to $3 |
| Prescription drugs                    | See WellCare’s Preferred Drug List (PDL) for the drugs WellCare covers. This list will also have drugs that may have limits such as Prior Authorization, Quantity Limits, Step Therapy, Age Limits or Gender Limits. Medications not on the Preferred Drug List may be covered with a Prior Authorization. | Co-pay is based on cost of services and ranges from $.50 to $3 | Co-pay is based on cost of services and ranges from $.50 to $3 |
| Private-duty nursing services         | $0                                          | $0                                                               | $0                                                                                       |</p>
<table>
<thead>
<tr>
<th>Benefits</th>
<th>Limits</th>
<th>Georgia Medicaid Co-payments</th>
<th>PeachCare for Kids® Co-payments for children at least 6 years old, but under 19 years.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Health Clinic (RHC) services</td>
<td>$2</td>
<td>$2</td>
<td></td>
</tr>
<tr>
<td>Speech therapy services</td>
<td>• Members younger than 21: as Medically Necessary&lt;br&gt;• Members older than 21: as Medically Necessary for short-term rehabilitation</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Substance abuse treatment services (inpatient)</td>
<td>Inpatient and rehabilitative services covered as part of a written service plan</td>
<td>$12.50</td>
<td>$12.50, unlimited if Medically Necessary</td>
</tr>
<tr>
<td>Swing bed services</td>
<td>• Services not requiring direct professional nursing care/nursing supervision are not covered&lt;br&gt;• Service must be provided within the State Hospital must have a swing bed agreement</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Targeted care management</td>
<td>Covered for:&lt;br&gt;• Pregnant women under age 21 and other pregnant women at risk for adverse outcomes&lt;br&gt;• Infants and toddlers with established risk for developmental delay&lt;br&gt;• Chronic conditions</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Benefits</td>
<td>Limits</td>
<td>Georgia Medicaid Co-payments</td>
<td>PeachCare for Kids® Co-payments for children at least 6 years old, but under 19 years.*</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------------------------------</td>
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<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Transplants (heart and lung)</td>
<td>Covered for Members younger than 21. Kidney, liver, bone marrow, and cornea are only covered transplants for ages 21 and older</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Vision services</td>
<td>Members 21 and older: covers 1 exam per year and a $100 dollar allowance for glasses</td>
<td>$0</td>
<td>Co-pay is based on cost of services and ranges from $.50 to $3</td>
</tr>
<tr>
<td></td>
<td>Members under the age of 21: Covered Services include exams and prescription eyewear.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*There are no co-pays for children under the age of six (6).

**Telemedicine services are a physician-patient encounter from one site to another. Telephone calls and internet usage which do not involve direct, in-person patient contact are not Covered Services.

**Extra Benefits for Georgia Medicaid and PeachCare for Kids® Members**
- Free over-the-counter (OTC) supplies. Members can get $12 credit for OTC items every month, for a total of $144 per year. Members can order items such as diapers, sunscreen, aspirin and more. The items can be mailed directly to the Member’s home;
- Healthy Rewards Program – Free reloadable VISA® debit card ($10-$30) for Members who complete certain healthy behaviors like visiting a PCP and getting checkups. The more healthy behaviors completed, the more healthy rewards they can earn.
- Free discount card to purchase health items for Members who complete a healthy behavior.
- Free gym membership for Members who complete a healthy behavior.
- Free Weight Watchers® Membership for qualified Members;
- Free cellphone: Members who have a high-risk pregnancy and need a cellphone to keep in touch with their Provider can get a free cellphone;
- Free Boys & Girls Clubs Membership for children ages six through eighteen (6–18). Does not include summer camp fees;
- Free Girl Scouts Membership:
- Girls ages 5–18 who join during the school year. WellCare will cover the $15 annual Membership fee and the $15 supply fee for badges and patches;
- Adult Membership – WellCare will also cover an annual Membership fee to join the Girl Scouts program;

- Free Boy Scouts of America Membership:
  - Boys ages 5–20 who join during the school year. WellCare will cover the $26 annual membership fees (includes insurance)
- Equine therapy for qualified SSI children, adults, and dually eligible Members who have a diagnosis of cerebral palsy or autism.
  - 10 free riding lessons per year
  - Must be identified by Care Management criteria
- WellCare Hugs (Prenatal Rewards Program) – Helps pregnant Members get the right care to stay healthy and have a healthy baby
- Free baby showers. Members receive a free gift, and tips for keeping mom and baby healthy
- Free personal health advisor is available to Members twenty-four (24) hours a day and seven (7) days a week
- Free maternity education booklet with tips for Members to help them stay healthy while pregnant
- Free hypoallergenic bedding available to qualified Members
- Health and wellness tools: Includes a health coach and health tips available on the website or by calling Customer Service
- Healthy Kids Club:
  - Provides health tips and tools to children ages 4–11 and their parents
  - Promotes immunizations and checkups
- Free general education diploma (GED®) Exam. Members ages sixteen (16) and older who don’t have a high school diploma can take the GED tests at no cost to them
- Adult dental for Members age 21 and older:
  - Free oral exams and cleanings every 6 months: no co-pay
  - Free annual bitewing X-ray for Members: no co-pay
  - Free simple tooth removals for Members; no co-pay
- Adult Vision for Members age 21 and older:
  - FREE eye exam: one per year for Members: no co-pay
  - $100 toward glasses for Members. Members can choose glasses outside of what is covered by Medicaid
  - Adult Members will also have the option to receive 1 of the following 4 “upgrades” during the year:
    ◊ scratch-resistant coating
    ◊ tint
    ◊ polycarbonate lenses including UV
    ◊ antireflective coating
- College Scholarship
The WellCare of Georgia Scholarship is a merit-based award available to WellCare of Georgia Members who have demonstrated academic achievement. The plan will offer ten, $5,000 scholarships. To be eligible, members must:

- Be a current active Member;
- Complete the WellCare of Georgia Scholarship Request Form (all areas must be completed);
- Must graduate from high school with a minimum 3.0 grade point average; OR
- Receive their GED® with a score of 600 or higher; OR
- Receive a minimum SAT score of 1080, OR a score of 20 or higher on the ACT.
- Selected Members must also submit proof that they are continuing their education at either a college or university.

Telemedicine
WellCare of Georgia is proud to partner with Providers to offer telemedicine services that enhance the ability of our Members to access the healthcare services they need. Telemedicine is the use of medical information exchange from one site to another via electronic communications to improve patients’ health status. It is the use of two-way, real time interactive communication equipment to exchange patient information from one site to another via an electronic communication system. This includes audio and video telecommunication equipment. The intent of our telemedicine services policy is to improve access to essential healthcare services that may not otherwise be available for our Members.

To provide coverage of Medically Necessary services using telecommunication systems, Providers must adhere to the requirements as set out in the Georgia Department of Community Health Part I Policies and Procedures for Medicaid/Peachcare for Kids® Manual as well as the Georgia Medicaid Telemedicine Handbook.

Requirements include, but are not limited to:

- The referring Provider must be licensed and practicing within the state of Georgia;
- The Member must be present and participating in the visit;
- All telemedicine activities must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996: Standards for Privacy of Individual Identifiable Health Information and all other applicable state and federal laws and regulations;
- The referring healthcare practitioner must obtain written consent from the eligible Georgia Medicaid Member prior to rendering service. If the Member is a minor child, a parent/guardian must present the child for telemedicine services and sign the consent form unless otherwise exempted by State or federal law.
WellCare of Georgia’s preferred partner for telemedicine is the Georgia Partnership for
TeleHealth (GPT). For more information, please contact GPT toll-free at 1-866-754-4325 or your WellCare Provider Relations representative.

Planning for Healthy Babies®
The Planning for Healthy Babies® (P4HB®) program offers family planning services to
women who do not receive Medicaid benefits. The goals of the program are to:
• Improve Georgia’s very low birth weight (VLBW) and low birth weight (LBW)
  rates;
• Reduce the number of unintended pregnancies;
• Provide family planning and family planning related services to low-income
  women;
• Increase child spacing intervals through effective contraceptive use; and
• Provide access to interpregnancy care (IPC) health services to women with a
  previous VLBW infant, which include access to a nurse care manager and
  Resource Mother.

Women ages eighteen (18) through forty-four (44) can join if they do not have health
insurance, their family income is below a certain level, their physician completes the
physician form (for IPC participants only), and they meet certain eligibility requirements.
Georgia women who meet the eligibility requirements for the P4HB® program will be
enrolled through the DCH enrollment process administered by the Georgia Department
of Human Services. Pregnant women enrolled in the Right from the Start Medicaid
(RSM) Program will be able to enroll when their RSM eligibility ends. For more
information visit: dch.georgia.gov/planning-healthy-babies.

Eligible Enrollees will receive a P4HB® program Membership card.

Family planning Enrollees can use the Georgia Association for Primary Health Care. For
more information, see the section titled Accessing Primary Care Services.

The Provider’s Role Is Key
As a Primary Care Provider, you’re responsible for:
• Supervising, coordinating and providing all primary care to each assigned IPC
  Enrollee;
• Coordinating and/or initiating referrals for specialty care; and
• Maintaining continuity of each IPC Enrollee’s health care and maintaining
  medical records, including documentation of all services provided by the PCP.

There are three options available to qualifying women:
• Family Planning;
• Interpregnancy Care Services (for women who have delivered a very low birth
  weight baby); or
• Resource Mother Outreach (for women on a Medicaid plan who have delivered a
  very low birth weight baby).
### Family Planning Covered Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Limits / Notes</th>
<th>Family Planning Co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency services</td>
<td>Family planning-related only (i.e., a complication after a tubal ligation procedure)</td>
<td>$0 (if an emergency related to a family planning concern)</td>
</tr>
<tr>
<td></td>
<td>$0 (if not an emergency related to a family planning concern)</td>
<td>$0 (if not an emergency related to a family planning concern)</td>
</tr>
<tr>
<td>Family planning services and</td>
<td>- Contraceptive supplies and follow-up care</td>
<td>$0</td>
</tr>
<tr>
<td>supplies</td>
<td>- Contraceptive management, education and counseling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Diagnosis and treatment of sexually transmitted infections (except for HIV/AIDS and hepatitis)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Drugs, supplies or devices related to women’s health services that are prescribed by a physician or advanced practice nurse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Drugs for the treatment of lower genital tract and genital skin infections/disorders and urinary tract infections, when the infection/disorder is identified or diagnosed during a routine/periodic family planning visit. A follow-up visit for the treatment/drugs may be covered.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Initial and annual complete physical exam, including a pelvic exam and Pap test, as well as follow-up visits which could include colposcopy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Pregnancy testing</td>
<td></td>
</tr>
<tr>
<td>FQHC services</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>Folic acid and/or multivitamin with folic acid</td>
<td>$0</td>
</tr>
<tr>
<td>Benefits</td>
<td>Limits / Notes</td>
<td>Family Planning Co-payment</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Tubal ligations (sterilizations)</td>
<td>Covered only if Member:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Is at least age 21 or older and mentally competent</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>• Voluntarily gives consent and completes all required documentation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility</td>
<td></td>
</tr>
<tr>
<td>Vaccinations</td>
<td>P4HB® Members age 18:</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>• All vaccines under the Vaccines for Children (VFC) Program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• WellCare shall provide all P4HB® Enrollees ages nineteen (19) and twenty (20) with Hepatitis B, Tetanus-Diphtheria (Td) and combined Tetanus, Diphtheria, Pertussis vaccinations according to the Advisory Committee on Immunization Practices (ACIP) guidelines as needed</td>
<td></td>
</tr>
</tbody>
</table>

**Interpregnancy Care (IPC) Covered Services**

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Limits / Notes</th>
<th>Interpregnancy Care Co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health services</td>
<td></td>
<td>$0 Substance abuse (detoxification and intensive outpatient rehabilitation)</td>
</tr>
<tr>
<td>Care management services</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Dental services</td>
<td></td>
<td>$0: 2 exams per benefit year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>X-rays once per year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 cleanings per benefit year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deep gum cleaning</td>
</tr>
<tr>
<td>Emergency services</td>
<td>Family planning-related only (i.e., a complication after a tubal ligation procedure)</td>
<td>$0 (if an emergency related to a family planning concern)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$0 (if not an emergency related to a family planning concern)</td>
</tr>
<tr>
<td>Benefits</td>
<td>Limits / Notes</td>
<td>Interpregnancy Care Co-payment</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
</tbody>
</table>
| Family planning services and supplies        | • Contraceptive supplies and follow-up care  
• Contraceptive management, education and counseling  
• Diagnosis and treatment of sexually transmitted infections (except for HIV/AIDS and hepatitis)  
• Drugs, supplies or devices related to women’s health services that are prescribed by a physician or advanced practice nurse  
• Drugs for the treatment of lower genital tract and genital skin infections/disorders and urinary tract infections, when the infection/disorder is identified or diagnosed during a routine/periodic family planning visit. A follow-up visit for the treatment/drugs may be covered.  
• Initial and annual complete physical exam, including a pelvic exam and Pap test, as well as follow-up visits which could include colposcopy  
• Pregnancy testing                                                                                                                                 | $0                            |
<p>| FQHC services                                |                                                                                                                                         | $0                            |
| Non-emergency transportation                 |                                                                                                                                         | $0                            |
| Primary care services                        | Office/outpatient visits                                                                                                                     | $0                            |
| Prescriptions                                | Folic acid and/or multivitamin with folic acid                                                                                               | $0                            |
| RHC services                                 |                                                                                                                                         | $0                            |</p>
<table>
<thead>
<tr>
<th>Benefits</th>
<th>Limits / Notes</th>
<th>Interpregnancy Care Co-payment</th>
</tr>
</thead>
</table>
| Tubal ligations (sterilizations) | Covered only if Member:  
• Is at least age 21 or older and mentally competent  
• Voluntarily gives consent and completes all required documentation  
• Is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility | $0                            |
| Vaccinations                     | P4HB® Members age 18:  
• All vaccines under the Vaccines for Children (VFC) Program  
• WellCare shall provide all P4HB® Enrollees ages nineteen (19) and twenty (20) with Hepatitis B, Tetanus-Diphtheria (Td) and combined Tetanus, Diphtheria, Pertussis vaccinations according to the Advisory Committee on Immunization Practices (ACIP) guidelines as needed | $0                            |

**P4HB® Program Interpregnancy Care (IPC) Prior Authorization Time Frames**  
For the P4HB® Program Interpregnancy Care services, the only IPC service that requires Prior Authorization is sterilization services.

See the Section 5 *Utilization Management* of this Handbook for WellCare’s other Service Authorization Decisions timeframes.

**Covered Services for Resource Mother Outreach**  
P4HB® Members may be eligible for extra support through WellCare’s Resource Mother Outreach. The Resource Mothers provide a broad range of services.

Some of these are:
- Help with personal and social problems
- Nutrition guidance
- Referral to quit smoking program
- Help with medical appointments for Member and Member’s baby
- Emotional support following substance abuse treatment
• Mentoring
• Support with PCP appointments, medication adherence and community linkage
• Help with scheduling medical and Non-emergency Transportation appointments;

There are no co-payments for Resource Mother Services.

**Provider Services**
The Provider Relations team is responsible for Provider education, recruitment, contracting, new Provider orientation, monitoring of quality and regulatory standards such as Healthcare Effectiveness Data and Information Set (HEDIS®), and investigation of Member complaints.

The Provider Operations team consists of Contract Operations, collection of credentialing and re-credentialing documents, and claims research and resolution.

WellCare offers an array of Provider services that includes initial orientation and education, either one-on-one or in a group setting, for all Providers. These sessions are hosted by WellCare’s Provider Relations representatives.

Provider Relations representatives are available to assist in many requests for participating WellCare Providers. Providers can contact their Provider Services representative for assistance or they can call the Provider Services number located on the *Quick Reference Guide* to request that a Provider Relations representative contact them.

**Interactive Voice Response (IVR) System**

**IVR system**
• New technology to expedite Provider verification and authentication within the IVR
• Provider/Member account information is sent directly to the agent’s desktop from the IVR validation process, so Providers do not have to re-enter information
• Full speech capability, allowing Providers to speak their information or use the touch-tone keypad

**Self-Service Features**
• Ability to receive Member co-pay information
• Ability to receive Member eligibility information
• Ability to request authorization and/or status information
• Unlimited claims information on full or partial payments
• Receive status for multiple lines of claim denials
• Automatic routing to the PCS claims adjustment team to dispute a denied claim
• Rejected claims information is now available through self-service

**TIPS for using our new IVR**
Providers should have the following information available with each call:
• WellCare Provider ID number
• NPI or Tax ID for validation, if Providers do not have their WellCare ID
• For claims inquiries – provide the Member’s ID number, date of birth, date of service and dollar amount
• For authorization and eligibility inquiries – provide the Member’s ID number and date of birth

Benefits of using the IVR Self-Service
• 24/7 – data availability
• No hold times
• Providers may work at their own pace
• Access information in real time
• Unlimited number of Member claim status inquiries
• Direct access to PCS – No transfers

The Phone Access Guide is posted on
www.wellcare.com/Wellcare/Georgia/Providers/Medicaid under the Providers section, Overview & Resources.

Providers may contact the appropriate departments at WellCare by referring to the Quick Reference Guide on WellCare’s website at:
www.wellcare.com/Georgia/Providers/Medicaid.

Website Resources
WellCare’s website, www.wellcare.com/en/Georgia, offers a variety of tools to assist Providers and their staff.

Available resources include:
• Provider Manuals
• Quick Reference Guides
• Clinical Practice Guidelines
• Clinical Coverage Guidelines
• WellCare Companion Guide
• Forms and documents
• Pharmacy and Provider lookup (directories)
• Authorization Lookup tool
• Training materials and job aids
• Newsletters
• Member rights and responsibilities
• Privacy statement and notice of privacy practices

Secure Provider Portal: Key Features and Benefits of Registering
WellCare’s secure online Provider Portal offers immediate access to what Providers need most. All participating Providers who create an account will be assigned permissions by a portal administrator and can use the following features:
• Claims Submission, Status, Appeal, Dispute – Submit a claim, check status, appeal or dispute claims, and download reports;
• **Member Eligibility, Co-Pay Information and More** – Verify Member eligibility, and view co-pays, benefit information, demographic information, care gaps, health conditions, visit history and more;

• **Authorization Requests** – Submit authorization requests, attach clinical documentation, check authorization status and submit appeals. Providers may also print and/or save copies of the authorization;

• **Pharmacy Services and Utilization** – View and download a copy of WellCare’s Preferred Drug List (PDL), access pharmacy utilization reports, and obtain information about WellCare pharmacy services;

• **Visit Checklist/Appointment Agenda** – Download and print a checklist for Member appointments, then submit online to get credit for WellCare’s Partnership for Quality (P4Q) program, if available;

• **Secure Inbox** – View the latest announcements for Providers and receive important messages from WellCare.

**Provider Registration Advantage**
The secure Provider Portal allows Providers to have one username and password, and be affiliated with multiple Providers/Offices. Administrators can easily manage users and permissions. Once registered for WellCare’s portal, Providers should retain their username and password information for future reference.

**How to Register**
To create an account, please refer to the *Provider Resource Guide* on WellCare’s website at [www.wellcare.com/en/Georgia](http://www.wellcare.com/en/Georgia). For more information about WellCare’s web capabilities, please call Provider Services or contact Provider Relations to schedule a website in-service.
Section 2: Georgia Health Information Network (GaHIN)

A Qualified Entity of the Georgia Health Information Network (GaHIN)

WellCare is a Qualified Entity of the GaHIN and encourages participating Providers to become a GaHIN Member User/Member Affiliate of the Network. The GaHIN is a nonprofit organization dedicated to the use and exchange of electronic health information all through the Network providing for safer, more timely and efficient patient-centered care. GaHIN is part of a public-private collaborative of healthcare stakeholders from around the state of Georgia, including Georgia Department of Community Health (DCH) and the Georgia Health Information Technology Extension Center (GA-HITEC).

GaHIN’s mission is to close the patient information gap across all care settings by working with its stakeholders and vendors to electronically connect disparate systems and data sources.

The goals of GaHIN are to:

- Improve patient-centered healthcare
- Increase provider efficiency
- Promote the health status of the state’s population

Take Advantage of GaHIN’s Products and Services

GaHIN offers two (2) products that are designed to give secure access to critical patient Protected Health Information (PHI) at the point of care and to foster greater Provider-to-Provider or health plan collaboration. In addition, the data capture and reporting capability within Georgia ConnectedCare facilitates every aspect of Meaningful Use and public health reporting.

Georgia ConnectedCare Features

Georgia ConnectedCare is a query-based exchange core service – an innovative technology solution that offers healthcare providers the ability to securely find patients, wherever and whenever they seek care – directly through the Provider’s electronic health record (EHR) system.

The following clinical information may be sent and received by Members and Member Affiliates through use of the GaHIN:

- Transcription notes (i.e., discharge summaries, histories and physicals, operative reports and emergency department reports)
- Continuity of care documents (CCDs)
- Immunization updates and queries
- Consult reports
• Referral requests
• Lab & pathology results
• Radiology reports
• Public health alerts and notification
• Admission, discharge and transfer information (planned)
• Lab & pathology ordering (planned)
• Radiology ordering (planned)
• Medicaid beneficiaries’ historical claims data (medical, dental and pharmacy)
• Bi-directional exchange of immunization information with Georgia Registry of Immunization Transaction and Services (GRITS)

**GeorgiaDirect Features**

**GeorgiaDirect** provides a personalized email address, such as [city.hospital@gadirect.net](mailto:city.hospital@gadirect.net), that enables Providers with Internet access to securely send patient health data to other authorized healthcare professionals. This service replaces less secure and inefficient methods of patient data exchange, such as faxes, unsecure email, and phone calls. The web-based software enables an environment in which all messages sent from and received by that address can be protected and processed in accordance with standards set by HIPAA.

This service is available to credentialed and authorized Georgia Providers at no charge. **GeorgiaDirect** secure email service will facilitate:

- **Referrals:** You can use GeorgiaDirect to send patient information to other Providers in your referral network
- **Transition of Care:** When transferring patients, use GeorgiaDirect to send treatment summary to other care locations
- **Hospital Discharge:** A hospital can use GeorgiaDirect to send the discharge instructions to Providers

**Features & Benefits:**

- Improve coordination of care with enhanced messaging
- Ensure secure email messaging with strict governmental standards
- Expedite referrals to reduce patient wait time and improve patient relations
- Increase Provider satisfaction with free, easy-to-use service

Below are the categories of persons and entities that may have access to GaHIN upon approval and executed appropriate contracts may access and use the network:

- Physicians
- Mid-level practitioners (physician assistants, nurse practitioners, certified nurse midwives)
- Doctors of Dentistry, Optometry and Podiatry
- Hospitals
- Safety Net Clinics
Members Right to Opt Out

The GaHIN and participating healthcare Providers take patient privacy and the security of patient health data very seriously. GaHIN policies along with state and federal law require that they use the minimum amount of personal information to ensure they are providing the right information for the right person to the right healthcare Provider.¹

Although there are many advantages for sharing patient health data, patients can choose to opt out by completing the practitioner’s opt-out form. For patients who choose to opt out, no healthcare Provider can share their electronic health record through the network. However, if the opt-out option was exercised previously and the patient changes their mind later, the patient can easily opt back into the network.

We hope you see the advantages of the GaHIN system and will decide that it’s critical to providing your patients with good health. If you would like to become a valued Member/Member Affiliate or are seeking more information related to any questions, please visit GaHIN’s website at: www.gahin.org, or contact the GaHIN office at: info@gahin.org.

How will I know if the exchange of health information is secure?

At GaHIN, privacy and security of patient information is of utmost importance. Unlike paper health record storage methods, GeorgiaDirect is built to only allow authorized Providers to view information on a “need-to-know” basis. Only Providers who have entered into a legal contract with GaHIN and agree to abide by its strict privacy and security policies and comply with all applicable federal and state laws are allowed access to their patient’s information. GaHIN complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH).

Are there any system requirements to use GeorgiaDirect messaging?

GeorgiaDirect messaging is a web-based product that does not require setup by your IT department. You would only need access to the internet to use the services.

¹ HIPAA prohibits GaHIN members and affiliates from sharing a patient’s health information for any purpose other than treatment, payment and healthcare operations without patient authorization, except in certain circumstances.
Section 3: Provider and Member Administrative Guidelines

Provider Administrative Guidelines

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

Participating WellCare Medicaid 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 contract and DCH 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 record documentation related to the provision of services to WellCare Members as required by state and federal laws;
- Provide Covered Services in a manner consistent with professionally recognized standards of healthcare [42 C.F.R. § 422.504(a)(3)(iii)];
- Use physician extenders appropriately. Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNP) should provide direct Member care within the scope of practice established by the rules and regulations of DCH and WellCare guidelines;
- Assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations;
- Clearly identify physician extender titles (examples: ARNP, PA, CNM, CRNA and other State approved physician extenders) to Members and to other healthcare professionals;
- Honor at all times any Member request to be seen by a physician rather than a physician extender;
- Administer, within the scope of practice, treatment for any Member in need of healthcare services;
- Maintain the confidentiality of Member information and records;
- Allow WellCare to use Provider performance data for quality improvement activities;
- Respond promptly to WellCare’s request(s) for medical record documentation in order to comply with regulatory requirements;
• Maintain accurate medical record documentation and adhere to all of WellCare’s policies governing content and confidentiality of medical record documentation as outlined in Section 4: Quality Improvement and Section 9: Compliance;

• Ensure that: (a) all employed physicians and other healthcare practitioners and Providers comply with the terms and conditions of the Agreement between the Provider and WellCare; (b) to the extent the physician maintains written agreements with employed physicians and other healthcare practitioners and Providers, such agreements contain similar provisions to the Agreement; and (c) the physician maintains written agreements with all contracted physicians or other healthcare 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;

• Provide patient-centered integrated care and coordinate services with behavioral health specialist;

• 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 regimens;

• Not discriminate in any manner between WellCare Medicaid Members and the Provider’s patients with commercial insurance;

• Ensure that the hours of operation offered to WellCare Members are no less than those offered to commercial Members;

• 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: (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of healthcare; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; or (g) disability;

• Freely advise and advocate on behalf of a Member regarding the health status, medical care, or treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services;

• Identify Members who are in need of services related to children’s health, domestic violence, family planning, prenatal/postpartum care, smoking cessation, or substance abuse. If indicated, Providers must refer Members to WellCare-sponsored or community-based programs; and

• 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 non-emergent transportation can be coordinated by WellCare but are administered outside of the managed care program.

Excluded services are defined as those services that are not considered Covered Benefits under the plan, and for which WellCare is not financially responsible. Providers are required to determine eligibility and Covered Services prior to rendering services.

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 Handbook and the Agreement, the Agreement shall govern.

Provider Identifiers
All participating Providers are required to have a unique Georgia Medicaid Provider number for each servicing practice location and a National Provider Identifier (NPI). For more information on NPI requirements, refer to Section 6: Claims.

Living Will and Advance Directive
Members have the right to control decisions related to their medical care, including the decision to accept or refuse medical or surgical treatment, and the right to formulate advance directives. Providers must comply with the advance directives including mental health advance directive requirements for hospitals nursing facilities, Providers of home and healthcare hospices, and CMOs specified in 42 CFR Part 49, subpart I, and 42 CFR Section 417.436(d).

Each WellCare Member (age eighteen (18) years or older and of sound mind), should receive information regarding living will and advance directives. This allows them to designate another person to make a healthcare 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 record documentation.

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

Provider Billing and Address Changes
Prior notice to a Provider Relations representative or Provider Services team 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;
• Panel changes; and/or
• Directory listing.

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

• Any contracted Provider must give at least ninety (90) days prior written notice to WellCare before terminating his or her relationship with WellCare “without cause,” unless otherwise agreed to in writing. This ensures that adequate notice may be given to WellCare Members regarding the Provider’s participation status with WellCare. Please refer to the Provider Agreement for the details regarding the specific required days for providing termination notice, as the Provider may be required by contract to give more notice than listed above;
• Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month; and
• Members in active treatment may continue Medically Necessary care for up to 90 days after the Provider termination, unless the Member completes the treatment or selects another treating Provider before then.

Please refer to Section 7: Credentialing of this Handbook for specific guidelines regarding rights to appeal plan termination (if any).

Note: 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 except under the following circumstances:

• A Provider becomes physically unable to care for Members due to illness;
• The Provider is deceased;
• The Provider moves outside of the service area and fails to notify WellCare; or
• The Provider fails credentialing.

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 Healthcare Needs
Individuals with Special Healthcare Needs (ISHCN) include Members with the following conditions, but not limited to:

• Intellectual disabilities 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 healthcare needs:
• Assess Members and develop plans of care for those Members determined to need courses of treatment or regular care;
• Coordinate treatment plans with Members, family and/or specialists caring for Members;
• Plan of care should adhere to community standards and any applicable sponsoring government agency quality assurance and utilization review standards;
• Allow Members needing courses of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as appropriate for the Members’ conditions or needs;
• Coordinate with WellCare, if appropriate, to ensure that each Member has an ongoing source of primary care appropriate to his or her needs, and a person or entity formally designated as primarily responsible for coordinating the 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 ISHCN, refer to Section 5: Utilization Management, Care Management and Disease Management.

Access Standards
Providers must adhere to the standards of timeliness for appointments and in-office waiting times for various types of services that 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 appointments and in-office waiting times. Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare.

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP – (Adult &amp; Pediatric Sick Visits)</td>
<td>&lt; 24 clock hours</td>
</tr>
<tr>
<td>PCP – Routine Well Care</td>
<td>&lt; 14 calendar days</td>
</tr>
<tr>
<td>Specialist – Routine</td>
<td>&lt; 30 calendar days</td>
</tr>
<tr>
<td>Well-Child Visit</td>
<td>&lt; 90 calendar days</td>
</tr>
<tr>
<td>OB/GYN – 1st Trimester</td>
<td>&lt; 14 calendar days</td>
</tr>
<tr>
<td>Dental – Routine</td>
<td>&lt; 21 calendar days</td>
</tr>
<tr>
<td>Dental – Urgent</td>
<td>&lt; 48 hours</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>&lt; 24 hours</td>
</tr>
<tr>
<td>Appointment Type</td>
<td>Access Standard</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>Elective Hospitalizations</td>
<td>&lt; 30 calendar days</td>
</tr>
<tr>
<td>Urgent After Hours Calls</td>
<td>&lt; 20 minutes</td>
</tr>
<tr>
<td>Non-Urgent After Hours Calls</td>
<td>&lt; 1 hour</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>&lt; 10 calendar days</td>
</tr>
<tr>
<td>Emergency Provider</td>
<td>Immediately (24 hours a day, 7 days per week) and without Prior Authorization</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scheduling Type</th>
<th>Wait Time Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduled Appointments</td>
<td>&lt; 60 minutes; and after 30 minutes, Member must be given an update on waiting time with an option of waiting or rescheduling appointment</td>
</tr>
<tr>
<td>Work-in or Walk-in Appointments</td>
<td>&lt; 90 minutes; and after 45 minutes, Member must be given an update on waiting time with an option of waiting or rescheduling appointment</td>
</tr>
</tbody>
</table>

**Responsibilities of Primary Care Physicians (PCP)**

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 twenty-one (21);
- Maintain a ratio of Members to full-time equivalent (FTE) physicians as follows:
  - One (1) physician FTE per 1,500 Medicaid, Family Planning or PeachCare for Kids® Members;
  - One (1) Advanced Registered Nurse Practitioner (ARNP) FTE for every 750 Medicaid, Family Planning or PeachCare for Kids® Members above 1,500; and
  - One (1) Physician Assistant (PA) FTE for every 750 Medicaid, Family Planning or PeachCare for 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;
- Provide or arrange for coverage of services, consultation or approval for referrals twenty-four (24) hours a day, seven (7) days a week. To ensure accessibility and availability, PCPs must provide one of the following:
  - A twenty-four (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 twenty (20) minutes if urgent or one (1) hour if non-emergent; or
• An advice nurse with access to the PCP or on-call physician within a maximum of thirty (30) minutes.

- Assure Members are aware of Non-Emergency Transportation (NET) services;
- 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 for the recommended preventive health service based on the Bright Futures™ periodicity table. For more information on encounters, refer to Section 6: Claims;
- Ensure Members use network Providers. To locate a WellCare Provider, visit www.wellcare.com/Georgia/Find-My-Plan, and
- Comply with and participate in corrective action and performance improvement plan(s).

Role of the Medical Home
A Patient-Centered Medical Home (PCMH) or "Medical Home" is a model of care which transforms the way primary care is delivered. The Agency for Healthcare Research and Quality (AHRQ) defines a medical home as “a model of the organization of primary care that delivers the core functions of primary health care”.¹ The National Committee for Quality Assurance (NCQA) defines it as “a way of organizing primary care that emphasizes care coordination and communication to transform primary care into ‘what patients want it to be’.”² This philosophy of healthcare delivery “encourages providers and care teams to meet patients where they are... It is a place where patients are treated with respect, dignity, and compassion, and enable strong and trusting relationships with providers and staff”.³

This model of care relies on the PCP to provide, manage and coordinate care and maintain a comprehensive medical record on each Member seen in his or her practice. The medical home is a model of healthcare delivery created to engage the Member and include him or her in any healthcare decisions. This model is intended to improve the efficiency and quality of the care delivered by collaborating with specialists, facilities and other Providers of care. This collaboration includes the exchange of information regarding specialty visits, any test results and clinical findings as well as information on prescriptions the specialist may have written for a Member back to the Medical Home. If a Member received care in an Emergency Department or is admitted to a hospital, the Medical Home has a process in place to receive notifications of those ED visits and hospital admissions so that the Medical Home can contact the Member for follow-up care.

WellCare encourages use of the Medical Home model of care for our Members as it has been proven to improve the quality of care they receive. The relationship between the PCP, the Member and their family is made stronger as a result of the Medical Home model which leads to the Member receiving more of their care with a PCP who knows
and understands their needs best. Medical Homes are truly Primary Care practices that emphasize the Member’s needs in every aspect of their life: physically, socially, and emotionally. The Providers in the Medical Home understand the Member’s and family’s special and health-related social and educational needs and connect them to community resources to assist the family in meeting those needs.

For Providers interested in becoming official Medical Homes using the NCQA’s Patient-Centered Medical Home (PCMH) recognition program, WellCare offers an Enhanced PCMH program providing assistance and expertise to practices. This program was launched in June 2014 and offers educational sessions, consultation and templates for many of the requirements. For a practice working on achieving their first PCMH recognition, WellCare can provide a 20% discount on the PCMH application fee through our relationship with NCQA as a Partner in Quality.

In addition to educational support to Providers working towards PCMH recognition, we also offer an incentive program for Providers that have already achieved PCMH recognition. This quarterly incentive program is available to all PCMH recognized Providers in our Georgia Medicaid Provider network.

If your practice is interested in learning more about our Enhanced PCMH program, receiving information about our Partner in Quality discount or the PCMH incentive program, please contact our PCMH team at: PCMHGA@wellcare.com or visit the Provider Portal link on our PCMH program at: www.wellcare.com/en/Georgia/Providers/Medicaid/Quality/PCMH-Recognition-Program.

Links to PCMH Websites for NCQA and The Joint Commission

For more information on the NCQA’s Patient-Centered Medical Home recognition program: www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx.

For more information on The Joint Commission’s Primary Care Medical Home certification program: www.jointcommission.org/accreditation/pchi.aspx.

REFERENCES


Dental Home
The purpose of the dental home is to:
- Have all caregivers and Members under the age of 21 know who they can see for dental care
- Emphasize the value of visiting the dentist not later than age 1
- Ensure continuity of care
- Establish good oral health habits early in life
- Build a strong dental relationship when the Member is young to decrease the need for extensive treatment later.
- Provide complete oral health for Members, and coordinate specialty referrals when necessary

The dental home is inclusive of all aspects of oral health that result from the interaction of the Member, parents, dentists, and other dental professionals resulting in an awareness of all issues impacting the Member’s oral health.

All Members under the age of 21, excluding the Planning for Healthy Babies® Enrollees, have a Primary Care Dentist (PCD) location listed on their ID cards as their “Dental Home”. This is a general or pediatric dental practice location responsible for the Member’s oral health. If the Member did not select a dentist, a specific dental practice was assigned based on claim history, age, and location. Members should be seen at their Dental Home practice at first tooth or by age 1. If the Member does not want to see the dentist listed on their ID card, they are permitted to see any participating dentist in the WellCare network, even if the dentist’s name is not on their ID card.

As the Member’s PCP, encourage the dental home as part of the Bright Futures™ recommendations, and if you see early signs of decay, make sure Members are referred to their PCD, as early detection can stop more serious issues later. The PCP sees a Member more often than the PCD, therefore providing opportunity to influence a visit to the dentist before a problem exists. If you have any questions regarding the Member’s dental home, please contact our Customer Service Department or your Provider Relations representative.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
All Providers, 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 preventive health visits, diagnostic and treatment services or referrals for all eligible Members in accordance with the current Bright Futures™ 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 immunizations in accordance with the current Advisory Committee on Immunization Practices (ACIP) guidelines;
• Providing immunizations in conjunction with EPSDT/Well-Child visits. Providers are required to use immunizations available without charge through the Vaccines for Children (VFC) program for Medicaid children eighteen (18) years old and younger; and PeachCare for Kids® Members;
• Addressing unresolved problems, referrals and results from diagnostic tests including results from previous EPSDT visits;
• Requesting a Prior Authorization for a Medically Necessary EPSDT special service in the event other healthcare, diagnostic, preventive or rehabilitative services, treatment or other measures described in 42 U.S.C. 1396d(a) are not otherwise covered under the Georgia 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 follow-up with Members to ensure they receive the necessary medical services; and
• Assisting Members with their transition to other appropriate care for children who age-out of EPSDT services.

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 eighty percent (80%) compliance with all elements of the review.

For more information on EPSDT Covered Services, refer to Section 1: Overview. For additional information regarding EPSDT requirements, see Section 4: Quality Improvement. For more information on the periodicity schedule based on the American Academy of Pediatrics® guidelines, refer to the AAP website at brightfutures.aap.org/materials-and-tools/Pages/default.aspx.

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

• Support of the Provider Relations, Provider Services, Health Services and Marketing and Sales Departments, as well as the tools and resources available on WellCare’s website at: www.wellcare.com/en/Georgia; and
• Information on WellCare’s network Providers for the purposes of referral management and discharge planning.

**Closing of Physician Panel**
When requesting closure of a physician panel to new and/or transferring WellCare Members, PCPs must:
• Submit the request in writing at least sixty (60) days (or such other period of time provided in the Agreement) prior to the effective date of closing the panel;
• Maintain the panel of all WellCare Members who were provided services before the closing of the panel; and
• Submit written notice of the re-opening 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 Medicaid (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 7: Credentialing.

In non-emergency cases, should a Provider have a covering physician/Provider who is not contracted and credentialed with WellCare, the Provider should contact WellCare for approval. For more information, refer to the Quick Reference Guide on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid.

Termination of a Member
A WellCare Provider may not seek or request to terminate his or 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 or 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 or 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 non-compliance 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 a Member form, attach supporting documentation, and fax the form to WellCare’s Provider Services. A copy of the form is available on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid.
Abuse, Neglect, or Exploitation

Mandated Reporters (definition): People in professions who have regular contact with vulnerable people such as children, disabled persons and senior citizens and are therefore legally required to report (or cause a report to be made) when abuse, neglect or exploitation is observed or suspected.

Georgia state law has identified Mandated Reporters in the Official Code of Georgia Annotated for adults and children §§ 30-5-1, et seq. and 19-7-5(c)(1) which include, but are not limited to: Physicians licensed to practice medicines, interns or residents; dentists; psychologists; chiropractors; podiatrists; pharmacists; physical therapists; occupational therapists; licensed professionals; counselors; nursing personnel; social work personnel; day care personnel; employees of a public or private agency engaged in professional health-related services; and law enforcement personnel.

As a Provider, you are classified as a Mandated Reporter. The Mandated Reporter will serve as the primary source of submitting the referral if there is reasonable cause to believe that a child or adult Member has been abused, neglected or exploited.

The report must be made immediately, but no later than 24 hours, to your local DFCS office or law enforcement to avoid penalty by law.

Substance Abuse Screening and Depression

PCPs should identify indicators of substance abuse and depression by way of a screening tool or an assessment. Sample screening tools are located on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid/Forms.

Smoking Cessation

PCPs should direct Members who smoke and wish to quit smoking to call WellCare’s Provider Services and ask to be directed to the Care Management Department. A care manager will educate the Member on national and community resources that offer assistance, as well as smoking cessation options available to the Member through WellCare. Members may also be directed to contact their local health department or the Georgia Tobacco Quit Line at 1-877-270-STOP (7867).

Adult Health Screening

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

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 ten (10) calendar days of receiving the notice of enrollment from WellCare. WellCare will mail all newly enrolled Members a Member Handbook via U.S. postal service. The Member Handbook is also available online at: www.wellcare.com/Georgia.

**Enrollment**
Members must apply for and maintain eligibility for medical assistance through their local Department of Family and Children Services (DFCS) office. Once determined eligible to participate in the Georgia Families® program, Members may elect WellCare as their healthcare plan. WellCare must obey laws that protect Members 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 assignment to WellCare, Members are provided 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 and other value-added items or services, if applicable.

**Member Identification Cards**
Member identification cards are intended to identify WellCare Members, the type of plan they have and to facilitate their interactions with healthcare Providers. Information found on the Member identification card may include the Member’s name, identification number, plan type, PCP’s name and telephone number, co-payment information, 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 cardholder.

**Eligibility Verification**
A Member’s eligibility status can change at any time. Therefore, all Providers are encouraged to request and copy a Member’s identification card, along with additional proof of identification such as photo identification, and file them in the patient’s medical record. In addition, Providers should access the secure portal of WellCare’s website at: www.wellcare.com/Georgia/Providers to validate a Member’s eligibility status. Providers shall verify Member eligibility in accordance with the terms of the Provider Agreement, which generally requires Providers to verify eligibility prior to rendering services. During the verification process, Providers shall obtain the name of the Member’s currently assigned PCP and applicable co-pay information.
Providers must verify eligibility as follows:

- Access the secure, online Georgia Medicaid Management System (GAMMIS) Portal at: [www.mmis.georgia.gov](http://www.mmis.georgia.gov). Additionally, Providers may choose to begin their eligibility search through one of the following sources:
  - Access the secure, online portal of WellCare’s website at: [www.wellcare.com/Georgia/Providers](http://www.wellcare.com/Georgia/Providers);
  - Access WellCare’s Interactive Voice Response (IVR) system; and/or
  - Contact Provider Services.

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.

### Community Assistance Line – Frequently Asked Questions

**What is the Community Assistance Line?**
The Community Assistance Line (CAL) is a toll-free number that Providers can use to refer their patients. The patient can call to be connected to social services in their community. It is a way to help Members and patients address social needs that can be barriers to good health.

**Why should I refer a Member or patient to call the Community Assistance Line?**
A Member or patient can call the Community Assistance Line for a referral to a social service such as food assistance, financial assistance, utility assistance, transportation, support groups, homeless shelters and other services that are not covered through the Member’s health benefits.

**Who answers the Community Assistance Line?**
The Community Assistance Line is answered by a team of specially trained Community Liaisons in the Tampa corporate office. When a Member calls, a Community Liaison speaks to the Member to find out what social service they need. The Community Liaison then searches the Navigator social service database, and provides the WellCare Member with the contact information for the agency. Community Liaisons are also responsible for populating the Navigator System with social support services across our different markets.

**Which Members or patients should be referred to the Community Assistance Line?**
A Provider can refer any Member or patient who has a service need that is not covered through the Member’s health benefit structure such as: food assistance, financial assistance, utility assistance, transportation, support groups, homeless shelters or other services.

**When can a Member or patient call the Community Assistance Line?**
The Community Assistance Line operates Monday–Friday, from 9 a.m. to 6 p.m. Eastern.
How does a Member or patient find out about the Community Assistance Line?
There are several ways a Member may be referred to the Community Assistance Line. They may receive the number from a Provider’s office, from a WellCare associate, through Customer Service, or through informational packets mailed directly to them.

What if a Member or patient calls and the social service they need isn’t available in their area?
If a Community Liaison cannot find the social service the Member needs, it is considered a “gap.” The Community Liaison will do research to try and fill the gap, or reach out to the local community advocate for help filling the gap. Once the appropriate service is identified, the Community Liaison will call the Member back with the information.

What is the telephone number for the Community Assistance Line?
The toll-free number is 1-866-775-2192. Video Relay is 1-855-628-7552. The Community Assistance Line operates Monday–Friday, from 9 a.m. to 6 p.m. Eastern.

Member Rights and Responsibilities
WellCare Members, both adults and children, have specific Rights and Responsibilities. These rights and responsibilities are for Georgia Medicaid and PeachCare for Kids® members, and Planning for Healthy Babies® Enrollees. Members and Enrollees have the right to get information about benefits and co-payments associated with services.

Members have the responsibility to:

- Know and confirm benefits and co-payments before getting treatments
- Keep with them, and show Providers, their Georgia Medicaid Member ID and WellCare’s Member ID cards before getting services
- Protect their Member ID cards from being used by another person
- Give information that WellCare and Providers need to give care
- Follow health plans and instructions for care that they have agreed on with their Provider
- Understand their health problems
  - To understand the care they are getting, if not ask questions
  - To follow the advice of their Provider and be aware of the possible outcomes if they do not
  - To know the medicines they take and why and how to take those medicines
  - To provide accurate and truthful information that would help improve their health status
  - To follow the treatment plan agreed upon by the Member and Provider.
- Help set up treatment goals that the Member and their Providers agree to
- Report any fraud and abuse of services
- Verify that the Provider they choose is part of WellCare’s network
- Keep scheduled appointments
- Pay any co-payments per their Covered Benefits
- Participate in their care
• Show consideration and respect to health care Providers and WellCare’s associates
• Report all changes – address, telephone numbers, employment or change in family size to WellCare and DFCS

Members have the right to:
• Get information about our health plan, services, practitioners and Providers
• Get information about their benefits and co-payments associated with these services
• Get information about their rights and responsibilities
• Know the names and titles of Providers caring for them
• Be treated with respect and dignity
• Have their privacy protected
• Decide with their Provider on the care they get
• Talk openly about care they need for their health, no matter the cost or benefit coverage, and the treatment choices and risks involved (the information must be given in a way they understand)
• Have the risks, benefits and side effects of medications and other treatments explained to them
• Know about their healthcare needs after they get out of the hospital or leave a Provider's office
• Refuse care, as long as they agree to be responsible for their decision
• Refuse to take part in any medical research
• File a grievance about our plan or the care we provide; also, to know that if they do, it will not change how they are treated
• Request an appeal of an Adverse Benefit Determination decision by using our appeal process
• Not be responsible for our debts in the event of bankruptcy and not be held liable for:
  o Covered Services provided to them for which the government does not pay us
  o Covered Services provided to them for which the government or we do not pay the provider who furnished the services
  o Payments of Covered Services under a contract, referral or other arrangement to which those payments are in excess of the amount they otherwise would owe if we provided the services directly
• Be free from any form of restraint or seclusion as a means of force, discipline, convenience or revenge
• Ask for and get a copy of their medical records from their Provider; also, to ask that the records be changed/corrected if needed
  o Requests must be received in writing from the Member or the person they choose to represent them
  o The records will be provided at no cost
  o They will be sent within 14 days of receipt of the request
• Have their records kept private
• Make their healthcare wishes known through advance directives
• Have a say in our Member rights and responsibilities policy
• Exercise these rights no matter their sex, age, race, ethnicity, income, education or religion
• Have our staff observe their rights
• Have all the above rights apply to the person legally able to make decisions about their healthcare
• Be provided quality services in accordance with 42 CFR 438.206 through 438.210, including:
  o Accessibility
  o Authorization standards
  o Availability
  o Coverage
  o Coverage outside of network
  o The right to a second opinion

Assignment of Primary Care Physician
Members enrolled in a WellCare Medicaid plan must choose a PCP or they will be assigned to a PCP within WellCare’s network. To ensure quality and continuity of care, the PCP is responsible for arranging all of the Member’s healthcare needs from providing primary care services to coordinating referrals to specialists and Providers of ancillary or hospital services.

Changing Primary Care Physicians
Members may change their PCP selection at any time by calling Provider Services. The requested change will be effective:
• If received before the tenth (10th) day of the month, the PCP becomes active during that month
• If received after the tenth (10th) day of the month, the PCP becomes active the first (1st) day of the following month

Women’s Health Specialists
PCPs may also provide routine and preventive healthcare services that are specific to female Members. The female Member may select a specialist or general practicing physician as her PCP.

Hearing-Impaired, Interpreter and Sign Language Services
Hearing-impaired, interpreter and sign language services are available to WellCare Members through WellCare’s Provider Services. PCPs should coordinate these services for WellCare Members and contact Provider Services if assistance is needed. Please refer to the Quick Reference Guide for the Provider Services telephone numbers on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid.
Section 4: Quality Improvement

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

- Quantitative and qualitative improvement in Member outcomes;
- Coordination and continuity of care with seamless transitions across healthcare settings/services;
- Cultural competency;
- Patient safety and confidentiality;
- Preventive health;
- Service utilization;
- Complaints/grievances;
- Appeals;
- Adverse events;
- Disease and Care Management;
- Behavioral health services;
- Member and Provider satisfaction;
- Availability and access to quality Providers;
- Tracking and trending of data;
- Identification of issues and outcomes;
- Internal process reviews;
- Evaluation of compliance to policies and procedures related to state, federal, and accreditation standards;
- Member and Provider newsletters; and
- Medical record reviews.

The QI Program activities include monitoring clinical indicators and outcomes, appropriateness of care, quality of care, Healthcare Effectiveness Data and Information Set (HEDIS®) measures, and medical record documentation 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 action plans when appropriate) when the results are less than desired or when areas needing improvement are identified.

The goals of the QI Program are to:

- Develop and maintain a well-integrated system that continuously measures clinical and operational performance, identifies the need for and initiates meaningful corrective action when appropriate, and evaluates the result of actions taken to improve quality of care and quality of service outcomes;
- Ensure availability and access to qualified Providers;
• Establish and maintain safeguards for Member privacy, including confidentiality of Member health information;
• Engage Members in managing, maintaining or improving their current health status through fostering the development of a PCP-patient relationship and participation in care programs;
• Provide a forum for Members, Providers, various healthcare associations and community agencies to provide feedback regarding the implementation of the QI Program;
• Ensure compliance with contract requirements, regulatory statutes and accreditation agencies;
• Identify best practices for performance and quality improvement; and
• Review and revise goals annually.

Provider Participation in the Quality Improvement Program
Network Providers are contractually required to cooperate with QI activities, including, but not limited to: investigation of Potential Quality of Care issues, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) audits, and HEDIS® chart reviews.

Providers are invited to volunteer for participation in certain QI Program activities. Avenues for participation include committee representation, quality/performance improvement projects, and feedback/input via satisfaction surveys, grievances, and calls to Provider Services. WellCare seeks input from and works with Members, Providers, and community resources and agencies to actively improve the quality of care provided to Members. 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, 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.

Value-Based Purchasing Program
Value-Based Purchasing (VBP) is an enhanced approach to purchasing and program management that focuses on value over volume. It is part of a comprehensive strategy that aligns incentives for Members, Providers, suppliers and the state to achieve the program’s overarching goals. The impact of initiatives is measured in terms of access, outcomes, quality of care and savings.

WellCare of Georgia operates three Provider Incentive Programs that will serve as the foundation of our VBP Program. These programs are offered after meeting specific performance measures and reward Providers for quality and efficiency after meeting specific performance measures.

• Pay-for-Performance Quality Incentive Program
• Physician Incentive Plans
• Patient Centered Medical Home Recognition Incentive

WellCare of Georgia shall comply with the Georgia Families® DCH Quality Strategic Plan to improve the health outcomes for all Georgia Families® Members. Improved health outcomes will be documented using established performance measures. DCH uses the Centers for Medicare & Medicaid Services (CMS) issued CHIPRA (Children’s Health Insurance Program Reauthorization Act of 2009) Core Set and the Adult Core Set of Quality Measures technical specifications along with the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Agency for Healthcare Research and Quality (AHRQ) technical specifications for the Quality and health improvement performance measures.

Member Experience
On an annual basis, WellCare conducts a Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey that measures Members’ experiences with the health plan on a representative sample of Members. Satisfaction with services, quality, and access is evaluated. The results are compared to WellCare’s performance goals and national benchmarks. Improvement action plans are developed to address any areas not meeting the standard. Both Medicaid Adult and Medicaid Child CAHPS® surveys are conducted annually.

EPSDT Screening Periodicity Schedule
The required screening components of the EPSDT program should be performed in accordance with the American Academy of Pediatrics® (AAP) Bright Futures™ recommendations for preventive health/well-child checkups located at: brightfutures.aap.org/materials-and-tools/Pages/default.aspx.

A Member should have an initial EPSDT Preventive health well-child visit in the following situations:
• Within ninety (90) days of enrolling with WellCare or upon change to a new PCP, if prior medical record documentation do not indicate current compliance with the periodicity schedule; and
• Within twenty-four (24) hours of birth for newborns.

The medical record must contain documentation of a comprehensive health history in addition to an unclothed physical examination to determine if the child’s development is within the normal range for the child’s age and health history.

Each Provider office is required to have the following equipment to provide a complete EPSDT preventive health visit:
• Scale for weighing infants
• Scale for weighing children and adolescents
• Measuring board or appropriate device for measuring length or height in recumbent position for infants and children up to the age of two (2) years
• Measuring board or accurate device for measuring height in the vertical position for children who are over two (2) years old
• Blood pressure apparatus with infant, child and adult cuffs
• Audiometer
• Vision charts
• Ophthalmoscope
• Otoscope
• Developmental/Behavioral Health: Tobacco/Alcohol/Drug Use Assessment, Developmental, Autism, and Depression screening tools and supplies
  • Screening Tool for Tobacco, Alcohol or Drug Use
  • Validated Developmental Screening Tool (standardized):
    • ASQ, ASQ-3, BDI-ST, BINS, BSII, CDI, IDI, PEDS, PEDS-DM
  • Autism Screening Tool
  • Depression Screening Tool
  • Maternal Depression Screening Tool
  • Process to report vaccines to Georgia Registry of Immunization Transactions and Services (GRITS)
  • Vaccines and immunization administration supplies (including refrigerator)
  • Method for sending mandated information to Georgia Healthy Homes and Lead Poisoning Prevention Program (GHHLPPP)
  • (Optional) Blood Lead Analyzer with Protocols/Procedures
    • Assess Process for reporting all results to GHHLPPP
  • (Optional) Device for measuring Hct and Hgb

If a PCP chooses not to provide immunizations during the preventive health visit, he or she has accountability to refer the Member to another network Provider (such as a health department entity) who can provide this service in a timely manner at no cost to the Member. WellCare will expect the PCP to follow up with the referred Provider to obtain documentation regarding the provision of the immunization(s) in order to maintain an accurate and complete medical record.

EPSDT Preventive Health Visit Components

Every periodic health supervision (well-child) visit must include:
1. A comprehensive health, psychosocial and developmental history;
2. Documentation of vital signs;
3. An unclothed comprehensive physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate examination);
4. Assessment of growth and nutritional status;
5. Assessment of immunization status and provision of appropriate immunizations. (Use the Advisory Committee on Immunization Practices (ACIP) schedules);
6. Screening for vision, hearing, and development, as per AAP guidance;
7. Laboratory testing where appropriate to age and exam findings, and in line with AAP guidance. (Some testing, if not bundled, may be covered under other programs, i.e., Physician Services, DSPS, etc. Please follow those programs’ guidelines for reimbursement.);
8. Oral health screening, preventive counseling, and referral to a dentist for ongoing dental care;
9. Screening for and, if suspected, reporting of child abuse and neglect;
10. Anticipatory guidance (Health Education); and
11. Referrals/follow-ups where appropriate based on history and exam findings.

1. **Medical History Assessment**

   **History must contain, but is not limited to:**
   - Present health status and past health history of Member;
   - Developmental information;
   - Allergies and immunization history - allergies must be clearly and easily found in records;
   - Family history;
   - Dietary (nutrition) history;
   - Risk assessment of lead exposure; and
   - Refusal of Care documentation form (as necessary).

2. **Psychosocial/Behavioral Assessment and Developmental Surveillance**

   Required for all ages: This assessment should occur with each clinical encounter with the child or adolescent. Comprehensive childhood surveillance of development includes activities that will document social, emotional, communication, cognitive, and physical development concerns (this content is listed at each health supervision visit in the Bright Futures™ Guidelines (BFG) under Surveillance of Development. Psychosocial/behavioral surveillance will encourage activities and interventions to promote mental health and emotional well-being.

   - **Developmental Assessment**
     Required at ages 9 months, 18 months, and 30 months: This screening must be accomplished using one or more of the following recommended standardized developmental screening tools:
     - Ages and Stages Questionnaire (ASQ) – 2 months to 5 years
     - Ages and Stages Questionnaire – 3rd Edition (ASQ-3)
     - Battelle Developmental Inventory Screening Tool (BDI-ST) – Birth to 95 months
     - Bayley Infant Neuro-developmental Screen (BINS) – 3 months to 2 years
     - Brigance Screens-II (BSII) – Birth to 90 months Child Development Inventory (CDI) – 18 months to 6 years
     - Infant Development Inventory (IDI) – Birth to 18 months
     - Parents’ Evaluation of Developmental Status (PEDS) – Birth to 8 years
Parents’ Evaluation of Developmental Status – Developmental Milestones (PEDS-DM)

- **Autism Screening**
  Required at ages 18 months and 24 months or any time parents raise a concern. The screening should be performed with an autism-specific screening tool. The Modified Checklist for Autism in Toddlers (M-CHAT) is the recommended tool and downloadable for free at [https://m-chat.org/](https://m-chat.org/). The M-CHAT is a validated developmental screening tool for toddlers between 16 and 30 months of age, and should not be used for children younger than 16 months of age. The M-CHAT is designed to identify children who may benefit from a more thorough developmental and autism evaluation. The M-CHAT can be administered and scored as part of the preventive health visit, and also can be used by specialists or other professionals to screen for developmental delay and autism. The M-CHAT online version features the latest scoring system, Modified Checklist for Autism in Toddlers, Revised with Follow-Up (M-CHAT-R/F), making the results more sensitive in detecting developmental concerns.

  Documentation in the medical record must include a note indicating the date on which the screening was performed; a copy of the screening tool used; and documented evidence of a screening result or screening score. If indicated, document the follow-up assessment, therapeutic interventions used, referrals made, and treatments received.

- **Alcohol and Drug Use Assessment**
  Required at 11 years through 20 years of age: At all adolescent (11–20 years) visits, preteens and teens should be asked about substance use. The screening should be performed and documented or the child referred for care at any encounter when a parent raises a concern. AAP recommends using the CRAFFT screening tool which can be accessed for free at: [http://www.ceasar-boston.org/CRAFFT/](http://www.ceasar-boston.org/CRAFFT/).

  Documentation in the medical record must include evidence of assessment, identification of the screening tool used and the screening results (i.e., CRAFFT score). If indicated, document the follow-up assessment, therapeutic intervention used, referrals made, and treatments received.

- **Depression Screening:**
  Required at 12 years through 20 years of age: At all adolescent (12–20 years) visits, preteens and teens should be asked about depression.

  AAP recommends using the Patient Health Questionnaire (PHQ)-2 which can be downloaded for free at: [http://www.cqaimh.org/pdf/tool_phq2.pdf](http://www.cqaimh.org/pdf/tool_phq2.pdf) or other tools available in the Guidelines for Adolescent Depression in Primary Care (GLAD-PC). The Bright Futures™ instructions for use of the PHQ-2 questionnaire are available at:
Document the screening tool used and the screening results in the medical record. If indicated, document the follow-up assessment, therapeutic intervention used, referrals made, and treatments received.

- **Maternal Depression Screening:**
  **Required at the 1-, 2-, 4- and 6-month visits:** At all visits (1-, 2-, 4-, and 6-months), the mother of newborn child or children should be asked about depression.

The relevant AAP guidance, in concert with Bright Futures™ recommendations (https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/Developmental-Behavioral-Psychosocial-Screening-and-Assessment-Forms.aspx), references screening mothers with one of the two methods endorsed by the U.S. Preventive Task Force: (1) the Edinburgh Postnatal Depression Scale (EPDS) [can be viewed at https://psychologytools.com/epds/], or (2) the Patient Health Questionnaire-2 (PHQ-2), the two-question screening, administered at 1-, 2-, 4- and 6-months postpartum, with follow-up referral for resources and treatment.

**NOTE:** Per the Bright Futures™ guidance, “Screening should occur per ‘Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice’” (http://pediatrics.aappublications.org/content/126/5/1032).

Document the screening tool used and the screening results in the medical record. If indicated, document the follow-up assessment, therapeutic intervention used, referrals made, and treatments received.

If evidence of depression is documented, EPSDT Providers may refer the mother to the Georgia Crisis and Access Line (GCAL). The GCAL is a statewide toll-free crisis hotline which provides access to resources and services to individuals in need of crisis management for mental health, addictive disease, and crises services. The GCAL can be reached 24 hours a day, seven days a week at 1-800-715-4225 (GCAL) or accessed on the web at: https://www.valueoptions.com/referralconnect/doLogin.do?e=Z2FjbSAg

3. **Physical Assessment**
   - A comprehensive physical exam is required for periodic and catch-up visits. The physical examination is the cornerstone of pediatric evaluation. Per the federal EPSDT policy guidelines, the physical examination must be an unclothed physical inspection (unclothed means to the extent necessary to conduct a full, age-appropriate examination) that checks the general appearance of the child to determine overall health status.
     a) Skin

https://brightfutures.aap.org/Bright%20Futures%20Documents/PHQ-2%20Instructions%20for%20Use.pdf
b) Head
c) Eyes, ears, mouth, throat, teeth, gums
d) Nodes
e) Height
f) Weight
g) Body Mass Index (BMI)
h) Head circumference for infants
i) Blood pressure assessment at every visit beginning at 3 years and as indicated
j) Heart and femoral pulses
k) Pulse and respiration
l) Lungs
m) Abdomen
n) External genitalia
o) Pelvic examination on all sexually active females and, if not sexually active, adolescents should not be routinely screened for cervical dysplasia prior to age 21 years.
p) Gait
q) Extremities
r) Spine
s) Neurological evaluation

- Documentation of vital signs
- Screening for, and if suspected, reporting of child abuse and neglect

Findings on all organ systems must be documented in the medical record. A checklist type form allowing documentation of normal/abnormal findings may be used for recording the different organ systems. Abnormal findings require further evaluation, follow-up or parental counseling.

4. Diagnostic Assessment

- Vision screening

**Children from birth to 3 years of age:** A Vision Risk Assessment is needed at every visit. This risk assessment includes: ocular history, vision assessment, external inspection of the eyes and lids, ocular motility assessment, pupil and red reflex examination.

If the risk assessment is positive, refer to an ophthalmologist.

**Children 3 years and older:** A Vision Screening is required at the 3-, 4-, 5-, 6-, 8-, 10-, 12-, and 15-year-old visits. A Vision Risk Assessment should be performed at all other visits. Patients uncooperative with screening and with no history, nor signs/symptoms of problems, should be re-screened within 6 months. To test visual acuity, use age-appropriate tests. BFG suggests the Snellen letter or Symbol E charts. The use of alternative tests (HOTV or Matching Symbol, Faye Symbol, Allen Pictures) should be considered for preschoolers.
If the risk assessment is positive, conduct a vision screening. If the vision screening is positive, refer to an ophthalmologist.

If a child wears eyeglasses, assessment regarding the need for referral for optometric re-evaluation must be made based on screening with eyeglasses and the length of time since the last evaluation.

Sensory Screening documentation consists of an age-appropriate assessment, assessment results (normal or abnormal) and examinations performed and results (pass/fail) data. Appropriate follow-up or referral is needed for results outside of the normal range. Document in the medical record if the child is uncooperative and re-screen at the next well-child visit or sooner if medically indicated.

- **Dental screening**
  Every child should begin to receive oral health risk assessments by 6 months of age. ([http://pediatrics.aappublications.org/content/134/6/1224](http://pediatrics.aappublications.org/content/134/6/1224))

The AAP recommends both the establishment of a dental home and the first dental exam no later than 12 months of age. Assessing for a dental home should occur at the 12-month and 18-month through 6-year visits.


For the 12-, 18-, 24-, and 30 month visits, assess whether the child has a dental home. If no dental home is identified, perform a risk assessment and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See “Maintaining and Improving the Oral Health of Young Children” ([http://pediatrics.aappublications.org/content/134/6/1224](http://pediatrics.aappublications.org/content/134/6/1224)).

For those at high risk, consider application of fluoride varnish for caries prevention.

Document a referral or inability to refer to a dental home if one has not been established. Document the risk assessment if less than 6 years and dental home not established. Document dental appointment for older children and care per AAPD periodicity schedule. Any abnormal findings must have an appropriate intervention for all children.

An oral health risk assessment tool has been developed by the AAP/Bright Futures™. This tool can be accessed at: ([https://www.aap.org/en-us/Documents/oralhealth_RiskAssessmentTool.pdf](https://www.aap.org/en-us/Documents/oralhealth_RiskAssessmentTool.pdf))
Fluoride Varnish
Once teeth are present, the application of fluoride varnish is required and may be applied every 3–6 months in the primary care or dental office for children between the ages of 6 months and 5 years. Indications for fluoride use are noted in the 2014 AAP clinical report “Fluoride Use in Caries Prevention in the Primary Care Setting” at: 
http://pediatrics.aappublications.org/content/early/2014/08/19/peds.2014-1699

Documentation: Evidence that fluoride varnish was applied once between the ages of 6 months and 5 years OR evidence that the Provider addressed the fluoride varnish requirement and/or its importance with the parent.

Fluoride Supplementation
Starting at tooth eruption, fluoridated toothpaste is recommended. 
(http://www.aapd.org/media/policies_guidelines/g_fluoridetherapy.pdf)

Documentation: Evidence that the Provider addressed the fluoride supplementation requirement and/or its importance with the parent.

- Hearing screening
  Newborns: All newborns should receive a newborn hearing screening per the AAP “Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs” 
  (http://pediatrics.aappublications.org/content/120/4/898.full). 
  If the newborn does not pass the hearing screening, refer for a follow-up outpatient rescreening within one month. For newborns who do not pass the rescreening, refer to an audiologist.

  Georgia’s Early Hearing Detection and Intervention (EHDI) Program is housed in the Georgia Department of Public Health along with the Newborn Metabolic Screening Program and the Children’s 1st Program. These three programs maintain and support a comprehensive, coordinated, statewide public health screening and referral system. EHDI includes:
  - Screening for hearing loss in the birthing hospital;
  - Referral of newborns who do not pass the hospital screening for rescreening;
  - Referral of newborns who do not pass the rescreening for diagnostic audiological evaluation; and
  - Linkage to appropriate intervention for those babies diagnosed with hearing loss.

  Refer to the Georgia EHDI Program: https://dph.georgia.gov/EHDI for further guidance.

- Infants and toddlers under age 2 years: These children should be monitored for auditory skills, middle ear status, and developmental milestones (surveillance).
Infancy and Early Childhood visits: Conduct a risk assessment at each preventive visit during the Infancy and Early Childhood years (from the 3-to-5-days visit through the 3-year-old visit). If the risk assessment is positive, refer to an audiologist.

Middle Childhood and Adolescent visits: Conduct a risk assessment during the preventive visit at ages 7 years and 9 years. If the risk assessment is positive, refer to an audiologist.

At the 4-, 5-, 6-, 8-, and 10-year visits: Appropriate universal hearing screening (objective) is required.

At the 11 years through 20 years visits: Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 20 years. See “The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies” at: http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext

- Nutrition assessment
  Nutritional status is assessed and the findings are documented in the medical record at each Preventive Health Visit. The federal EPSDT policy guidelines mandate assessment of nutritional status but state it can be accomplished during many different parts of the exam. “Accurate measurements of height and weight...are among the most important indices of nutritional status.” “If information suggests dietary inadequacy, obesity or other nutritional problems, further assessment is indicated.”

  Documentation: Evidence of the assessment.

- Lead Screening
  Blood Lead Risk Assessment: The Blood Lead Risk Assessment is required at 6-, 9- and 18-months and 3-to-6-years per the BFG periodicity schedule. A questionnaire, based on currently accepted public health guidelines, should be administered to determine if the child is at risk for lead poisoning. A recommended tool is the Georgia Healthy Homes and Lead Poisoning Prevention Program (GHHLPPP) Blood Lead Risk Assessment Questionnaire which can be found at dph.georgia.gov/lead-screening-guidelines-children.

  Childhood Lead Risk Assessment Questions
  1. Does your child live in or often visit a house that may have been built before 1978?
  2. Does your child live in or often visit a house built before 1978 that is being remodeled or is having paint removed?
  3. Does your child live with or often visit another child that had or has an elevated blood lead level?
4. Does your child live with anyone that works at a job where lead may be found or has a hobby that uses lead?
5. Does your child chew on or eat nonfood items like paint chips or dirt?
6. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?
7. Does your child receive medicines such as greta, azarcon, kohl, or pay- loo-ah?

*Any ‘yes’ answer indicates the child is High Risk and should have a blood lead test. NOTE: All children ages 12 months and 24 months must have a blood lead test.

**Blood Lead Level Screen (BLL):**
A BLL screening (test) is required at 12 and 24 months.

All children between the ages of 36 months and 72 months must receive one Blood Lead Level (BLL) IF they have not previously been tested for lead exposure.

Note: Completing a lead risk assessment questionnaire DOES NOT count as a blood lead level screening and does not meet Medicaid requirements.

Results: A blood test result equal to or greater than 5 micrograms per deciliter (ug/dL) obtained by capillary specimen (finger stick) must be confirmed using a venous blood sample. If a child is found to have blood levels equal to or greater than 5 micrograms per deciliter (ug/dL), Providers should use their medical discretion with reference to the current Centers for Disease Control and Prevention (CDC) guidelines covering patient management and treatment, including follow-up blood tests and initiating investigations as to the source of lead where indicated. These children will be enrolled in the Plan's Lead Care Management program for follow up. (See Lead Care Management Program Description)

- **Anemia screening (Hematocrit and Hemoglobin)**
  Anemia screening is done with a report on Hemoglobin and Hematocrit (H&H) in the record. H&H is recommended at the following ages with results documented in the child’s medical record.

  **At 12 months:** Screening must be performed on all Members with documentation of a hemoglobin or hematocrit measurement.

  **At 4 months:** Selective screening may be performed on all preterm, low birth weight infants and those not on iron-fortified formula.

  **Anemia Risk Assessment:** An anemia risk assessment is required at the 4-, 15-, 18-, 24-, and 30-month visits, and annually starting at 3 years.

  Documentation includes evidence of screening, if required, and/or test results as well as any further evaluation, treatment or counseling for results outside of the
normal limits. Evidence of a risk assessment performed at the 4-, 15-, 18-, 24-, and 30-month visits, and annually thereafter starting at 3 years. This can be part of the nutrition assessment.

- **Tuberculin Risk Assessment and Test**
  Tuberculin Risk Assessment is required at the 1-, 6-, 12-, and 24-month visits, then annually beginning at age 3 years. An assessment is given using a risk assessment questionnaire. The questionnaire should assess at least four (4) major risk factors:
  
  - Contact with TB disease
  - Foreign birth
  - Foreign travel to TB endemic countries; and
  - Household contact with TB

  The AAP Bright Futures™ Guidelines for Health Supervision of Infants, Children, and Adolescents (3rd edition) recommends asking the following questions:

  1) Was your child born in a country at high risk for tuberculosis?
  2) Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?
  3) Has a family member or contact had tuberculosis or a positive tuberculin skin test?

  *Any ‘yes’ answer indicates the child is High Risk and should have a TB test that is read by a Health Professional.*

  Documentation requirements include a validated risk assessment and responses. If positive on initial risk assessment questions, there should be a TB test recorded.

  Resources: [https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx](https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx)

- **Tuberculin Test**
  TB testing is not required at any age. The TB test is only administered to a child when questions are positive on the TB risk assessment or as the practitioner designates.

  Documentation: If administered, a recorded Tuberculin skin test. If the practitioner needs to defer testing for reasons that cannot be validated with professionally written guidelines, consult with state TB experts. If a child cannot be given the screening test on this day, a follow-up visit is necessary. Document risk appropriate attempts to contact and re-schedule the appointment if the parent fails to keep the follow-up appointment.
IMPORTANT: If the TB skin test result for a high-risk child less than six (6) months is negative, please retest the child at six (6) months of age.

For more information about Tuberculosis in Georgia, including child risk screening forms, please contact 1-404-657-2634 or visit [https://dph.georgia.gov/tuberculosis-tb-prevention-and-control](https://dph.georgia.gov/tuberculosis-tb-prevention-and-control)

- **Dyslipidemia Screening**
  Dyslipidemia Risk Assessment and selective screening is conducted at 2, 4, 6, 8 year and adolescence (12 through 16 year) visits.

  Screening is done once between 9 and 11 years and once between 17 and 20 years. Universal screening is needed if not done previously in late adolescence (see periodicity schedule).

  Documentation: Results of risk assessment and screening. Abnormal findings during assessment or screening require further evaluation, follow up or parental counseling.


- **Blood Pressure Assessment**
  Children younger than 3 years: Infants and children with specific risk conditions need a blood pressure assessment. See the Bright Futures™ Guidance.

  Children 3 years and older: Blood pressure assessment is performed at every visit.

  All measurements should be documented in numerical values. All measurements outside of the normal range must have an intervention.


- **Immunizations**
  An immunization assessment is required for all children. This is a key element of preventive health services. Immunizations, if needed and appropriate, shall be given at the time of the preventive health visit. The federal EPSDT policy guidelines mandate the use of the current ACIP schedule at: [www.cdc.gov/vaccines/index.html](http://www.cdc.gov/vaccines/index.html).
All immunizations (historic and current) must be documented in the medical record and recorded in the Georgia Registry of Immunization Transactions and Services (GRITS). Refusals must be documented with a signed document.

- **Sexually Transmitted Infections (STI)/ Human Immunodeficiency Virus (HIV) Screening**
  
  Risk Assessment: At the 11 through 20 year visits.

  **Screening:** STI screening should be performed for all sexually active patients. All adolescents should be screened for HIV once between the ages of 16 and 18 years.

  **Documentation:** Evidence of screening for all sexually active patients and results or referral. Results of risk assessment and screening. Abnormal findings during assessment or screening require further evaluation, treatment, follow-up, referral or parental counseling.

90-day Non-Compliant Report – WellCare will send to each PCP, on a monthly basis, a list of EPSDT-eligible Members who have not had a preventive health visit within ninety (90) days of enrolling with WellCare and/or are not in compliance with the EPSDT periodicity schedule. The PCP is required to contact the Members’ parents or guardians to schedule an appointment. WellCare will also send letters to the parents and guardians of EPSDT-eligible children to remind them of preventive services needed based on the child’s age. If the PCP has medical record evidence that appropriate screens have occurred for the Member, this information should be sent to WellCare so that those Members can be removed from future reports.

Providers are responsible for monitoring, tracking and following up with members who have not had a preventive health visit and those who have missed appointments to assist them in obtaining an appointment.

**Clinical Practice Guidelines (CPGs)**

WellCare adopts validated evidence-based Clinical Practice Guidelines and uses the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other Provider may supersede Clinical Practice Guidelines, the guidelines provide clinical staff and Providers with information about medical standards of care (includes the diagnosis, management and treatment of the member) 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 Corporate Medical Policy Committee (MPC) and the Market Utilization Management Medical Advisory Committee (UMAC). Provider compliance with Clinical Practice Guidelines is monitored by WellCare. In addition, random audits of member medical record documentation are performed on three CPGs, (ADHD, Asthma, and Diabetes) and results are reported to the DCH. Clinical Practice Guidelines, including Preventive Health guidelines, are available on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Clinical-Guidelines/CPGs](http://www.wellcare.com/Georgia/Providers/Clinical-Guidelines/CPGs).
HEDIS®
The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than ninety percent (90%) of America’s health plans to measure performance on important dimensions of care and service.

The tool comprises ninety-four (94) measures across seven (7) domains of care, including:

- Effectiveness of Care;
- Access and Availability of Care;
- Experience of Care;
- Utilization and Risk Adjusted Utilization;
- Relative Resource Use;
- Health Plan Descriptive Information; and
- Measures Collected Using Electronic Clinical Data Systems

HEDIS measures address a broad range of important health issues. Among them are the following:

- Asthma Medication Use
- Persistence of Beta-Blocker Treatment after a Heart Attack
- Controlling High Blood Pressure
- Comprehensive Diabetes Care
- Breast Cancer Screening
- Antidepressant Medication Management
- Childhood and Adolescent Immunization Status
- Childhood and Adult Weight/BMI Assessment

See more at: [http://www.ncqa.org/hedis-quality-measurement/what-is-hedis](http://www.ncqa.org/hedis-quality-measurement/what-is-hedis)

The generation of HEDIS® performance measure rates 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 record documentation and claims data are reviewed to capture 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.

For the purposes of behavioral health, the following are a few of the measures that are currently monitored:

- **Antidepressant Medication Management**: Acute phase – 84 days of continuous therapy; continuation phase – 180 days of continuous therapy.
- **Follow-up care for children prescribed ADHD medication**: One follow-up visit within 30 days of initiation of medication. At least two follow-up visits between 4 and 9 weeks if the child is on the medication for at least 210 days.
• Patients discharged from an inpatient mental health admission receive: A follow-up visit with a mental health Provider within 7 and 30 days after discharge.

Medical Record Documentation
Medical record documentation should be comprehensive and reflect all aspects of care for each Member. Records are to be maintained in a secure, timely, legible, current, detailed, and organized manner which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Complete medical record documentation includes, but is not limited to: medical charts, prescription files, hospital records, provider specialist reports, consultant and other healthcare professionals’ findings, appointment records, and other documentation sufficient to disclose the quantity, quality appropriateness, and timeliness of service provided. Providers are required to maintain legible, accurate, and complete medical records in order to support and justify the services provided.

Medical record documentation must be signed by the person performing the service and dated.

To comply with regulatory and accreditation requirements, the Quality Improvement Department may conduct annual medical record audits in physician offices. A patient’s record will be reviewed for content and evidence that care and screenings have been documented, as applicable. Physicians will be given results at the time of the audit, and a corrective action plan will be required if the score is not higher than eighty percent (80%).

The goal of conducting medical record audits is multifold, including the ability of WellCare to assess the level of Provider compliance to documentation standards and Clinical Practice Guidelines (disease and preventive, etc.) and to gauge quality of care and patient safety practices.

All Medical Records, including all entries in the medical record:
• Should be organized in a manner to enable easy access to its content and be neat, complete, clear, concise, detailed, comprehensive and timely and include all recommendations and essential findings in accordance with good professional practice;
• Must be maintained in a manner that permits effective professional medical review and medical audit processes;
• Must be maintained in a manner that facilitates an adequate system for follow-up treatment;
• Must be signed;
• Must include the name and profession of the practitioner rendering services, for example, RN, MD, DO, including signature or initials of practitioner;
• Must be legible to readers and reviewing parties and maintained in an orderly and detailed manner;
• Must be dated and recorded in a timely manner. Late entries should include date and time of occurrence and date and time of documentation;
• Should not be altered. Corrections are to be made by a single line through the inaccurate material, dated and initialed;
• Should only include standard abbreviations and symbols;
• Must include the patient’s name or ID number on each page of the electronic or paper record;
• Should include the following personal and biographical data in the record:
  o Name;
  o Member ID;
  o Age;
  o Date of birth;
  o Sex;
  o Address;
  o Home and work telephone numbers;
  o Emergency contact;
  o Legal guardianship;
  o Marital status;
  o Name of spouse;
  o Next of kin or closest relative;
  o Employer; and
  o Insurance information or family history as applicable;
• Must reflect the primary language spoken by the Member and translation or communication needs of the Member. Translation or communication needs could reflect the need for an interpreter, sign language or Braille materials, etc., as appropriate;
• Must prominently note any adverse drug reactions and/or food allergies or “no known allergies” (NKA) and known reactions to drugs. This may include a sticker inside of the chart or prominent notation in a conspicuous place in the record;
• Tobacco/alcohol/substance use answers for patients ages 12 and older;
• Must easily identify the past medical history, including serious accidents, hospitalizations, operations, illness, prenatal care and birth as appropriate. As appropriate, medical record documentation from previous Providers should be obtained and easily accessible. Old records including past medical history, physical examinations, necessary tests and possible risk factors for the Member relevant to treatment should be used to assess the periodicity schedule and maintain continuity of care;
• Must maintain a current immunization record;
• Must provide a current medication list. This includes prescribed medications, including dosages and dates of initial or refill prescriptions or sample medications;
• Must provide a problem list, with past and current diagnoses and procedures and be used to provide continuity of care. This includes a summary of significant surgical procedures, past and current diagnoses or problems, medication reactions, health maintenance concerns, etc.;
• Must contain information about consultations, referrals and specialist reports;
• Must include notations on all forms or notes regarding follow-up care, calls or visits, when indicated;
- Must include a screening for substance abuse of tobacco, alcohol and drugs, and documentation of appropriate counseling/referrals if needed and follow-up;
- Must include a screening for domestic violence and documentation of appropriate counseling/referrals if needed, and follow-up;
- For all Members older than eighteen (18), must provide evidence that the Member was asked about or executed an advance directive, including a mental health directive, and documentation of acceptance or refusal. **Note:** The record must contain evidence that the Member was provided written information concerning the Member’s rights regarding advance directives and whether or not the Member has executed an advance directive. The Member does not have to have an advance directive completed. A signed statement that the Member has been asked if he or she has one and if not, offering one will suffice. A stamp may be used. The Provider shall not, as a condition of treatment, require the Member to execute or waive an advance directive; and
- Must detail informed consent discussions, where appropriate.

Additionally all behavioral health Medical Records, including all entries in the medical record, shall include:

**Required Components:**

A. **Linkage** – Clear link between assessment and/or re-assessment and interventions provided.
B. **Consumer profile** – Should also include observations and description of individual affect; behaviors; symptoms; and level of functioning.
C. **Specific Services/interventions/modality provided** – Specific details of all provided activities including date, time, frequency, duration, location, and when appropriate, methodology.
D. **Consumer response to interventions** – Identification of how and in what manner the service, activity and modality have impacted the individual, what was the effect and how was it evidenced.
E. **Monitoring** – Evidence that selected interventions and modalities are occurring and monitored for expected and desired outcomes.
F. **Consumer progress** – Identification of progress, or lack thereof, toward goals as well as overall progress toward wellness.
G. **Next Steps** – Targeted next steps in services and activities to support stability.

**Required progress note documentation:**

A. **Presence of Note** – For any claim submitted, a note must be present to justify the specific interventions.
B. **Service billed** – All progress notes must contain the corresponding HIPAA code which must include any designated modifiers.
C. **Timeliness** – All activities/services are documented (written and filed) within the current individual record within a pre-established time frame set by Provider policy not to exceed 7 days. Best practice guidelines should be used.
D. **Legibility** – All documentation that is handwritten must be legible and easily discernible to all the readers.
E. **Conciseness and clarity** – Clear language, grammar, syntax and sentence structure is used to describe the activity and related information.

F. **Standard format** – Providers are expected to follow best practices and select a format to create a prescribed narrative that can be used consistently throughout the Provider’s practice. Specific details regarding actual practice should be described in Providers’ policies and procedures. All formats must document a clear match or link between the progress note, assessment and treatment plan data.

G. **Security and Confidentiality** – All documentation is managed in such a manner to ensure individual confidentiality and security while providing access and availability as appropriate.

H. **Activities dated** – Documentation specifies the date/time and time of service.

I. **Dated entries** – All progress note entries should include the date of service, signature of individual providing the service and the date the individual providing the service signed the document. Back-dating and post-dating are not permitted.

J. **Duration of activities** – Documentation of the duration of the service must be noted for all services to include the number of units, times and dates. Documentation must include time-in and time-out for all services.

K. **Location of Intervention** – For services that may be billed as either in- or out-of-clinic, progress notes shall reflect the location as either. If the intervention is provided out-of-clinic, the note must reflect the specific location of the intervention; this indication must be specific enough that it can be generally understood where the service occurred.

L. **Participation in Intervention** – Progress notes must reflect the specific interaction that occurred during the reported time frame including, but not limited to, all participants (individual, family, team members) during the session.

M. **Signature, printed staff name, qualifications and/or title** – The writer of the documentation is designated by name and credentials/qualifications. If an individual is a licensed practitioner, the printed name must be on the name listed on his or her practitioner’s license on all medical record documentation. An original signature is required. The printed name must be the name and qualifications and/or title may be recorded using a stamp or typed on to the document. Automatic or electronic documentation must include a secure electronic signature.

Documentation indicating diagnostic or therapeutic intervention as part of a clinical research study is clearly contrasted from those entries pertaining to usual care.

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. Records remaining under the care, custody, and control of the physician or healthcare Provider shall be maintained for a minimum of ten (10) years from the date of when the last professional service was provided. Providers should have procedures in place to permit the timely access and submission of medical record documentation to WellCare upon request. Information from the medical record documentation audit may be used in the re-credentialing process as well as quality control.
activities. Information from the medical record documentation review may be used in the re-credentialing process as well as quality activities.

For more information on medical record documentation compliance, including confidentiality of Member information and release of records, refer to Section 9: Compliance.

Web Resources
WellCare periodically updates clinical, coverage, and preventive guidelines as well as other resource documents posted on the WellCare website. Please check WellCare’s website frequently for the latest news and updated documents at: www.wellcare.com/Georgia/Providers/Medicaid.

Patient Safety Plan

Overview
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 documentation standards, communication and coordination of care across the health care network, medication allergy awareness/documentation, drug interactions, using evidence-based Clinical Practice Guidelines to reduce practice variations, tracking and trending adverse events/quality of care issues, and grievances related to safety.

Quality of Care Issues
Quality of care issues may be generated by the Administrative Review, Customer Service, Grievance, Risk Management, Care Management and/or Utilization Management Department, or may be identified through routine record review. Quality of care issue types include:

- Delay/Omission of Care
- Procedural Issue
- Readmission within 30 Calendar Days
- Patient Safety
- Death or Serious Disability
- Post-Op Complications
- Medication Issues

These cases are referred to the Quality Improvement Department for further investigation and review by the Medical Director who determines the need for peer review via the Credentialing Committee.

If the Medical Director determines there is a possible quality of care issue, the physician will be asked, in writing, to provide additional information to address the issue. The response is reviewed and a final determination is rendered.
The determination is categorized in the following manners:

• Substantiated – There is evidence of a deviation in the standard of care; or
• Unsubstantiated – There is no evidence of a deviation from the standard of care.

Once that determination is made, the outcome is classified in the following manner:

• Adverse event; or
• No adverse event

Results of peer review activity will be reported to state and regulatory agencies as appropriate. A summary of the incident(s) including the final disposition, will be included in the Provider’s profile.

**Incident Reporting**

Any injury, regardless of degree, or any adverse or unexpected occurrence incurred by a Provider or Member should be reported to WellCare.

*Incidents* are statutorily defined as any untoward or adverse event that results in death, serious impairment of bodily function or any other result that requires medical intervention other than minimal first aid treatment. Serious incidents involving WellCare Members shall be reported to WellCare’s Risk Manager immediately as these incidents must be reported within forty-eight (48) hours of the incident. The Risk Management Department’s phone number can be found on the *Quick Reference Guide* located on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Medicaid](http://www.wellcare.com/Georgia/Providers/Medicaid).

Examples of such incidents are death, fetal death, brain damage, spinal damage, surgical procedure performed on the wrong patient or wrong site, or wrong surgical procedure performed.

Other incidents involving WellCare Members which are required to be communicated to WellCare include:

• A slip or fall;
• Medication error;
• Reaction requiring treatment;
• Abusive patient or family Member;
• A theft or loss from Provider’s office;
• Malfunction or damage of equipment during treatment;
• Accusations of malpractice by a patient or family Member; and/or
• Non-compliance which may potentially be considered life-threatening.

An *Incident Report Form*, located on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Medicaid/Forms](http://www.wellcare.com/Georgia/Providers/Medicaid/Forms), should be used to report all incidents to WellCare’s Risk Manager.

Further reporting to WellCare’s insurance carrier and governmental agencies, as appropriate, shall be arranged within the prescribed time frames by WellCare’s Risk Manager. Physicians are reminded that serious negative events or incidents which occur
in a Provider’s office or facility must be reported to the appropriate regulatory agency directly by the Provider.

**Hospital Patient Safety Program**

WellCare is committed to offering services that ensure the safe delivery of clinical care to its Members. WellCare’s Patient Safety Program exists to establish the framework for demonstrating this commitment. Through execution of standardized internal processes and collaborative participation of hospitals, WellCare’s active Patient Safety Program goals include fostering a supportive environment to provide improved patient health care and safety through reduction in avoidable medical errors. Some objectives of WellCare’s Patient Safety Program include, but are not limited to:

- Support of and ongoing collaboration with participating hospitals to encourage and endorse patient safety activities;
- Continual monitoring of performance against national patient safety benchmarks; and
- Educating hospitals about safe practices.

In support of safe clinical practices, WellCare’s policies and procedures define and also provide for the monitoring of nationally accepted quality of care indicators.

Through tracking and trending of relevant Plan metrics, WellCare can identify opportunities for improvement and facilitate education of a specific practitioner and/or the hospital community at large in order to reduce the potential for patient safety incidents.

WellCare addresses key elements of patient safety, such as coordination of care between hospitals, medical record review findings, adverse event and quality of care grievance tracking/trending, electronic medical record documentation implementation, pharmaceutical management practices and Member interactions. Annually, WellCare will define the specific areas of patient safety to be monitored which may include, but are not limited to, the following metrics as indicators of safe clinical care:

- Number of quality of care complaints per one thousand (1,000) Members;
- Number of adverse events reported per quarter;
- Percent of physician medical record documentation compliant to the standard of drug allergies or "NKA" recorded;
- Percent of hospitals using electronic medical record documentation and automated order entry systems; and
- Number of therapeutic duplications and potential drug-to-drug interactions prescribed per one thousand (1,000) Members.

Following the objectives as outlined in the Plan, WellCare will use newsletters, Provider Relations representatives, and tailored education to periodically communicate the key activities of patient safety initiatives, including network patient safety performance data and survey results.
Hospital Program Overview

WellCare is dedicated to improving safety and reducing medical errors for patients within hospitals. Participating hospitals are required to have a Patient Safety Program to identify and resolve, through process improvement, situations that could jeopardize patient safety.

Hospital Patient Safety Program Requirements

Each participating hospital must implement a Program with the following requirements:

- The Program defines, identifies and manages risks to patient safety including medical errors throughout the organization;
- Data reporting systems for the collection of data on defined processes that affect patient safety;
- Implementation of pertinent best practices for reducing medical errors and enhancing positive care outcomes;
- A system of classifying adverse events according to severity;
- Information systems that support the program by enabling mining/trending of both administrative and clinical data to identify potential patient safety topics and facilitating activity prioritization at least semiannually;
- A uniform reporting standard for adverse events, including medication errors/omissions, inappropriate use/overuse of restraints and seclusions, and delays in evaluation, testing and/or treatment;
- Processes for annual education of staff, which includes sharing of evidence-based best practices for reducing medical errors, improving patient safety, and enhancing quality of care;
- Methods for ad hoc training of staff in response to an identified safety concern, to include implementation of corrective actions for continuous improvement;
- Coordination of care to other levels of care as part of the discharge planning process, including the scheduling of follow-up appointments and education of patients regarding medication benefits and risks;
- Mechanisms for coordination of care across disciplines and the organization;
- Initial review of adverse events by the medical director, physician advisor, chief of staff or department chairperson, and a mechanism for determining which incidents will be forwarded to peer review and credentialing committees;
- Safety alerts and quick communication of strategies to prevent errors that show a connection to high-risk events; and
- Avenues for patients to participate in decisions regarding their care and to make suggestions for improving patient safety.

Program Compliance

All network hospitals accredited by The Joint Commission are expected to comply with the most current National Patient Safety Goals.

WellCare will periodically assess the status of each hospital's efforts to improve patient safety through data measures, survey results, and each hospital's actions to further communicate performance improvement findings to WellCare Members and Providers. WellCare will also seek out and publicize any best practices identified in the promotion of patient safety in the hospital setting.
If a hospital has not been accredited by The Joint Commission or has not implemented a Program, WellCare will require the hospital to submit a plan of action regarding compliance with CMS standards. If the plan of action is approved, WellCare will permit the hospital to become compliant with policy within a prescribed time period provided the plan of action is implemented.

In addition, on an annual basis, WellCare will define specific measures to be monitored as indicators of safe clinical care. These will be communicated through the Provider newsletters.
Section 5: Utilization Management (UM), Care Management (CM) and Disease Management (DM)

Utilization Management

Overview
WellCare’s Utilization Management (UM) Program is designed to meet contractual requirements with federal regulations and DCH while providing Members access to high quality, cost-effective, Medically Necessary care. For purposes of this section, terms and definitions may be contained in this section, in Section 14: Definitions of this Handbook, or both.

The goal of the UM Program is to achieve the best outcomes while providing quality healthcare at the most appropriate setting and the most appropriate time for the Members. The UM Program:

- Ensures culturally sensitive delivery of services that are Medically Necessary, appropriate, and consistent with the Member's diagnosis and level of care required.
- Provides access to the most appropriate and cost efficient healthcare services.
- Provides ongoing monitoring, tracking and trending of care rendered to WellCare Members in order to ensure that quality healthcare is provided.
- Works collaboratively with the Care Management, Disease Management, and Quality Improvement Departments by identifying and referring potential quality of care issues for review and implementation of intervention plans, as indicated.
- Monitors overutilization and underutilization, continuity and coordination of care and implements corrective action and intervention plans, as needed.
- Works collaboratively with the Provider Services Department and the Appeals and Grievance Committees with timely review and response to Member or Provider grievances/appeals relating to utilization management decisions.
- Facilitates communication and partnerships among participants, Providers, facility Providers, delegated entities, and WellCare in an effort to enhance cooperation and appropriate utilization of healthcare services.
- Monitors, implements and maintains systems to enable compliance with government and legislative requirements of utilization management processes.

Medically Necessary Services
The determination of whether a Covered Benefit or Service is Medically Necessary complies with the requirements established in WellCare’s contract with the DCH. Please refer to Section 14: Definitions for the definition of Medical Necessity.

WellCare provides to Members Medically Necessary services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services provided to beneficiaries under fee-for-service Medicaid. WellCare will ensure that services provided to each Member are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are provided.
WellCare’s Utilization Management Program includes components of Prior Authorization, prospective, concurrent, and retrospective review activities. Each component is designed to provide for the evaluation of healthcare and services based on WellCare Members’ coverage, and the appropriateness of such care and services, and to determine the extent of coverage and payment to Providers.

WellCare does not reward practitioners, Providers or associates who perform utilization reviews, including those of the delegated entities, for denials. No one is compensated or otherwise given incentives to encourage denials that result in underutilization. Utilization reviews are based on appropriateness of care and existence of coverage. Utilization denials (adverse determinations) are based on lack of Medical Necessity or lack of Covered Benefits.

**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 Georgia and professional knowledge and/or clinical expertise in the related healthcare specialty actively participate in the discussion, adoption, application and annual review and approval of all utilization decision-making criteria.

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

- InterQual™;
- LOCUS/CASII for Mental Health Treatment
- ASAM for Substance Abuse Treatment
- WellCare Clinical Coverage Guidelines;
- Medical Necessity;
- Member benefits;
- State Medicaid Contract;
- State Provider Handbooks, as appropriate;
- Local and federal statutes and laws;
- Medicaid and Medicare guidelines; and
- Hayes Health Technology Assessment.

The nurse reviewer and/or Medical Director involved in the UM process applies Medical Necessity criteria in context with the Member’s individual circumstance and the capacity of the local Provider delivery system. When the above criteria do not address the individual Member’s needs or unique circumstance, the Medical Director will use clinical judgment in making the determination.

The review criteria and guidelines are available to the Providers upon request. 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* on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Medicaid](http://www.wellcare.com/Georgia/Providers/Medicaid).
Utilization Management Process
The UM process is comprehensive and includes the following review processes:
- Notifications;
- Referrals;
- Prior Authorizations/Pre-certification (Prospective Review);
- Concurrent Review;
- Discharge Planning; and
- Retrospective Review.

The Utilization Management Department adheres to state, federal, and accreditation standards for service authorization decisions and adverse determinations, which include notification time frames. These standards are applied to urgent/expedited and routine requests for prospective, concurrent and retrospective services.

WellCare’s forms for the submission of notifications and authorization requests are on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Medicaid/Forms](http://www.wellcare.com/Georgia/Providers/Medicaid/Forms).

The Georgia Web Portal electronic forms for the submission of notifications and authorization requests can only be accessed upon login of Georgia Medicaid Management Information System (GAMMIS) at: [www.mmis.georgia.gov](http://www.mmis.georgia.gov).

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 Prenatal Program and identify Members who may benefit from the High-Risk Pregnancy Program. Obstetrical Providers are required to notify WellCare of pregnant Members via the Georgia Web Portal submission process ([www.mmis.georgia.gov](http://www.mmis.georgia.gov)) using the Prenatal Notification Form as soon as possible after the initial visit. This process will expedite care 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, including newborn delivery notifications, should be submitted via the Georgia Web Portal ([www.mmis.georgia.gov](http://www.mmis.georgia.gov)) and include Member demographics, facility name, and admitting diagnosis.

Referrals
For an initial referral to a participating Provider, 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, in the most appropriate setting. Prior Authorization may be obtained by the Member’s PCP, treating specialist, or facility. All Non-participating Providers are required to obtain Prior Authorization before rendering non-emergency related care.

Reasons for requiring Prior Authorization may include:
- Review for Medical Necessity;
- Appropriateness of rendering Provider;
- Appropriateness of setting; and/or
- Care and disease management considerations.

Prior Authorization is required for elective or non-emergency services as designated by WellCare. Prior Authorization requirements by service type may be found on the Quick Reference Guide on WellCare’s website at www.wellcare.com/Wellcare/Georgia/Providers/Medicaid.

Providers can also use WellCare’s searchable Authorization Lookup Tool (ALT) at: www.wellcare.com/Georgia/Providers/Authorization-Lookup.

Some Prior Authorization guidelines to note are:
- The Prior Authorization request should include the diagnosis to be treated and the Current Procedural Terminology (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 may not be 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 non-urgent admission.

Authorization Request Forms
WellCare encourages Providers to use WellCare’s, or the Georgia Medicaid Management Information System’s (GAMMIS) Portal (www.mmis.georgia.gov), to access standardized Prior Authorization request forms to ensure receipt of all pertinent information and enable a timely response to the Provider’s request, including:
- Inpatient Authorization Request Form is used to submit authorization requests for inpatient confinements including elective, acute, skilled nursing facility, rehabilitation, long-term and subacute admissions. Selective inpatient services require electronic submission using Georgia DCH’s electronic Prior Authorization Portal when sending to WellCare. Please check WellCare’s Authorization Lookup Tool prior to submission for more guidance and information.
• **Outpatient Authorization Request Form** is used to submit authorization requests for select outpatient surgical, diagnostic, and therapeutic services including transition of care and out-of-network requests. Some outpatient services will require online submission using the GAMMIS Portal’s standardized form when submitting to WellCare. Please check our ALT prior to submission for more guidance and information.

• **DME Services Authorization Request Form** is used to submit authorization requests for items such as motorized wheelchairs, insulin pumps and Dynasplint® Systems. You must submit your request using the GAMMIS Portal’s standardized form when submitting to WellCare.

• **Skilled Therapy Services Authorization Request Form** is used to submit authorization requests for physical therapy (PT), occupational therapy (OT) and speech therapy (ST) services. You must submit your request using the GAMMIS Portal’s standardized form when submitting to WellCare.

• **Home Health Authorization Request Form** is used to submit authorization requests for services such as skilled nursing, home health aide and skilled therapy visits that are rendered in a home setting.

• **A Prenatal Notification Form** should be completed by the obstetrician/gynecologist (OB/GYN) during the first visit and submitted to WellCare using the GAMMIS Portal’s standardized form as soon as possible after the initial visit. Notification of obstetric 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.

To ensure timely and appropriate authorization, 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 information may result in placed phone calls, and/or faxes, or a GAMMIS Portal response message to the ordering Provider for the missing information and could result in a delay for the Member.

Prior Authorization requirements by service type are on the **Quick Reference Guide** on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Medicaid](http://www.wellcare.com/Georgia/Providers/Medicaid). Providers can also use the searchable Authorization Lookup Tool located on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Authorization-Lookup](http://www.wellcare.com/Georgia/Providers/Authorization-Lookup).

Forms are located on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Medicaid/Forms](http://www.wellcare.com/Georgia/Providers/Medicaid/Forms). All forms should be submitted via fax to the number listed on the form. Electronic forms are located on the GAMMIS Portal at [www.mmis.georgia.gov](http://www.mmis.georgia.gov). All electronic PA Request forms can only be accessed and submitted via online submission upon log in to GAMMIS.

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

Concurrent review activities involve the evaluation of a continued hospital, long-term acute care (LTAC) hospital, skilled nursing facility or acute rehabilitation stay for medical appropriateness, using 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 utilization manager, Care Management staff, or hospital clinical staff involved in the Member’s care. Concurrent review is initiated as soon as WellCare is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the Member, complexity, treatment plan, and discharge planning activity. The continued length of stay authorization will occur concurrently based on 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 Care Management.

The concurrent review process incorporates the use of InterQual™ and other Medical Necessity 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 in a timely manner, Providers must submit notification and clinical information 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 non-payment.

- Hospitals must notify WellCare by phone by the next business day following the admission. No medical authorization will be made at this time, unless all clinical information is provided. Clinical information must be provided on the next calendar day if not already presented at the time of notification.
- WellCare has staff available twenty-four (24) hours a day, seven (7) days a week. If a hospital would like to have an immediate authorization decision rendered, and is able to provide clinical information at the time of notification, the call will be transferred to the nurse review staff (or on-call nurse). A WellCare nurse will review the clinical information, and will respond to the facility with an authorization status decision within one (1) calendar day after reviewing the information.
- If a Member is admitted, and subsequently discharged before the next business day (i.e., over a weekend) the facility must still notify WellCare, and provide clinical information so that an authorization decision can be made.
- Facilities must notify WellCare of admissions for the delivery of newborn or stillborn babies. Notification must be submitted via the Georgia Web Portal submission process (www.mmis.georgia.gov) by the next business day following the birth. Baby clinical information (gender, weight, date of birth) must
be provided no later than the next business day, if not included in the initial notification. WellCare will respond to the facility with an authorization number within two (2) business days of the receipt of complete information.

- Failure of a hospital(s) to notify WellCare of a Member’s inpatient admission by the next business day, or failure to communicate information related to service(s) rendered to a Member will result in the denial of the submitted claim(s) associated with the said admission or service(s).

Based on professionally generated criteria, WellCare will review all admissions to and services provided in an acute care setting. All participating hospital reviews must be in compliance with procedures outlined in the hospital's utilization review plan. An entry must be made in the utilization review notes on the review date, indicate the name and title of the reviewer and be signed by the reviewer.

If the hospital uses an electronic entry system for utilization review, the entry must indicate a unique identifier with the name and title of the reviewer on file as well as the date the entry was made.

**Back Transfers**

WellCare follows the DCH policy pertaining to back transfers. Providers can access the policy on the Georgia Medicaid Management Information System (GAMMIS) website at: [www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabld/54/Default.aspx](http://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabld/54/Default.aspx).

**Discharge Planning**

Discharge planning begins upon admission and is an essential part of the concurrent review process. It is designed to quickly identify medical and/or psychosocial issues that will need post-hospital intervention. It may include coordinating services required to assist in arranging for and implementing a Member’s transition to a more appropriate or lower level of care, as needed. The concurrent review nurse coordinates services with the PCP, attending physician, and/or the discharge planning personnel at the hospital.

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. Behavioral health hospital discharge planning personnel must coordinate a post-hospitalization follow-up appointment at the appropriate level of care within seven (7) days of hospital discharge. Notification of post-discharge care and discharge summary must be sent to concurrent review nurse and Member’s PCP within twenty-four (24) hours of Member discharge. A signed consent form must be obtained from Members as required for discharge notification. An inpatient review nurse may refer an inpatient Member with identified complex discharge needs to Care Management for post-discharge follow-up.

When a covered Member is hospitalized, and is disenrolled from WellCare during the hospital stay, WellCare shall maintain responsibility for the coordination of care, and will work with the facility and the Member’s new MCO (insurer) regarding discharge planning for that Member.
When a covered newborn remains hospitalized, and is disenrolled from WellCare during the hospitalization, WellCare shall remain responsible for the coordination of care and discharge planning until the child has been appropriately discharged from the hospital and placed in an appropriate care setting.

**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** – It is the policy of WellCare to assure, through retrospective review, the compliance by Providers to generally acceptable coding guidelines. Retrospective review will request specific medical record documentation from the Provider in order to conduct this review to determine if coding compliance is accurate and appropriate.

- **Retrospective Review Initiated by Providers** – Retrospective review is performed when a service has been provided and no authorization has been given. 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. Post-service authorization requests are also reviewed to determine if any of the following circumstances exist:
  - The Provider was not able to determine the Member’s eligibility;
  - The service was urgent in nature and there was not time to submit a request prior to service delivery;
  - The service is part of an ongoing plan of treatment for a newly eligible Member; or
  - Extenuating circumstances existed that precluded the Provider from submitting a timely pre-service or concurrent review authorization request.

Providers are expected to adhere to the business rules for submission of service authorization requests. Post-service requests that do not meet one of the above conditions may be administratively denied. Exceptions may be granted if specifically addressed through contract language. Post-service authorization decisions will be made within thirty (30) calendar days of receipt of the post-service request.

The Member or Provider may request a copy of the criteria used for a specific determination of Medical Necessity by contacting the Utilization Management Department via Provider Services. Refer to the *Quick Reference Guide* on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Medicaid](http://www.wellcare.com/Georgia/Providers/Medicaid).

**Service Authorization Decisions**

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<thead>
<tr>
<th>Type of Authorization</th>
<th>Decision</th>
<th>Extension</th>
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<tbody>
<tr>
<td>Standard Pre-service</td>
<td>Three (3) Business Days</td>
<td>Fourteen (14) calendar days</td>
</tr>
<tr>
<td>Expedited Pre-service</td>
<td>Twenty-four (24) hours</td>
<td>Five (5) Business Days</td>
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</tbody>
</table>
Standard Pre-Service Authorization
WellCare will provide a service authorization decision as expeditiously as the Member’s health condition requires and within the state-established time frame which will not exceed three (3) business days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days if:
  • The Member, or the Provider, requests an extension; or
  • WellCare justifies (to the state agency upon request) a need for additional information and how the extension is in the Member’s best interest.

WellCare will fax an authorization response to the Provider fax number(s) included on the authorization request form and/or to the Georgia Web Portal.

Expedited Pre-Service Authorization
If a Provider indicates, or WellCare determines, that following the standard time frame could seriously jeopardize the Member’s life or health or ability to attain, maintain, or regain maximum function, WellCare must make an expedited authorization decision and provide notice as expeditiously as the Member’s health condition requires, no later than twenty-four (24) clock hours after receipt of the request for service. WellCare may extend the twenty-four (24) clock hour period for up to five (5) Business Days if:
  • The Member or Provider requests an extension; or
  • WellCare justifies a need for additional information and how the extension is in the Member’s 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: www.wellcare.com/Georgia/Providers/Medicaid.

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

Urgent Concurrent Authorization
An authorization decision for services that are ongoing at the time of the request, and that are considered to be urgent in nature, will be made within twenty-four (24) hours of receipt of the request. An extension may be granted for an additional forty-eight (48) hours if:
  • The request to extend urgent concurrent care is not received at least twenty-four (24) hours prior to the expiration of the previous authorization; or
• Previous care was not authorized, and WellCare was not able to obtain needed clinical information within the initial twenty-four (24) hours after the request, with at least one documented request for the clinical information.

**Services Requiring No Authorization**

In order to facilitate timely and effective treatment of Members, WellCare has determined that many routine procedures and diagnostic tests are allowable without authorization, including:

- Certain diagnostic tests and procedures considered by WellCare to routinely be part of an office visit. Routine clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories and physician offices under a Clinical Laboratory Improvement Amendment (CLIA) waiver do not require Prior Authorization. The exceptions to this rule are:
  - 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 the certificate must be submitted to WellCare.

All services performed without Prior Authorization are subject to Retrospective Review by WellCare. Prior Authorization requirements by service type may be found on the [Quick Reference Guide](www.wellcare.com/Georgia/Providers/Medicaid) on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Authorization-Lookup](www.wellcare.com/Georgia/Providers/Authorization-Lookup).

**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 treating physician on the Notice of Action communication. The treating physician is provided the 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 seven (7) business days following the decision. The physician will have the opportunity to discuss the decision with the peer clinical reviewer making the determination or with a different clinical peer if the original reviewer cannot be available within one (1) business day of the physician request. WellCare will respond within one (1) business day. The review determination notification contains instructions on how to use the Peer-to-Peer Reconsideration process.

**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 the Contractor has taken or intends to take, including the service or procedure that is subject to the Action;
- Additional information, if any, that could alter the decision;
- The specific reason used as the basis of the Action;
- The reasons for the Action must have a factual basis and legal/policy basis;
• The Member’s right to file an Appeal through the Contractor’s internal Grievance System;
• The Provider’s right to file a Provider Complaint;
• The requirement that a Member exhaust the Contractor’s internal Appeal Process;
• The procedures for exercising the rights outlined in this Section;
• The circumstances under which expedited review is available and how to request it; and
• The Member’s right to have Benefits continue pending resolution of the Appeal with the Contractor, Member instructions on 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 person or individual of the healthcare team, including a Member, parent(s) and/or guardian(s), or a social worker exercising a custodial responsibility.

The second opinion must be provided by a qualified healthcare professional within network, or WellCare shall arrange for the Member to obtain one outside the network if there is not a participating Provider with the expertise required for the condition. The second opinion shall be provided at no cost to the Member.

**Planning for Healthy Babies®**

WellCare pays Providers in accordance with Appendix H of DCH’s Family Planning Manual. Appendix H refers the Provider to various sections within the manual which include some CPT/modifier billing guidelines (i.e. sections 901.1- 901.9). For more information, visit [www.mmis.georgia.gov](http://www.mmis.georgia.gov).

**Individuals with Special Healthcare Needs**

Members with chronic conditions are defined as adults and children who have:

• Any ongoing physical, behavioral, or cognitive disorder, including chronic illnesses, impairments and disabilities; and
• An expected duration of at least twelve (12) months with resulting functional limitations, reliance on compensatory mechanisms (medications, special diet, assistive device, etc.) and service use or need beyond that which is normally considered routine.

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; and
  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 healthcare 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.

**Emergency/Urgent Care and Post-Stabilization Services**
Emergency services are not subject to Prior Authorization requirements and are available to Members twenty-four (24) hours a day, seven (7) days a week. See Section 14: Definitions for definitions of “emergency” and “urgent”. Urgent care services are provided as necessary and are not subject to Prior Authorization or pre-certification.

Post-stabilization services are services related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or improve, or resolve the Member’s condition. WellCare does not require Prior Authorization for Post-Stabilization Services. After the Member is stabilized, Providers must obtain Prior Authorization of additional Covered Services, including, without limitation, for inpatient admission. Once the Member is stabilized, the Provider shall contact WellCare for discharge planning or to obtain Prior Authorization for the provision of other Covered Services. Financial responsibility for payment of Post-Stabilization Covered Services will be determined in accordance with the DCH Contract and applicable laws.

Please see *Emergency Room and Outpatient Services* in Section 13: Facilities for more information.

**Continuity of Care**
In the event that a physician should terminate his or her contract with WellCare, Members in active treatment may continue to receive care from the terminated Provider in the following circumstances:
- Any Member who is suffering from, and receiving active healthcare services for, a chronic or terminal illness or who is an inpatient will have the right to receive healthcare services from that physician for a period of up to ninety (90) days from the date of the termination of the physician’s contract. A Member would be considered as having a chronic condition/receiving healthcare services for conditions including, but not limited to:
  o Major organ or tissue transplantation services which are in process, or have been authorized;
  o Chronic illness, which has placed the Member in a high-risk category and/or resulted in hospitalization or placement in nursing or other facilities; and/or
o Significant medical conditions, (e.g. diabetes, hypertension, pain control or orthopedics) that require ongoing care of specialist appointments;
• Members who are in treatment such as chemotherapy, radiation therapy, and/or dialysis; and
• Any Member who is pregnant and receiving healthcare services in connection with that pregnancy at the time of the termination of that Member’s physician’s contract will have the right to continue receiving healthcare services from that physician throughout the remainder of that pregnancy, including six (6) weeks post-delivery care.

If a Member is receiving treatment from the terminated Provider and the ninety (90) day transition period has expired, WellCare will consider whether an in-network Provider could provide the Medically Necessary services or if continued care with the terminated Provider must be continued.

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 thirty (30) days of enrollment, authorization is not required for certain Members with previously approved services by the DCH 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.

Transition of care rules apply when one of the following criteria is met:
• The Member has been diagnosed with a significant medical condition within the last thirty (30) calendar days;
• The Member needs an organ or tissue replacement;
• The Member is receiving ongoing services such as chemotherapy and/or radiation; or
• The Member has received Prior Authorization for services such as scheduled surgeries, or out-of-area specialty services from another CMO, the state, or its agents.

After the initial thirty (30) days, Providers are required to follow WellCare’s Prior Authorization or concurrent review requirements.

When relinquishing Members, WellCare will cooperate with the receiving health plan regarding the course of ongoing care with a specialist or other Provider.

When WellCare becomes aware that a covered Member will be disenrolled from WellCare and will transition to a Georgia Medicaid Fee-for-Service (FFS) program or
another CMO, a WellCare review nurse/care 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.

WellCare must identify and facilitate coordination of care for Members during changes or transitions between plans and/or DCH. Members with special circumstances may require additional and/or distinctive assistance during the transition period. Special circumstances include Members designated as having "special healthcare needs".

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 DCH/CMO approval for reconsideration. Refer to the Quick Reference Guide on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid for the Appeals Department contact information.

Limits to Abortion, Sterilization, and Hysterectomy Coverage
The following services have special requirements from the state of Georgia.

Abortion
Prior Authorization is not required for abortion procedures. However, WellCare will deny any Provider claims submitted without the required abortion certification form or with an incomplete or inaccurate abortion certification form.

Abortions are covered for eligible WellCare Members if the Provider certifies that the abortion is Medically Necessary to save the life of the mother or if the pregnancy is the result of rape or incest.

Abortions are not covered if used for family planning purposes. An Abortion Certificate of Necessity Form (DMA-311) must be properly executed and submitted to WellCare with the Provider’s claim. This form may be filled out and signed by the physician and is located on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid/Forms.

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

In addition, WellCare also requires the submission of the History, Physical and Operative Report and the Pathology Report with all claims that have ICD-10 procedure codes to ensure that abortions are not being billed through the use of other procedure codes. WellCare requires all diagnosis coding to use ICD-10, or its successor, as mandated by the Centers for Medicare & Medicaid Services (CMS). Refer to Section 9: WellCare Compliance Program for additional information.
Sterilizations
WellCare will not and is prohibited from making payment for sterilizations performed on any person who:

- Is under twenty-one (21) years of age at the time he or she signs the consent;
- Is not mentally competent; or
- Is institutionalized in a correctional facility, mental hospital or other rehabilitation facility.

The Informed Consent for Voluntary Sterilization (DMA-69) Form is required for sterilizations. This form is on WellCare's website at: www.wellcare.com/Georgia/Providers/Medicaid/Forms. 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.

For sterilization procedures, the mandatory waiting period between signed consent and sterilization is thirty (30) calendar days. The signed consent form expires one hundred eighty (180) calendar days from the date of the Member's signature.

In the case of premature delivery or emergency abdominal surgery performed within thirty (30) calendar days of signed consent, the physician must certify that the sterilization was performed less than thirty (30) calendar days but not less than seventy-two (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 thirty (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 thirty (30) calendar days, but not more than one hundred eighty (180) calendar days, prior to the sterilization. The physician must sign the consent form after the sterilization has been performed.

A link to ICD-10-CM procedure codes associated with sterilization can be found in the Section 9: WellCare Compliance Program of this Handbook. All claims with these procedure codes will be reviewed prior to payment to ensure proper coding and to ensure that the sterilization consent form is attached to those claims requiring a form.

Hysterectomy
Prior Authorization is required for the administration of a hysterectomy to validate Medical Necessity when performed in an inpatient setting. 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 and the attending physician must sign and date the *Patient’s Acknowledgement of Hysterectomy Prior Receipt Acknowledgement Form (DMA-276)*;

• 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 Hysterectomy Prior Receipt Acknowledgement Form (DMA-276)* with the claim prior to submission to WellCare.

This form is on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Medicaid/Forms](http://www.wellcare.com/Georgia/Providers/Medicaid/Forms).

WellCare will deny payment on any claims 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.

A link to ICD-10-CM procedure codes associated with hysterectomies can be found on the website at: [www.wellcare.com/Georgia/Providers/ICD-10-Compliance](http://www.wellcare.com/Georgia/Providers/ICD-10-Compliance).

All claims with these procedure codes will be reviewed prior to payment to ensure proper coding and that appropriate forms are attached.

- Hysterectomy Information
- *Hysterectomy Prior Receipt Acknowledgement Form (DMA-276)*:

These forms can be found on the website at: [www.wellcare.com/Georgia/Providers/Medicaid/Forms](http://www.wellcare.com/Georgia/Providers/Medicaid/Forms).

Some hysterectomy codes require the *Patient’s Acknowledgement of Hysterectomy Prior Receipt Acknowledgement Form*.

*Hysterectomies are not a covered service for P4HB members.*

**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 entity. The agreement must be approved by DCH 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;
- Semiannual 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 10: Delegated Entities.

**Care Management Program**

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

WellCare’s multidisciplinary Care Management teams are led by specially trained Registered Nurses (RN), Licensed Behavioral Health Care Managers, Social Workers, Community Health Workers, Health Coaches, and Community Advocates. The Care Management team performs a comprehensive assessment of the Member’s clinical status, develops an individualized treatment plan, establishes Member-focused goals, and monitors trends and evaluates the outcome for possible revisions of the care plan. The Care Managers work collaboratively with PCPs and specialists to coordinate care for the Member and expedite access to care and needed services.

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

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

- Referral from a Member’s PCP or other specialist;
- Self-referral;
- Referral from a family Member;
- Referral after a hospital discharge;
- Completion of a Health Risk Assessment (HRA);
- Disease Management Program referral, and/or
Data mining for Members with high utilization.

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

- **Clinical Assessment and Evaluation** – A comprehensive assessment of the Member is completed to determine where he or she is in the health continuum. This assessment gauges the Member's support systems and resources and seeks to align them with appropriate clinical needs.
- **Care Planning** – Collaboration with the Member and/or caregiver to identify the best way to fill any identified gaps or barriers to improve access and adherence to the plan of care.
- **Service Facilitation and Coordination** – Working with community resources to facilitate Member adherence with the plan of care. Activities may be as simple as reviewing the plan with the Member and/or caregiver or as complex as arranging services, transportation and follow-up.
- **Member Advocacy** – Advocating on behalf of the Member within the complex labyrinth of the healthcare system. Care Managers assist Members with seeking the services to optimize their health. Care Management emphasizes continuity of care for Members through the coordination of care among physicians, Community Mental Health Centers, and other Providers.

Members with the following concerns are commonly included in the Care Management Program:

- **Catastrophic** – Traumatic injuries, i.e., amputations, blunt trauma, spinal cord injuries, head injuries, burns, and multiple traumas;
- **Multiple Chronic Conditions** – Multiple comorbidities such as diabetes, chronic obstructive pulmonary disease (COPD), and hypertension, or multiple intricate barriers to quality healthcare, i.e., acquired immune deficiency syndrome (AIDS);
- **Transplantation** – Organ failure, donor matching, post-transplant follow-up;
- **Complex Discharge Needs** – Members discharged home from an acute inpatient stay or Skilled Nursing Facility (SNF) with multiple services and coordination needs (i.e., DME, PT/OT, home health), complicated, non-healing wounds, advanced illness, etc.; and
- **Individuals with Special Healthcare Needs** – Children or adults who have serious medical or chronic conditions with severe physical, mental, and developmental disabilities. The Provider (or entity formally designated as primarily responsible for coordinating the healthcare services furnished to the Member) may coordinate with WellCare’s Care Management team to ensure that a comprehensive care plan is established to address the physical, behavioral, social, and community resources appropriate to maximize the Member’s care delivery or treatment plan.

**Transitional Care Management and Discharge Care Coordination**

Transitional Care Management, a part of Care Management, is focused on reaching out to Members recently discharged from the hospital to identify and assist with immediate,
event-driven needs that may negatively impact the Member’s healthcare status if left unresolved. The goal is to ensure that complex, high-risk Members are discharged with a safe and effective plan in place, to promote Members’ health and well-being, and to reduce avoidable readmissions. WellCare’s inpatient review staff performs discharge planning during hospitalization. This includes screening Members for services that will be needed at discharge and assisting in coordinating these services. Care Management coordinators contact members post-discharge to screen for gaps that may have occurred since discharge. Members identified with gaps are referred to a Discharge Care Coordinators for assistance in resolving issues. The SCM will refer Members with long-term needs to Complex Care Management or Disease Management.

The Transitional 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.

**Disease Management Program**

**Overview**

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

The Disease Management Program targets the following conditions:

- Asthma – adult and pediatric;
- Coronary artery disease (CAD);
- Congestive heart failure (CHF);
- Chronic obstructive pulmonary disease (COPD);
- Diabetes – adult and pediatric;
- Hypertension;
- Depression;
- Obesity; and
- Smoking cessation.

WellCare’s Disease Management Program educates Members and their caregivers regarding the standards of care for chronic conditions, triggers to avoid, and appropriate medication management. The program also focuses on educating Providers regarding the standards of specific disease states and current treatment recommendations. Intervention and education can improve the quality of life of Members, improve health outcomes and decrease medical costs. In addition, WellCare makes available to Providers and Members general information regarding health conditions on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Clinical-Guidelines/CPGs](http://www.wellcare.com/Georgia/Providers/Clinical-Guidelines/CPGs).
Candidates for Disease Management
WellCare encourages referrals from Providers, Members, hospital discharge planners and others in the healthcare community.

Interventions for Members identified vary depending on their level of need and stratification level. Interventions are based on industry-recognized Clinical Practice Guidelines. Members identified at the highest stratification levels receive a comprehensive assessment by a Disease Management nurse clinician, disease-specific educational materials, identification of a care plan and goals, and follow-up assessments to monitor adherence to the plan and attain goals. The DM Clinician also collaborates with Providers by using an Interdisciplinary Care Team approach.

Disease-specific Clinical Practice Guidelines adopted by WellCare may be found on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Clinical-Guidelines/CPGs](http://www.wellcare.com/Georgia/Providers/Clinical-Guidelines/CPGs).

Access to Care and Disease Management Programs
If a Provider would like to refer a WellCare Member as a potential candidate to the Care Management Program or the Disease Management Program, or would like more information about one of the programs, Providers may call the WellCare Care Management Referral Line. Members may self-refer by calling the Care Management toll-free line or contacting the Nurse Advice Line after hours or on weekends (TTY available).

For more information on the Care Management Referral Line, refer to the Quick Reference Guide on WellCare’s website at: [www.wellcare.com/Wellcare/Georgia/Providers/Medicaid](http://www.wellcare.com/Wellcare/Georgia/Providers/Medicaid).
Section 6: Claims

Overview
The focus of WellCare’s Claims Department is to process claims in a timely manner. WellCare has established toll-free telephone numbers for Providers to access a representative in WellCare’s Provider Services Department.

For more information, refer to the Quick Reference Guide on WellCare’s website at: georgia.wellcare.com/Provider/resources.

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

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

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

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

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


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

Timely Claims Submission
Unless otherwise stated in the Agreement, the Provider must submit claims (initial, corrected and voided) no later than one hundred eighty (180) days or six (6) months after the date the services were furnished. The start date for determining the timely filing period is the “from” date reported on a CMS-1500 or 837-P for professional claims or the “through” date used on the UB-04 or 837-I for institutional claims. Unless prohibited by
federal law or the Centers for Medicare & Medicaid Services (CMS), WellCare may deny payment for any claims that fail to meet WellCare’s submission requirements for Clean Claims or that are received after the time limit in the Agreement for filing Clean Claims.

The following items can be accepted as proof that a “Clean” Claim was submitted timely:

- A clearinghouse electronic acknowledgement indicating the claim was electronically accepted by WellCare; and
- A Provider’s electronic submission sheet with all the following identifiers:
  - Patient name;
  - Provider name;
  - Date of service to match Explanation of Benefits (EOB)/claim(s) in question;
  - Prior submission bill dates; and
  - WellCare product name or line of business.

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

- A 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 Identification (Tax ID/TIN) and National Provider Identifier (NPI) on all claims submissions. WellCare will reject claims without the Tax ID and/or NPI. More information on NPI requirements, including HIPAA’s NPI Final Rule Administrative Simplification, is available on the Centers for Medicare & Medicaid Services (CMS) website at: [www.cms.gov](http://www.cms.gov).

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 Strategic National Implementation Process (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 the timely filing limits. For more information, see the Encounters Data Section below.

Claims Submission Requirements
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 an original (red and white) 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. WellCare requires all diagnosis coding to use ICD-10, or its successor, as mandated by the Centers for Medicare & Medicaid Services (CMS). Refer to Section 9: WellCare Compliance Program of this Handbook for additional information. 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 on WellCare’s website at: www.wellcare.com/Wellcare/Georgia/Providers/Medicaid.

Electronic Claims Submissions
WellCare accepts electronic claims submissions 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 5010. For more information on EDI implementation with WellCare, refer to the Wellcare Companion Guides which may be found on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid/Claims.

Because most clearinghouses can exchange data with one another, Providers should work with their existing clearinghouse, or with WellCare’s contracted clearinghouse, to establish EDI with WellCare. 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 on WellCare’s website at: www.wellcare.com/Wellcare/Georgia/Providers/Medicaid.

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

Specific WellCare requirements for claims and encounter transactions, code sets and SNIP validation are described below. For more information on EDI implementation with WellCare, refer to the Wellcare Companion Guides which may be found on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid/Claims.

Paper Claims Submissions
For timelier processing of claims, Providers are encouraged to submit electronically. Claims not submitted electronically may be subject to penalties per 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: www.wellcare.com/Georgia/Providers/Medicaid.
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 elements and formatting described below:

- Paper claims must only be submitted on original (red ink on white paper) claim forms.
- Any missing, illegible, incomplete or invalid information in any field will cause the claim to be rejected or processed incorrectly.
- Per the Centers for Medicare & Medicaid Services (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, hand-write, or stamp any extraneous data on the form;
    - In black ink;
    - In large, dark font such as, PICA or ARIAL, and 10-, 11- or 12-point type; and
    - In capital letters.
  - The typed information must not have:
    - Broken characters;
    - Script, italics or stylized font;
    - Red ink;
    - Mini font; or
    - Dot matrix font.

**CMS Fact Sheet about UB-04:**

**CMS Fact Sheet about CMS-1500:**

**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 (2) or more admissions are related based on the data analysis. Based upon the claim review (including a review of medical record documentation if requested from the Provider), WellCare will make all necessary adjustments to the claim, including recovery of payments that are not supported by the medical record. Providers who do not submit the requested medical record documentation, or who do not remit the overpayment amount identified by WellCare, may be subject to a recoupment.

**Unplanned IP Readmission**
WellCare may request medical documentation for a specific Member if it appears that two (2) or more admissions are related and potentially unplanned. Based upon the review, WellCare will make all necessary adjustments to the claim, including recovery of
payments which are not supported by the review. Providers who do not submit the requested medical documentation or do not remit the overpayment amount identified by WellCare may be subject to a recoupment. For more information, refer to the IP Readmission Policy under Provider Bulletins in the WellCare Provider Web Portal.

72-Hour Rule
WellCare follows the Centers for Medicare & Medicaid Services (CMS) guidelines for outpatient services treated as inpatient services (including, but not limited to, outpatient services followed by admission before midnight of the following day, preadmission diagnostic services, and other preadmission services). Please refer to the CMS Claims Processing Manual for additional information or the Georgia DCH Part I Policies and Procedures for Medicaid/PeachCare for Kids® Manual.

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 record documentation 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 the Provider Agreement and O.C.G.A. 33-24-59.5(b) (1).

Coordination of Benefits (COB)
WellCare shall coordinate payment for Covered Services in accordance with the terms of a Member’s benefit plan, applicable state and federal laws and CMS guidance. Providers shall bill primary insurers for items and services they provide to a Member before they submit claims for the same items or services to WellCare. Any balance due after receipt of payment from the primary payer should be submitted to WellCare for consideration and the claim must include information verifying the payment amount received from the primary plan. COB information can be submitted to WellCare by an EDI transaction with the COB data completed in the appropriate COB elements. Only paper submitters need to send a copy of the Explanation of Benefits (EOB). WellCare may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services to the extent permitted by applicable laws. Providers shall follow WellCare 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, DCH 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, vendors and Providers must submit complete, accurate, and timely encounter files to WellCare as follows (subject to change as directed by WellCare):

- Encounters submission will be weekly;
- Capitated entities will submit within ten (10) calendar days of service date; and
- Non-capitated entities will submit within ten (10) calendar days of the paid date.

The above applies to original, voided, or replaced/overlaid encounters.

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’s or Provider’s encounters, the encounters are loaded into WellCare’s Encounters System and processed. The encounters are subjected to a series of SNIP editing to ensure that the encounter has all the required information and that the information is accurate.

For more information on WEDI™ SNIP Edits, refer to their Transaction Compliance and Certification white paper at: www.wedi.org/knowledge-center/white-papers-articles/white-papers/resources/2002/08/01/testing-and-certification-white-paper-version-3.0.

For more information on submitting encounters electronically, refer to the WellCare Companion Guides which may be found on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid/Claims. Vendors are required to comply with any additional encounters validations as defined by the state and/or CMS.

Encounters Submission Methods
Delegated vendors and Providers may submit encounters using several methods: electronically, through WellCare’s contracted clearinghouse(s), via Direct Data Entry (DDE) or using WellCare’s Secure File Transfer Protocol (SFTP) 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: www.wellcare.com/Georgia/Providers/Medicaid/Claims.

Submitting Encounters Using Direct Data Entry (DDE)
Delegated vendors and Providers may submit their encounter information directly to WellCare using WellCare’s DDE portal. The DDE tool can be found on the secure, online Provider Portal at http://georgia.wellcare.com/Provider/default. For more information on free DDE options, refer to the Georgia Medicaid Provider Resource Guide, which may be found on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid.

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 (4) encounter types are:
- Dental – 837D format;
- Professional – 837P format;
- Institutional – 837I format; and
- 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 an original, voided or a replaced/overlaid encounter. The definitions of the types of encounters are as follows:
- Original Encounter is an encounter that has never been submitted to WellCare previously;
- Voided Encounter is an encounter that WellCare deletes from the encounter file and is not submitted to the state; and
- Replaced or Overlaid Encounter is 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.
Providers may not bill WellCare Members for:
- The difference between actual charges and the contracted reimbursement amount;
- Services denied because of timely filing requirements;
- Services denied due to failure to follow Plan procedures;
- Covered Services for which a claim has been returned and denied for lack of information;
- Remaining or denied charges for those services where a contracted Provider fails to notify the plan of a service that required Prior Authorization. Payment for that service will be denied; and/or
- Covered Services that were not Medically Necessary, in the judgment of WellCare, unless prior to rendering the service, the Provider obtains the Member’s informed written consent and the Member receives information regarding the Member’s financial responsibility for the specific services.

Providers may bill WellCare Members only:
- When the service to be rendered is not covered by DCH; or
- When there are procedures or treatments covered by DCH that are available to the Member in lieu of the non-covered procedure or treatment, the Member must indicate on the disclosure form his or her willingness to accept the non-Covered Service.

The Member shall sign a statement evidencing his or her knowledge of said disclosures. The statement should also include the cost of the non-Covered Service and an assurance that there are no other Covered Services available to the Member. In addition, the disclosure statement must contain the payment arrangements. If the Member will be subject to collection action upon failure to make the required payment, the terms of said action must be included in the disclosure document. A copy of the disclosure form must be kept in the Member’s treatment record.

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

Never Events are defined as a surgical or other invasive procedure to treat a medical condition when the practitioner erroneously performs:
- A different procedure altogether;
- The correct procedure but on the wrong body part; or
- The correct procedure on the wrong patient.

Hospital Acquired Conditions are additional non-payable conditions listed on the CMS website at:
Healthcare Providers may not bill, attempt to collect from, or accept any payment from WellCare or the Member for PPCs or hospitalizations and other services related to these non-covered procedures.

**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 Georgia 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 Georgia Medicaid. Providers shall accept WellCare’s payment as payment in full or will bill Georgia Medicaid if WellCare has not assumed DCH’s financial responsibility under an agreement between WellCare and DCH. For more information on holding harmless dual-eligible Members, refer to the *Georgia DCH Part I Policies and Procedures Manual*.

**Cost Share**
Some Members may have to share the cost of healthcare services. In that case, the Member is responsible for paying the co-pay amount to the Provider. It is up to the Provider to ensure the Member’s co-pay has been collected. However, a Provider shall not refuse to treat a Member on the basis of the Member’s inability to pay the co-pay amount.

The Member’s cost share is available on the DCH eligibility site or by contacting WellCare’s Provider Services. The Provider will collect the applicable co-pay from the Member.

**Claims Payment Disputes**
The claims payment dispute process is used by a participating Provider when he or she believes the amount reimbursed by WellCare is incorrect. Claim payment disputes must be submitted to WellCare in writing within ninety (90) calendar days of the date of denial of the Explanation of Payment (EOP).

The following documentation is required;
- Date(s) of service;
- Member name;
- Member WellCare ID number and/or date of birth;
- Provider name;
- Provider Tax ID/TIN;
- Total billed charges;
- The Provider’s statement explaining the reason for the dispute; and
- Supporting documentation when necessary (e.g., proof of timely filing, medical record documentation).
To initiate the process, refer to the Quick Reference Guide located on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid. Following the outcome of payment determination, Providers may be afforded further appeal rights.

For more information, please refer to Section 8: Appeals and Grievances.

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

How to submit a Corrected or Voided Claim electronically:
- Loop 2300 Segment CLM composite element CLM05-3 should be ‘7’ or ‘8’– indicating to replace ‘7’ or void ‘8’
- Loop 2300 Segment REF element REF01 should be ‘F8’ indicating the following number is the control number assigned to the original bill (original claim reference number)
- Loop 2300 Segment REF element REF02 should be ‘the original claim number’ – the control number assigned to the original bill (original claim reference number for the claim you are intended to replace.)
- Example: REF*F8*Wellcare Claim number here~

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

To submit a Corrected or Voided Claim via paper:
- For Institutional claims, the Provider must include 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>117</td>
<td>117</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Claim number of Prior Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>299370064</td>
</tr>
</tbody>
</table>

- For Professional claims, the 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:
Any missing, incomplete or invalid information in any field may cause the claim to be rejected.

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 out for the newly submitted corrected claim.

Reimbursement
WellCare applies the Centers for Medicare & Medicaid Services (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).

Ground Ambulance Transportation
The ambulance transportation benefit is defined in title XVIII of the Social Security Act (the Act) in §1861(s)(7): “ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations.” This statutory definition incorporates by reference the regulations thereunder, which are those at 42 CFR §410.40 (Coverage of ambulance services), as well as, the regulations at 42 CFR §410.41 (Requirements for ambulance suppliers) which are, themselves, incorporated into §410.40 by reference in §410.40(a)(1). Thus, in effect, §1861(s)(7) of the Act together with 42 CFR §§410.40-410.41 comprise the ambulance benefit definition.

Reimbursement is approved based on the level of service provided, not the vehicle used. If a local government requires an “Advanced Life Support” response for all calls, WellCare pays only for the level of service that was Medically Necessary.

Payment will not be made when other transportation could be used without endangering the patient’s health, regardless of whether such means of transportation is actually available.
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 examination 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 the Centers for Medicare & Medicaid Services (CMS) policy.

Multiple Procedures
Payment for multiple procedures is based on:
- One-hundred percent (100%) of maximum allowable fee for primary surgical procedure;
- Fifty percent (50%) of maximum allowable fee for second through the fifth surgical procedure; and
- Twenty-five percent (25%) of maximum allowable fee for all subsequent surgical procedures.

The percentages apply when eligible multiple surgical procedures are performed under one (1) continuous medical service, or when multiple surgical procedures are performed on the same day and by the same surgeon.

For more information, refer to the Georgia DCH Part I Policies and Procedures Manual.

Assistant Surgeon
Assistant Surgeons (modifier 80) are reimbursed at sixteen percent (16%) of the maximum allowable fee for the procedure code. Multiple surgical procedures for modifier 80 are reimbursed as follows:
- Sixteen percent (16%) of one hundred percent (100%) of the maximum allowable fee for primary surgical procedure (first claim line);
- Sixteen percent (16%) of fifty-percent (50%) of the maximum allowable fee for the second through the fifth surgical procedure; and
- Sixteen percent (16%) of twenty-five percent (25%) of the maximum allowable fee for all subsequent 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.

For more information, refer to the Georgia DCH Physician Services Manual.

**Co-Surgeon**
Each Provider will be paid sixty two point five percent (62.5%) of the maximum allowable fee for the procedure code. In these cases, each surgeon should report his or 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 Georgia DCH Physician Services Manual.

**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, 59, 62, 66, 76, 77, 78, 79, 80, and 99, LT/RT, QK, QS, and TC.

For more information, refer to the Georgia DCH Physician Services Manual.

**Allied Health Providers**
If there are no reimbursement guidelines on the Georgia DCH Medicaid website specific to payment for non-physician practitioners or Allied Health Professionals, WellCare follows the Centers for Medicare & Medicaid Services (CMS) reimbursement guidelines regarding Allied Health Professionals.

**Overpayment Recovery**
WellCare strives for one-hundred percent (100%) payment quality but recognizes that a small percent of financial overpayments will occur while processing claims. An overpayment can occur due to reasons such as 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 adhere to Georgia Regulatory Statute (O.C.G.A.) 33-20A-62.

**Last Date of Service = < 90 Days from WellCare Claim Receipt Date**
• The statute permits a 12-month recovery period from the last date of service or discharge date. However, sending an advance notice of intent to audit grants an additional six months to report the findings.

**Last Date of Service > 90 Days from WellCare Claim Receipt Date**

• The statute permits a 12-month recovery period from the claim receipt date. However, sending an advance notice of intent to audit grants the lesser of an additional six months after the claimant's initial submission of such a claim or 12 months after the date of service.

However, no such time limit shall apply to overpayment recovery efforts which are based on a reasonable belief of fraud or other intentional misconduct, or abusive billing.

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

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

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

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

For more information on contacting Provider Services, refer to the Quick Reference Guide on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Medicaid](http://www.wellcare.com/Georgia/Providers/Medicaid).

**Benefits during Disaster and Catastrophic Events**
Refer to the Provider Agreement.
Section 7: Credentialing

Overview
Credentialing is the process by which the appropriate WellCare peer review bodies, or its delegated entities including Aperture Credentialing, LLC, hereinafter referred to as DCH’s Credentialing Verification Organization (CVO), evaluate the credentials and qualifications of practitioners including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/healthcare delivery organizations. For purposes of this Credentialing Section, all references to “practitioners” shall include Providers delivering health or health-related services including the following: physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/healthcare delivery organizations.

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

Practitioners are required to be credentialed prior to being listed as participating network Providers of care or services to WellCare Members.

The Credentialing Department, or its designee, is responsible for gathering all relevant information and documentation through a formal application process. The applicant (Provider) must attest that the credentialing application is 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/healthcare delivery organizations are required to be credentialed in order to be network Providers of services to WellCare Members.
- Satisfactory site inspection evaluations may be required periodically in accordance with state, federal, and accreditation requirements.
• After the credentialing process has been completed, a timely notification of the credentialing decision is forwarded to the Provider.

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

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

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

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

The status of your credentialing/re-credentialing application submitted to the CVO using DCH's Provider Enrollment Web Portal at: [www.mmis.georgia.gov](http://www.mmis.georgia.gov) can be obtained by entering your Application Tracking Number (ATN) using the Provider Enrollment Wizard. The results displayed will identify the current details regarding the status of your application. As an alternative, Providers may contact the HP Provider Call Center by calling 1-800-766-4456, option 4, Monday–Friday, from 7 a.m. to 7 p.m. to obtain assistance with credentialing and re-credentialing.

Baseline Criteria
The baseline criteria for practitioners to qualify for Provider network participation are as follows:

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 M.D./D.O./D.P.M./D.D.S./D.M.D.).

Work History – Practitioners must provide a minimum of five (5) 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.
State Licensing/Contracting Agencies – Facility Providers, including behavioral health agency Providers, are required to maintain active credential status and contract with the appropriate state agency in the specialty being practiced as a Provider for WellCare.

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 – All healthcare Providers that are covered entities under HIPAA must obtain a National Provider Identifier (NPI) to participate in WellCare’s network.

Liability Insurance
WellCare Plan Providers (all disciplines) are required to carry and continue to maintain comprehensive commercial general liability (CGL) and professional liability insurance in the minimum limits as indicated below, unless otherwise agreed by WellCare in writing:
- $1,000,000/$3,000,000 per Provider.

Providers must furnish copies of current CGL and 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 have been established for:
- Office-site criteria:
  - Physical accessibility;
  - Physical appearance; and
  - Adequacy of waiting room and examination room space;
- Medical/treatment record keeping criteria;
- Evidence that the Health Plan has determined that the following documents are posted in the Provider's waiting room/reception area:
  - Office Hours; and
  - Member Rights and Responsibilities.

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

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

Site visits can also be conducted unannounced and unscheduled at any or all of the provider’s service locations prior to enrollment, post-enrollment, re-enrollment, revalidation, or during any period of time in which the provider is enrolled. Site visits will be conducted for providers who are designated as “moderate” or “high”.

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

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

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

- Advanced Registered Nurse Practitioners (ARNP);
- Certified Nurse Midwife (CNM);
- Physician Assistant (PA); and
- Osteopathic Assistant (OA).

Independent AHPs include but are not limited to the following:

- Licensed clinical social worker;
- Licensed mental health counselor;
- Licensed marriage and family therapist;
- Licensed professional counselors;
- Physical therapist;
- Occupational therapist;
- Audiologist; and
- Speech/language therapist/pathologist.

**Ancillary Healthcare Delivery Organizations**
Ancillary and organizational applicants must complete an application and, as applicable, undergo a SIE if unaccredited. WellCare is required to verify accreditation, licensure, Medicare certification (as applicable), regulatory status, and liability insurance coverage prior to accepting the applicant as a WellCare Provider.
Re-Credentialing
In accordance with regulatory, accreditation, WellCare, and its designee’s policy and procedure, re-credentialing is required at least once every three (3) years. Effective December 1, 2015, the CVO will be responsible for all re-credentialing activities.

Updated Documentation
In accordance with contractual requirements, Providers shall furnish copies of current professional or comprehensive commercial general liability insurance, license, DEA certificate, and accreditation information (as applicable to Provider type) to WellCare prior to the 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 currently 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.

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 sole discretion 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, it may result in reporting to regulatory agencies.
The Provider Dispute Resolution Peer Review Process has two (2) levels. All disputes in connection with the actions listed below are referred to a first-level Peer Review Panel consisting of at least three (3) qualified individuals of whom at least one (1) is a participating Provider and a clinical peer of the practitioner who filed the dispute.

The practitioner also has the right to consideration by a second-level Peer Review Panel consisting of at least three (3) qualified individuals of which at least one (1) is a participating Provider and a clinical peer of the practitioner that filed the dispute and the second-level panel is comprised of individuals who were not involved in earlier decisions.

The following actions by WellCare entitle the affected practitioner 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 the 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 thirty (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.

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 ten (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. Practitioners affiliated with Provider organizations (e.g., PHOs/IPAs) with standing delegated credentialing agreements with WellCare are exempt from DCH’s CVO process. Compliance is monitored on a monthly/quarterly basis and formal audits are conducted annually. Please refer to Section 10: Delegated Entities in this Provider Handbook for further details.
Section 8: Appeals and Grievances

Complaint/Grievance/Administrative Review/Administrative Law Hearing/PeachCare for Kids® Committee Review

Provider Complaint Process

- Provider Complaint: A written expression by a Provider, which indicates dissatisfaction or dispute with WellCare’s policies, procedures, or any aspect of WellCare’s administrative functions.

- A Provider may file a complaint in writing regarding dissatisfaction or dispute with WellCare’s policies, procedures, or administrative functions, by mailing or faxing a Complaint Request Form with supporting documentation, to WellCare’s Grievance Department. The form is located on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid/Forms.

- Providers have thirty (30) calendar days from the date of the incident to file a Provider complaint. Providers may consolidate complaints that involve the same or similar issues, regardless of the number of complaints the bundle contains. Complaints received after that time will be closed for untimely filing. If the Provider feels he or she has filed the complaint within the appropriate time frame, the Provider may submit documentation showing proof of timely filing. The only acceptable proof of timely filing is a registered postal receipt signed by a representative of WellCare or similar receipt from other commercial delivery services.

- WellCare strives to address all complaints within (45) calendar days.

- A Provider Complaint cannot involve a Claim.

- WellCare’s grievance and complaint coordinators have the authority to review complaints.

For more information on how to contact the Grievance Department, refer to the Quick Reference Guide on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid.

Member Grievance Process

Grievance: An expression of dissatisfaction about any matter other than an Action.

The Member or the Member’s authorized representative (with written consent from the Member), acting on the Member’s behalf, may file a grievance. If the Member wishes to use a representative, then he or she must complete an Appointment of Representative...
(AOR) statement. For more information, see the Appointment of Representative Section below.

A Provider cannot file a grievance on behalf of a Member or Planning for Healthy Babies® enrollee.

Examples of grievance issues that may be submitted include, but are not limited to:

- Provider Services including, but not limited to:
  - Rudeness by Provider or his/her office staff;
  - Failure to respect the Member’s rights;
  - Quality of care/services provided;
  - Refusal to see the 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 (1) hour; and/or
  - Handicap accessibility.

**Member Grievance Submission**

An oral grievance request can be filed, toll-free, by calling 1-866-231-1821 and P4HB® Members may call 1-877-379-0020. An oral request must be followed up with a written request from the Member or the Member’s authorized representative. The time frame for resolution begins the date the oral filing is received by WellCare.

WellCare will acknowledge the Member’s standard grievance in writing within ten (10) business days from the date the grievance is received by WellCare. The acknowledgement letter will include:

- The name and telephone number of the grievance coordinator; and
- A request for any additional information, if needed, to investigate the issue.

**Member Grievance Resolution**

Upon receipt of the Member’s grievance, WellCare will collect pertinent facts from all parties during the investigation and issue a disposition. A resolution letter will be mailed to the Member within ninety (90) calendar days from the date the grievance is received by WellCare.

The resolution letter will include:

- The results/findings of the resolution;
- Actions taken;
- The substance of the grievance;
- All information considered in the investigation of the grievance;
• The date of the grievance resolution; and
• Member rights regarding a Medicaid Fair Hearing (only if the resolution is issued beyond ninety (90) calendar days).

When the time frame to close a grievance exceeds ninety (90) calendar days, Members have the right to request an Administrative Law Hearing within thirty (30) calendar days of the date the grievance determination letter is mailed by WellCare. A Member may not request an Administrative Law Hearing if dissatisfied with the outcome of the grievance (only if the resolution is issued beyond 90 calendar days). The Member’s request for an Administrative Law Hearing must be submitted in writing to WellCare within thirty (30) calendar days of the Notice of Adverse Action mailed by WellCare. Requests should be submitted to:

WellCare Health Plans, Inc.
Administrative Law Hearing Request
Suite 800
211 Perimeter Center Parkway, NE
Atlanta, GA 30346

For more information on how to contact the Grievance Department, refer to the Quick Reference Guide on WellCare’s website at www.wellcare.com/Wellcare/Georgia/Providers/Medicaid.

Appointment of Representative
If the Member wishes to use a representative for a grievance and/or an appeal, then he or she must complete an Appointment of Representative (AOR) statement. 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 www.wellcare.com/Georgia/Providers/Medicaid/Forms.

Members are provided reasonable assistance in completing forms and other procedural steps for an appeal, including, but not limited to, providing interpreter services and toll-free telephone numbers with TTY capability (1-866-231-1821, TTY 711).

Member Appeal Process

An Appeal is a formal request for a review of an Adverse Benefit Determination. A Member, the Member’s authorized representative or the Provider acting on behalf of the Member with the Member’s written consent may file an Appeal request either orally or in writing.

Examples of Adverse Benefit Determination that can be administratively reviewed include, but are not limited to, the following:
• 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;
• The failure of WellCare to act within the time frames provided in 42 CFR 438.408 (b); or
• 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 the individuals who make decisions on Appeals are individuals who were not involved in any previous level of review or decision-making and who are healthcare professionals who have the appropriate clinical expertise in treating the Member’s condition or disease if deciding any of the following:

• An Appeal of a denial that is based on lack of Medical Necessity
• An Appeal that involves clinical issues

A Member Appeal request must be filed with sixty (60) Calendar Days of the Adverse Benefit Determination Notice.

If the request for a Member Appeal is submitted after sixty (60) calendar days, then good cause must be shown in order for WellCare to accept the late request. Examples of good cause include, but are not limited to, the following:

• The Member did not personally receive the Notice of Adverse Benefit Determination or received the notice late;
• The Member was seriously ill, which prevented a timely appeal;
• 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.

WellCare will send a letter to the Member within ten (10) business days acknowledging receipt of the Appeal request.

**Types of Appeals**
The Member, Member’s authorized representative or the Provider acting on behalf of the Member with the Member’s written consent, has the right of appeal for services not yet provided. The Provider has the right of appeal for services that have already been provided and billed to WellCare. All services that qualify for Appeals fall into the categories of “Pre-service” or “Retrospective”.

• **Expedited Pre-service Appeals** (services not yet provided and the Member has an urgent need)
• **Standard Pre-service Appeals** (services not yet provided)
• **Retrospective Administrative Review** (services already provided)
WellCare must make a determination from the date of receipt of the request for Appeals and notify the appropriate party within the following time frames:

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

The Expedited, Standard Pre-Service and Retrospective determination periods for Member appeals may be extended by up to fourteen (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 the Member does not request an extension, WellCare will attempt to provide oral notice regarding the extension and provide the Member or P4HB® Member with written notice of the reason for the delay within two (2) business days of the decision to extend the time frame.

**Expedit**ed Appeal Process

To request an expedited Appeal, a Member, P4HB® Member or a Provider with written consent (regardless of whether the Provider is contracted with WellCare) must submit an oral or written request directly to WellCare. A request to expedite an Appeal of a proposed action 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. Expedited appeals may be filed orally and or in writing. For expedited appeals, if the request is made orally, written follow-up is not required.

For expedited resolution of an Appeal request, WellCare will resolve the request and provide written notice to the parties involved as expeditiously as the Member’s health condition requires, but no more than seventy-two (72) hours from the time WellCare receives the Appeal request. WellCare will make reasonable efforts to provide verbal notice to the Member regarding the determination.

Members who orally request an expedited Appeal are not required to follow up with a written request.

A request for payment of a Provider regarding a service already provided to a Member is not eligible to be reviewed as an Expedited Appeal Request.

- **Denial of an Expedited Appeal Request**
  WellCare will provide the Member with prompt oral notification within twenty-four (24) hours regarding the denial of an expedited Appeal and the Member’s rights, and will mail a letter to the Member within two (2) calendar days of the oral notification that explains:
  - That WellCare will automatically transfer and process the request using the thirty (30) calendar day time frame for standard Appeals beginning on the date WellCare received the original request;

- **Resolution of an Expedited Appeal**
  WellCare will complete the expedited review of 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 seventy-two (72) hours after receiving a valid complete request for an expedited Appeal.

**Standard Appeal Process**

A Member, a Member’s authorized representative or a Provider on behalf of a Member with the Member’s written consent, may file a standard pre-service or retrospective Appeal request either orally or in writing within sixty (60) calendar days of the date of the Notice of Adverse Benefit Determination.

If an Appeal is filed orally through Customer Service, the request must be followed up with a written, signed statement to WellCare within ten (10) calendar days of the oral filing. For oral filings, the time frames for resolution begin on the date the oral filing was received.

**Reversal of Denial of an Expedited or Standard Member Appeal**

If upon standard Appeal, WellCare overturns its initial Adverse Benefit Determination decision denying a Member’s request for a service, WellCare will issue an authorization or process payment for the request.

WellCare will authorize or provide the disputed services promptly and as expeditiously as the Member’s health condition requires, 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, in accordance with state policy and regulations, if the services were furnished while the review was pending and the disposition reverses a decision to deny, limit or delay services.

**Affirmation of Denial of an Expedited or Standard Member Appeal**

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

- Issue a Notice of Appeal Resolution to the Member and/or appellant;
- Include in the Notice the specific reason for the review decision in easily understandable language with reference to the benefit provision, guideline, protocol, or other similar criteria on which the decision was based, as well as inform the Member:
  - Of the right to request a State Administrative Law Hearing within one hundred twenty (120) calendar days of the date the Notice of Adverse Action was mailed by WellCare and how to do so;
  - Of his or her right to continue to receive benefits pending a State Administrative Law Hearing; and
  - That the Member may be liable for the cost of any continued benefits if WellCare’s action is upheld.

**Member Overview**

WellCare will not take, or threaten to take, any punitive action against any Provider acting on behalf of or in support of a Member requesting an Appeal or an expedited Appeal.
Members have the opportunity to review their files and other applicable information relevant to the reviews of the decision at any time during the Appeal review process. Members may also submit additional information and documents of fact or law. The time frame to submit additional information is limited for expedited Appeals.

To request an Appeal or to submit additional information, mail to:

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

Provider Overview
Provider Appeal Review: A review of an adverse action for denial of payment requested by a Provider not on behalf of a Member.

When processing a Provider Appeal, WellCare will abide by the State’s guidelines and requirements as described in the Government Contract and as outlined in WellCare’s internal Provider Appeal Policy C7AP-006, Provider Appeals and complaint process.

A Provider may request an Appeal Review by mailing or faxing a request with supporting documentation, to WellCare’s Appeals Department.

WellCare Health Plans, Inc.
Attn: Appeals Department
P.O. Box 31368
Tampa, FL 33631-3368
Fax: 1-866-201-0657

Providers are encouraged to submit requests using the Provider Appeal Review Request Form. The form is located on WellCare’s website at: www.wellcare.com/Wellcare/Georgia/Providers/Medicaid.

Providers have 30 calendar days from the original utilization management or claim denial to file an Appeal. Appeals submitted after that time will be denied for untimely filing. If the Provider feels she or he filed the appeal within the appropriate time frame, the Provider may submit documentation showing proof of timely filing. The only acceptable proof of timely filing is a registered postal receipt signed by a representative of WellCare or similar receipt from other commercial delivery services.

Upon receipt of all required documentation, WellCare has 30 calendar days to review the Appeal for Medical Necessity and conformity to WellCare guidelines and to render a decision to reverse or affirm.

Providers may consolidate appeals of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled Appeal.
Appeals received without the necessary documentation may be denied for lack of information.

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**
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 reversed. The Provider will be notified of this decision in writing.

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

**Affirmation of Denial**
If it is determined during the Administrative 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 will be provided in the letter. The Provider may also request a copy of the benefit provision, guideline, protocol and other similar criteria used in making the Appeal decision by sending a written request to the Appeals addresses listed in the decision letter.

The Provider will also be made aware of the right to a hearing before an Administrative Law Judge at the Office of State Administrative Hearing (OSAH).

The request for an Administrative Hearing must be in writing and must specify issue(s) under appeal and the relief requested. The request for Administrative Hearing must be accompanied by a copy of the Administrative Review response (Administrative Review denial notice).

A request must be made within fifteen (15) business days of the date of the Administrative Review response.

Please note there may be fees associated with the request for an Administrative Hearing. Please contact the office of State Administrative Hearings at 404-657-2800 or [www.osah.ga.gov](http://www.osah.ga.gov) to find out the current fee. The fee is assessed at the Court’s direction and may be allocated between the parties by the judge.
Continuation of Benefits while the Member Appeal, Administrative Law Hearing/PeachCare for Kids® Committee Review are Pending

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

- Within ten (10) calendar days of WellCare mailing the Notice of Adverse Benefit Determination; or
- Within the intended effective date of WellCare’s Proposed Action, whichever comes later.

WellCare will continue the Member's benefits if:

- The Member Appeal or hearing request is filed timely as described above;
- The Member Appeal involves the termination, suspension or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized Provider;
- The original period covered under the original authorization has not expired; and
- The Member requests continuation of benefits.

Benefits will be continued until one of the following occurs:

- The Member withdraws the Administrative Law Hearing request;
- Ten (10) calendar days pass after WellCare mailed the Notice of Adverse Benefits Determination unless the Member, within the ten (10) calendar day time frame, has requested continuation of benefits until an Administrative Law Hearing decision is reached;
- An Administrative Law Hearing Judge issues a hearing decision adverse to the Member; or
- The time period or service limits of a previously authorized service have been met.

WellCare will authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, if the services were not furnished while the Administrative Law Hearing was pending and the adverse decision is reversed.

If WellCare or the Administrative Law Judge reverses a decision to deny authorization of services, and the Member received the disputed services while the appeal was pending, WellCare will pay for those services.

WellCare will pay for disputed services, in accordance with state policy and regulations, if the services were furnished while the Administrative Law Hearing was pending and the decision to deny, limit or delay services is reversed. At the discretion of DCH, the Member may be liable for the cost of continued benefits if WellCare’s action is upheld.
Administrative Law Hearing/PeachCare for Kids® Formal Appeals Committee Review

Member Right to Hearing (Non-PeachCare for Kids® Members)

The Member, or the Member’s authorized representative with written consent from the member or P4HB® Member has the right to request an Administrative Law Hearing after completing WellCare’s internal Appeal process. Parties to the Administrative Law Hearing include WellCare, as well as the Member, the Member’s authorized representative, the representative of a deceased Member’s estate or P4HB® Member. The Member and his or her representative may review the case file and present evidence during the hearing.

The Member or a Member's authorized representative with written consent from the Member may request an Administrative Law Hearing within one hundred twenty (120) calendar days of the date the Notice of Adverse Benefit Determination is mailed by WellCare. The hearing request and a copy of the Adverse Benefit Determination letter must be received within one hundred twenty (120) calendar days from the date the Adverse Benefit Determination letter was mailed.

A Provider cannot request an Administrative Law Hearing on behalf of the Member, but can be a representative or a witness in a hearing process.

The requests for an Administrative Law Hearing must be sent to the following address:

WellCare Health Plans, Inc.
Administrative Law Hearing Request
Suite 800
211 Perimeter Center Parkway, NE
Atlanta, GA 30346

PeachCare for Kids® Member Right to a Formal Appeals Committee Review

Once the PeachCare for Kids® Member has completed WellCare’s internal Pre-Service Appeal process, if the PCK Member’s Parent or authorized representative elects to dispute WellCare’s denial of service decision, the Member’s Parent or authorized representative has the option of having the decision reviewed by the PeachCare for Kids® Formal Grievance Committee.

The Member’s Parent or authorized representative must request the Review within one hundred twenty (120) calendar days of the date the Notice of Adverse Benefit Determination is mailed by WellCare. The Review request and a copy of the Notice of Adverse Benefit Determination letter must be received within one hundred twenty (120) calendar days from the date the Notice of Adverse Benefit Determination was mailed.

The Request for a PeachCare for Kids® Member Formal Grievance Committee Review must be sent to the following address:
The decision of the Formal Grievance Committee will be the final recourse available to the Member.

**Provider Right to Hearing**

The Provider has the right to request an Administrative Law Hearing after exhausting WellCare’s internal Provider Appeal Review process. Parties to the Administrative Law Hearing include WellCare, the Provider and the Provider’s authorized representative.

The Provider or the Provider’s authorized representative may request an Administrative Law Hearing within fifteen (15) business days from the date the Provider receives the Notice of Adverse Action/Final Appeal Denial Notice letter from WellCare.

The hearing request and a copy of the adverse action letter must be received by WellCare within fifteen (15) business days from the date the Notice of Adverse Action letter was received by the provider, O.C.G.A. §49-4-153( e)(1). A Provider’s Administrative Law Hearing request must include:

- A clear expression by the Provider that he/she wishes to present his/her case to an administrative law judge;
- Identification of the Action being appealed and the issues that will be addressed at the hearing;
- A specific statement of why the Provider believes WellCare’s Action is wrong; and
- A statement of the relief they are seeking.

The request for an Administrative Law Hearing must be sent to the following address:

WellCare Health Plans, Inc.
Administrative Law Hearing Request
Suite 800
211 Perimeter Center Parkway, NE
Atlanta, GA  30346

OR

The Provider may select binding arbitration, as provided by O.C.G.A. § 33-21A-7(b), to be conducted by a private arbitrator. If the Provider and WellCare are unable to agree on an arbitrator, the rules of the American Arbitration Association® shall apply. Arbitration conducted pursuant to this Code section shall be binding on the Parties and all cost of arbitration, not including attorney’s fees, shall be shared equally by the Parties.
There are fees associated with filing an arbitration request with the American Arbitration Association® (AAA). Consult AAA’s website at [www.adr.org](http://www.adr.org) to obtain the current fee schedule and an address in which to submit the request.

The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) calendar days of being selected, unless the Contractor and the Provider mutually agree to extend this deadline.
Section 9: WellCare Compliance Program

Overview
WellCare’s Corporate Ethics and Compliance Program, as may be amended from time to time, includes information regarding WellCare’s policies and procedures related to fraud, waste and abuse, and provides guidance and oversight as to the performance of work by WellCare, WellCare employees, contractors (including delegated entities) and business partners in an ethical and legal manner. All Providers, including Provider employees and subcontractors and their employees, are required to comply with WellCare Compliance Program requirements.

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


Information on the ICD-10 transition and codes can also be found at: [www.wellcare.com/Georgia/Providers/ICD-10-Compliance](http://www.wellcare.com/Georgia/Providers/ICD-10-Compliance).

WellCare’s compliance-related training requirements include, but are not limited to, the following initiatives:

- HIPAA Privacy and Security Training
  - Summarizes privacy and security requirements in accordance with the federal standards established pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
  - 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 is not limited to:
    - Laws and regulations related to fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback Statute, HIPAA, etc.);
    - Obligations of the Provider, including Provider employees and Provider subcontractors and their employees, to have appropriate policies and procedures to address fraud, waste, and abuse;
    - Process for reporting suspected fraud, waste and abuse;
- Protections for employees and subcontractors who report suspected fraud, waste and abuse; and
- Types of fraud, waste and abuse that can occur.

- Cultural Competency Training
  - Development of programs to educate and identify the diverse cultural and linguistic needs of the Members in which the Providers serve.

- Disaster Recovery and Business Continuity
  - Development of a Business Continuity Plan that includes the documented process of continued operations of the delegated functions in the event of a short-term or long-term interruption of services.

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

Details of the Corporate Ethics and Compliance Program may be found on WellCare’s website at: www.wellcare.com/Georgia/Corporate/Compliance.

**Provider Education and Outreach**
Providers may:
- Display State-approved, health-plan specific materials in-office;
- Announce a new affiliation with a health plan; 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:
- Orally, or in writing, comparing benefits or Provider networks among health plans, other than to confirm their participation in a health plan’s network;
- Furnishing lists of their Medicaid patients to any health plan with which they contract, or any other entity;
- Furnishing health plans’ Membership lists to the health plan, including WellCare, or any other entity; and
- Assisting with health plan enrollment.

**Code of Conduct and Business Ethics**

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

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 WellCare’s 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/or abuse by calling the WellCare Fraud, Waste and Abuse Hotline at 1-866-678-8355.

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

Federal and state regulatory agencies, law enforcement and WellCare vigorously investigate incidents of suspected fraud, waste 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 record documentation and other documentation must be legible and support the level of care and service indicated on claims. Providers engaged in fraud, waste 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 Centers for Medicare & Medicaid Services (CMS) rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicaid managed care organization meet annual compliance and education training requirements with respect to FWA. To meet federal regulation standards specific to Fraud, Waste and Abuse (§ 423.504), Providers and their employees must complete an annual FWA training program.

To report suspected fraud, waste and abuse, please refer to the Quick Reference Guide on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid or call WellCare’s confidential and toll-free Compliance Hotline at 1-866-678-8355. Details of the Corporate Ethics and Compliance Program and how to contact the WellCare Fraud, Waste and Abuse Hotline, may be found on WellCare’s website at: www.wellcare.com/Georgia/Corporate/Compliance.
Confidentiality of Member Information and Release of Records

Medical record documentation 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 or 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 record documentation 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 a 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. 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 record documentation;
- 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.

The NPP informs the Member of his or her rights under HIPAA and how the Provider and/or WellCare may use or disclose the Member’s PHI. HIPAA regulations require each covered entity, such as healthcare Providers, to provide a NPP to each new patient or Member.

Written consent of the Member is required for the transmission of the clinical and medical record information of a former enrolled Member to any physician not connected with WellCare. The extent of clinical or medical record information to be released in each instance shall be based upon tests of Medical Necessity and a “need to know” on the part of the practitioner or a facility requesting the information.
Disclosure of Information
Periodically, Members may inquire as to the operational and financial nature of their health plan. WellCare will provide that information to any 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 Department 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: www.wellcare.com/Georgia/Providers/Medicaid.

Cultural Competency Program and Plan

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

The objectives of the Cultural Competency program are to:

- Identify Members that may have cultural, linguistic or disability-related barriers for which alternative communication methods are needed
- Use culturally sensitive and appropriate educational materials based on the Member’s race, ethnicity, condition of disability and/or primary language spoken
- Ensure that resources are available to overcome the language and communication barriers that exist in the Member population
- Make certain that Providers care for and recognize the culturally diverse needs of the population
- Teach staff to value the diversity of both their coworkers inside the organization and the population served, and to behave accordingly
- Provide cultural competency and disability training to all staff members. Ensure training is provided both orally and in written format.

Cultural competence in healthcare describes a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. Healthcare services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

Culturally and linguistically appropriate services (CLAS): The collective set of culturally and linguistically appropriate services (CLAS) mandates, guidelines, and recommendations intended to inform, guide, and facilitate required and recommended
practices related to culturally and linguistically appropriate health services. The U.S. Department of Health and Human Services, Office of Minority Health, has issued national CLAS standards. WellCare is committed to a continuous effort to perform according to those standards.

The components of WellCare’s Cultural Competency program include:

- **Data Analysis**
  - State-supplied data for Medicaid and SCHIP populations
  - Demographic data available from the U.S. Census and any special studies done locally
  - Claims and encounter data to identify the healthcare needs of the population by identifying the diagnostic categories that are the most prevalent
  - Member requests for assistance, plus complaints and grievances, to identify areas of opportunity to improve service to Members from a cultural and linguistic angle
  - Data on race, ethnicity, and language spoken for Members can be collected both electronically from the state data received and through voluntary self-identification by the Member during enrollment/intake or during encounters with network Providers.

- **Community-Based Support**
  - Outreach to community-based organizations which support minorities and the disabled in ensuring that the existing resources for Members are being used to their full potential.

- **Management Accountability for Cultural Competency**
  - The Quality Improvement Committee maintains ultimate responsibility for the activities carried out by the health plan related to cultural competency. The committee oversees the day-to-day operations of the Quality Program in the health plan including the Cultural Competency Program and improvement activities undertaken by the individual WellCare plans.

- **Diversity and Language Abilities of Health Plan Staff**
  - Non-Discriminating – WellCare may not discriminate with regard to race, color, religion, creed, age, sex, pregnancy, veteran status, marital status, sexual orientation, national origin, ancestry, disability, genetic information or other legally protected basis 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 who have potential linguistic barriers for which alternative communication methods are needed and will contact WellCare to arrange appropriate assistance;

Members may receive interpreter services at no cost when necessary to access Covered Services through a vendor, as arranged by the Provider Services 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 Provider Services 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 line for hearing-impaired services. WellCare’s Provider Services Department is responsible for any necessary follow-up calls to the Member. The toll-free TTY number can be found on the Member identification card.

**Linkage to Community**

- WellCare is dedicated to partnering with community organizations to promote cultural understanding and to meet the needs of the diverse population. Wherever possible, WellCare will pursue linkages with national, state-level and local organizations dedicated to advancing both the broad interests and the health interests of groups having needs for culturally-based supports.

**Member/Patient Education**

- The multicultural basis of WellCare’s patient education program is drawn from the Healthy People 2020 initiative. Healthy People 2020 is a “national health promotion and disease prevention initiative that brings together government agencies, nonprofit, voluntary, and professional organizations, businesses, communities, and individuals to improve the health of all Americans, eliminate disparities in health, and improve years and quality of healthy life.”
  (www.healthypeople.gov/2020/about/default.aspx)

- Given the nature of the population WellCare serves, from the 2020 list of conditions with disparate impacts on racial and ethnic minorities, WellCare has chosen diabetes, asthma and cardiovascular disease as the areas Member health education will focus on.

- Upon enrollment, Members receive a welcome packet that includes a Member Handbook, which outlines WellCare’s Disease Management Program.

**Member Rights**

- WellCare adopts and acts on the basis of the Medicaid Member rights and responsibilities as approved by each state’s Medicaid agency. All associates including Customer Service representatives are expected to treat Members in a manner that respects their rights and the expectations of their responsibilities.
• **Provider Education**
  o WellCare’s Cultural Competency Program provides a Cultural Competency Checklist to assess the Provider office’s Cultural Competency;
  o For more information on the Cultural Competency Program, registered Provider Portal users may access the Cultural Competency training on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Medicaid](http://www.wellcare.com/Georgia/Providers/Medicaid). A paper copy, at no charge, may be obtained upon request by contacting Provider Services or a Provider Relations representative;
  o Access the full Cultural Competency Plan from the Provider website at: [www.wellcare.com/Georgia/Providers/Medicaid/Forms](http://www.wellcare.com/Georgia/Providers/Medicaid/Forms); and
  o Providers must adhere to the Cultural Competency Program as set forth above.

• **Provider Performance Monitoring**
  o In the event that Members file complaints or grievances with WellCare concerning a Provider that behaves in a manner inconsistent with standards for culturally and linguistically appropriate services, WellCare will investigate the matter with the same degree of concern applied to any other complaint or grievance. Offending Providers will be expected to take corrective measures, and WellCare will follow up to make certain that such action indeed was taken.
  o If WellCare observes patterns in complaint and grievance information that suggest there are systemic deficiencies in Providers’ conformance to cultural competency aims, WellCare will investigate the root causes and define broad performance improvement projects to eliminate the weakness.

• **Ongoing Self-Assessment**
  o WellCare will continually assess the cultural competency of the company, both nationally and at the level of each health plan unit, to ensure that WellCare is meeting the diverse needs of its Members, Providers and staff. A component of the self-assessment will be to have focus groups of Members, Providers, and staff to explore the needs of all WellCare constituent groups and to listen to suggestions for improving WellCare’s Cultural Competency Program.
  o Annually the Cultural Competency Program will be reviewed, revised and presented to the Quality Improvement Committee to ensure compliance with the program objectives.

**Cultural Competency Survey**
WellCare’s Cultural Competency Program and Plan is listed on the website, and Providers may access the Cultural Competency Survey on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Medicaid/Forms](http://www.wellcare.com/Georgia/Providers/Medicaid/Forms).
Section 10: Delegated Entities

Overview
WellCare may, by written contract, delegate certain functions under WellCare’s contracts with the Centers for Medicare & Medicaid Services (CMS) and/or applicable State governmental agencies. These functions include, but are not limited to, contracts for administration and management services, sales & marketing, utilization management, quality management, care management, disease management, claims processing, credentialing, network management, Provider appeals, and Customer Service. WellCare may delegate all or a portion of these activities to another entity (a Delegated Entity).

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

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

Refer to Section 9: Compliance for additional information on compliance requirements.

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

- Validating the eligibility of proposed and existing Delegated Entities for participation in the Medicaid and Medicare programs.
- Conducting pre-delegation audits and reviewing the results to evaluate the prospective entity’s ability to perform the delegated function.
- Providing guidance on written agreement standards with delegated entities to clearly define and describe the delegated activities, responsibilities and required regulatory reports to be provided by the entity.
- Conducting ongoing monitoring activities to evaluate an entity’s performance and compliance with regulatory requirements and accreditation standards.
• Conducting annual audits to verify the entity’s performance and processes support sustained compliance with regulatory requirements and accreditation standards.

• The development and implementation of Corrective Action Plans (CAPs) if the Delegated Entity’s performance is substandard or terms of the agreement are violated.

• Review and initiate recommendations to Senior Management and the Chief Compliance Officer for the revocation and/or termination of those entities not performing to the expectations of the current contractual agreement and regulatory requirements.

• Track and trend compliance with oversight standards, entity performance, and outcomes

Section 11: Behavioral Health

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

Behavioral Health Services should be holistic, patient-centered and integrated with physical. Some behavioral health services may require Prior Authorization, including all services provided by non-participating Providers. WellCare uses Milliman Clinical Guidelines (MCG) for all Behavioral Health Services and American Society of Addiction Medicine (ASAM) criteria, for substance use disorder. These criteria are well-known and nationally accepted guidelines for assessing level of care criteria for behavioral health.

Medically Necessary Services:
All behavioral health services must be appropriate and Medically Necessary/Indicated. WellCare defines Medically Necessary services as services that are:

• Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible Member’s medical condition;

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

• Compatible with the standards of acceptable medical practice in the community;

• Not provided solely for the convenience of the Member or the convenience of the healthcare Provider or hospital;

• Not primarily custodial care unless custodial care is a Covered Service or Benefit under the Member’s Evidence of Coverage; and

• No other effective, more conservative, or substantially less costly treatment, service, or setting is available at the time of treatment based on the diagnosis.
For complete information regarding benefits, exclusions and authorization requirements, or in the event a Provider needs to contact WellCare’s Provider Services for a referral to a behavioral health Provider, refer to the Quick Reference Guide on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid.

Prior Authorization for Services
WellCare encourages community-based services and Member treatment at the least restrictive level of care whenever possible. WellCare also encourages Providers to offer a full-range of recovery-based services and engage in non-medical services and supports as indicated to provide holistic care focused on whole-health wellness, long-term independence, and skills building.

Prior Authorization is required for certain outpatient and community-based services including, but not limited to, assertive community treatment (ACT), psychological testing, intensive outpatient programs, partial hospital programs, residential treatment programs and inpatient hospital services. Most outpatient behavioral health services provided by physicians, physician assistants and nurse practitioners do not require a service authorization. Prior authorization request forms for IOP, partial hospitalization and higher levels of care are made available to Providers online or upon request. For IOP, partial hospitalization and higher levels of care please either fax your authorization request or call the health plan directly for a live request.

For complete information regarding authorization requirements please visit the behavioral health link on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid/Behavioral-Health. Behavioral health outpatient and community-based services authorizations can be requested, via the Georgia Web Portal. The Georgia Web Portal electronic forms for the submission of notifications and authorization requests can only be accessed upon log in to Georgia Medicaid Management Information System (GAMMIS) at: www.mmis.georgia.gov.

Behavioral Health Emergency Services
Behavioral health emergency services are specifically for Members who are experiencing an acute crisis. An acute crisis is an occurrence that meets the level of severity for involuntary examination, and, in the absence of a suitable alternative or psychotropic medication, would require hospitalization of the Member. Examples of an emergency behavioral health crisis include, but are not limited to, the following:

- Suicidal thoughts/actions
- Homicidal thoughts/actions
- Violent behaviors with objects
- Unable to care for self with daily living activities due to suffering a decline in functional impairment
- Alcohol or drug dependent and experiencing severe withdrawal symptoms such that medical supervision is required for the safety of the Member

In the event of a Member experiencing a behavioral health crisis, the safety of the Member and others should be the first concern. Instruct the Member and/or caregiver to seek immediate attention at the nearest behavioral health crisis facility or an emergency room. Contact emergency dispatch services (911) if the Member is in imminent danger to himself or herself or others and is unable or unwilling seek help on their own.
Continuity and Coordination of Care between Medical and Behavioral Healthcare Providers

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. Providers are required to use the ICD-10 or the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) when assessing the Member for behavioral services and document the diagnosis and assessment/outcome information in the Member’s medical record.

Behavioral health Providers are required to submit, with the Member’s or Member’s legal guardian’s consent, an initial and quarterly summary reports, thereafter of the Member’s behavioral health status to the PCP. Communication with the PCP should occur more frequently if clinically indicated and should be bidirectional to benefit the Member’s care.

WellCare encourages behavioral health Providers to pay particular attention to communicating with PCPs at the time of discharge from an inpatient hospitalization. Hospitals are required to fax a discharge summary to the Member’s PCP and behavioral health treating Provider. This communication, with the properly signed Member consent, shall be sent to the Member’s identified PCP noting any changes in the treatment plan including medication changes on the day of discharge. Additionally, psychiatric units and hospitals are required to obtain the appropriate signed consent and notify PCPs of all inpatient admissions.

To ensure continuity of care, patient safety and Member well-being is maintained, and integrated care is delivered, communication between behavioral health care Providers, PCPs and other treating Providers is critical. This is especially true for Members with chronic conditions and comorbidities receiving pharmacological therapy. Fostering a culture of collaboration and cooperation will help sustain a seamless continuum of care between medical and behavioral health and will positively impact Member health outcomes.

Responsibilities of Behavioral Health Providers

WellCare monitors Providers against access standards to ensure Members can obtain needed health services within the acceptable appointment waiting times. The provisions below are applicable only to behavioral health Providers and do not replace the provisions set forth in Section 3: 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>Mental Health</td>
<td>14 calendar days</td>
</tr>
<tr>
<td>BH Provider – Urgent</td>
<td>&lt; 48 hours</td>
</tr>
<tr>
<td>BH Provider – Post-inpatient discharge</td>
<td>&lt; 7 days</td>
</tr>
<tr>
<td>BH Provider – Routine</td>
<td>&lt; 10 days</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 (7) days from the date of discharge.

In the event that a Member misses an appointment, the outpatient behavioral health Provider must contact the Member within twenty-four (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 WellCare’s toll-free behavioral crisis hotline that is staffed twenty-four (24) hours a day. The behavioral crisis phone number is 1-800-411-6485 and it is printed on the Member’s card and is available on WellCare’s website. Members and providers may also access the Georgia Crisis and Access Line at 1-800-715-4225 for assistance and referrals including referrals to mobile crisis.

For information about WellCare’s Care Management and Disease Management programs, including how to refer a Member for these services, please see Section 5: Utilization Management (UM), Care Management (CM) and Disease Management (DM).

**Service Guidelines for Behavioral Health Providers**

WellCare Members who have a DSM-5 diagnosis and/or meet Medical Necessity criteria for behavioral health services may be referred to a behavioral health Provider. This may be a self-referral for treatment if warranted. Behavioral health Providers can offer behavioral health and substance abuse services when the services are in the scope of the professional license; the behavioral health Provider is a credentialed Medicaid Provider; and the services are within the scope of the Member’s benefit plan as provided by WellCare. It is the responsibility of the Provider to determine Medical Necessity, seek authorizations when appropriate and ensure the competent delivery of service to WellCare Members by qualified staff.

It is the responsibility of each Provider/facility to ensure qualified staff is providing services ordered by the organization’s physician and/or licensed clinician. All behavioral services require an order for service. The following is a list of the ordering practitioner guidelines:

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH Provider – Non-life threating Emergency</td>
<td>&lt; 6 hours</td>
</tr>
<tr>
<td>BH Appointment Wait Time</td>
<td>&lt; 60 minutes</td>
</tr>
</tbody>
</table>
**List is not inclusive of all services.**

Unless otherwise specified in WellCare’s policy, facility Providers must ensure adequate staffing to provide behavioral health services. This includes, but is not limited to, having appropriately licensed staff to deliver services and meet the Member's needs. The organization is responsible for having policies and procedures that demonstrate that appropriate professional staff conduct treatment for all behavioral health services and must ensure adequate staffing patterns to provide access to services that include the following at a minimum:

- Medical Director/Psychiatrist who is available to provide direct services to Members and is appropriately licensed in the state
- A Clinical Director who is a full-time employee and is independently licensed with at least two (2) years of experience in behavioral health service delivery
- Licensed clinicians (LCSW, LPC, LMFT)
- An addiction counselor (MAC, CACII, CADC, CCADC)
- Paraprofessional

Below is a list of the professionals who may provide the services ordered for WellCare Members:
### SERVICE

<table>
<thead>
<tr>
<th>Medical Doctor</th>
<th>Licensed Psychologist</th>
<th>Licensed Clinician (LPC, LMFT, LCSW)</th>
<th>Paraprofessional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Assessment/Service Plan Development</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Community Support Individual (CSI)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Diagnostic Assessment</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Nursing Services</td>
<td></td>
<td>LPN, RN or APRN only</td>
<td></td>
</tr>
<tr>
<td>Family Outpatient Counseling/Training</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Group Outpatient Counseling/Training</td>
<td>X</td>
<td>X</td>
<td>X (group training)</td>
</tr>
<tr>
<td><strong>Individual Therapy, Family Therapy and Group Therapy</strong></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Psychiatric Treatment</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Family Intervention</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

** List is not inclusive of all services. Associate license and licensure track Master’s level S/T credentials are acceptable with adequate documentation of supervision.

**Behavioral Health Advisory Council**

WellCare values the input of its behavioral health Members, advocates, and Providers. A Behavioral Health Advisory Council has been established in order to assist WellCare’s services and programs meet the needs and expectations of the behavioral health community. WellCare encourages its Providers to participate by providing feedback and input to the advisory council.
Section 12: Pharmacy

Overview
WellCare’s pharmaceutical management procedures are an integral part of the Pharmacy Program that ensure and promote the use of the most clinically appropriate agent(s) to improve the health and well-being of WellCare 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);
- Pharmacy Lock-In Program;
- Coverage Determination Review Process; and
- Network Improvement Program (NIP).

These processes are described in detail below. In addition, prescriber and Member involvement is critical to the success of the Pharmacy Program. To help Providers’ patients get the most out of their pharmacy benefit, Providers are encouraged to consider the following guidelines when prescribing:

- Follow national standards of care guidelines for treating conditions, i.e., National Institutes of Health (NIH) Asthma Guidelines, Joint National Committee (JNC) VIII 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 on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid.

Preferred Drug List (PDL)
WellCare’s PDL is a published prescribing reference and clinical guide of prescription drug products selected by WellCare’s Pharmaceutical and Therapeutics Committee (P&T Committee). The PDL denotes any of the pharmacy utilization management tools that apply to a particular pharmaceutical.

The P&T Committee selects medications based on drug 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 Limits, Age Limits, Prior Authorization and Step Therapy). There is also a PDL search tool where the medication can be searched alphabetically, by brand and generic name, or by therapeutic class.
Providers may obtain a PDL on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid/Pharmacy. Changes to the PDL and applicable pharmaceutical management procedures are communicated to Providers as follows:

- Quarterly updates in Provider and Member newsletters;
- Website updates; and/or
- Pharmacy and Provider communications that detail any major changes to a particular therapy or therapeutic class.

**Additions and Exceptions to the Preferred Drug List (PDL)**

Providers may request consideration for addition of a drug to WellCare’s PDL by writing to WellCare and explaining the medical justification. For contact information, refer to the Quick Reference Guide at: www.wellcare.com/Georgia/Providers/Medicaid.

For more information on requesting exceptions, refer to the Coverage Determination Review Process in this Handbook.

**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 available as the therapeutic equivalent to a brand-name drug. To request an exception to the mandatory generic policy, a Coverage Determination Request Form should be submitted. Clinical justification as to why the generic alternative is not appropriate for the Member should be included with the Coverage Determination Request Form.

For more information on the Coverage Determination Review process, including how to access the Coverage Determination Request Form, see Coverage Determination Review Process in this Handbook.

**Injectable and Infusion Services**

Select self-injectable and infusion drugs are covered under the outpatient pharmacy benefit. Most self-injectable products and all infusion drug requests require a Coverage Determination Review using the Injectable/Infusion Form which is located on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid/Forms.

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.

**Coverage Limitations**

WellCare covers all drug categories currently available through the Georgia 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;
• Agents used to promote smoking cessation;
• Non-prescriptive, over-the-counter (OTC) drugs* with a few exceptions listed on the PDL;
• Cough and cold combination medications for Members twenty-one (21) and older;
• Drugs for the treatment of erectile dysfunction;
• DESI drugs or drugs that may have been determined to be identical, similar or related;
• Prescription vitamins or mineral products, except for prenatal vitamins, folic acid 1mg, and fluoride preparations that are not in combination with other vitamins listed on the PDL;
• Investigational or experimental drugs; and
• Agents prescribed for any indication that is not medically accepted.

WellCare will not reimburse for prescriptions for refills too soon, duplicate therapy or excessively high dosages for the Member.

*All OTC drugs listed on the PDL as covered will require a prescription for the pharmacy to dispense.

**Step Therapy (ST)**
The P&T Committee has developed Step Therapy (ST) programs. These programs encourage the use of therapeutically equivalent, lower-cost medication alternatives (first-line therapy) before “stepping-up” to less cost-effective alternatives.

Step therapy programs are intended to be a safe and effective method of reducing the cost of treatment by working to ensure that an adequate trial of a proven, safe and cost-effective therapy is attempted before progressing to a more costly option. First-line drugs are recognized as safe, effective and economically sound treatments. The first-line drugs on WellCare’s PDL have been evaluated through the use of clinical literature and are approved by WellCare’s P&T Committee. Please refer to the PDL to view drugs requiring step therapy.

**Quantity Limits (QL)**
Quantity limits are used to work toward ensuring that pharmaceuticals are supplied in a quantity consistent with the Food and Drug Administration (FDA) approved dosing guidelines. Quantity limits can also be used to help prevent billing errors. Please refer to the PDL to view drugs with Quantity Limits.

**Age Limits (AL)**
Some medications have an age limit associated with them. WellCare uses Age Limits to help ensure proper medication utilization when necessary. Please refer to the PDL to view drugs with age limits.
Over-the-Counter (OTC) Medications
WellCare will only pay for over-the-counter (OTC) items listed on the PDL that are prescribed to the Member. Examples of OTC items listed on the PDL include:

- Multivitamins and multiple vitamins with iron (chewable or liquid drops);
- Iron;
- Non-sedation antihistamines;
- Enteric coated aspirin;
- Diphenhydramine;
- Insulin;
- Topical antifungals;
- Ibuprofen suspension;
- Permethrin;
- Meclizine;
- Insulin syringes;
- Urine test strips;
- H-2 receptor antagonists; and
- Proton pump inhibitors.

For a complete listing, please refer to the PDL which can be found on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid/Pharmacy.

Pharmacy Lock-In Program
The WellCare pharmacist reviews potential Members for lock-in identified through internal reports. These reports identify Members who overutilize or improperly utilize medications in certain therapeutic classes, receive duplicative therapy from multiple physicians, or frequently visit the emergency room seeking pain medications. Such Members may be placed in Pharmacy Lock-In (Lock-In) status for a minimum of one (1) year. While in Lock-In, the Member will be restricted to one (1) prescribing physician and one (1) pharmacy to obtain their medications. Claims submitted by other prescribers or other pharmacies will not be paid for the Member. Members identified will also be referred for Care Management.

The Care Management team will work with the Member to create an individualized Care Plan. Care managers provide monitoring, education, communication and collaboration, and can assist with access to alternative treatments to improve a Member’s health. For questions or concerns regarding the Lock-in program, Members or Providers may call 1-866-231-1821, Monday–Friday, 7 a.m. to 7 p.m. Eastern. TTY/TDD users may call 711.

The WellCare pharmacist performs an annual review of Members in the Lock-In Program to determine the need for further Lock-In according to established procedures. A summary of the annual review is presented at the WellCare Pharmacy Quality Oversight Committee (PQOC) meeting.
Member Co-Payments

<table>
<thead>
<tr>
<th>Category</th>
<th>Co-Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>PreferredGeneric</td>
<td>$0.50</td>
</tr>
<tr>
<td>PreferredBrand</td>
<td>$0.50</td>
</tr>
<tr>
<td>Non-PreferredBrand Or</td>
<td>Under $10.00 = $0.50</td>
</tr>
<tr>
<td>Non-PreferredGeneric</td>
<td>$10.01-$25.00 = $1.00</td>
</tr>
<tr>
<td></td>
<td>$25.01-$50.00 = $2.00</td>
</tr>
<tr>
<td></td>
<td>$50.01 or more = $3.00</td>
</tr>
</tbody>
</table>

Coverage Determination Review Process (Requesting Exceptions to the PDL)

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 (PA);
- Brand-name drugs when a generic exists; and
- Drugs that have a Step Therapy (ST) edit and the first-line therapy is inappropriate.

Providers may request an exception to WellCare’s PDL orally 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: www.wellcare.com/Georgia/Providers/Medicaid/Pharmacy.

To submit a request orally or in writing, refer to the contact information listed on the Quick Reference Guide on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid.

If authorization cannot be approved or denied, and the drug is Medically Necessary, a seven (7) day emergency supply of the non-preferred drug shall be supplied to the Member.

Prior Authorization (PA) 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.). The criteria are available upon
request when submitted to WellCare’s Pharmacy Department by the Member or Provider.

**Medication Appeals**
To request an appeal of a Coverage Determination Request decision, contact the Pharmacy Appeals Department via fax, mail, in person or phone. Refer to the *Quick Reference Guide* on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Medicaid](http://www.wellcare.com/Georgia/Providers/Medicaid).

Once the appeal of the Coverage Determination Review request decision has been properly submitted and obtained by WellCare, the request will follow the appeals process described in *Section 8: Appeals and Grievances.*

**Member Pharmacy Access**
WellCare maintains a comprehensive network of pharmacies to ensure that pharmacy services are available and accessible to all Members twenty-four (24) hours a day.

In areas where there are no twenty-four (24) hour pharmacies, Members may call Pharmacy Services for information on how to access pharmacy services after hours. Contact information is located on the *Quick Reference Guide* on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Medicaid](http://www.wellcare.com/Georgia/Providers/Medicaid).

**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 is an expert in the special handling, storage and administration of these medications (i.e., injectables, infusibles, orals). This team knows the insurance process and the Member’s plan benefits. This means less chance of delays in a Member receiving needed medication(s). Prescription orders generally ship directly to the Member’s home, Provider’s office, or alternative address provided by the Member within twenty-four (24) to forty-eight (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, refer to WellCare’s website at: [www.wellcare.com/Georgia/Providers/Exactus-Specialty-Pharmacy](http://www.wellcare.com/Georgia/Providers/Exactus-Specialty-Pharmacy).
Section 13: Facilities

All provisions contained within the Provider Handbook are applicable to all Providers unless otherwise noted in this section.

Hospital Statistical and Reimbursement Report (HS&R)
All requests made to WellCare for a Hospital Statistical and Reimbursement Report (HS&R) must be submitted in writing to WellCare Regulatory Affairs at SM_WellCareGA_HS&R@wellcare.com

The request should include the following elements:
- Name of Requestor;
- Facility/Institution Name;
- Number of licensed beds;
- Service Dates From–Through; and
- Paid Dates From–Through.

WellCare will complete the facility-specific HS&R report within thirty (30) days of the written request receipt date. The report will adhere to the detail specifications provided by DCH.

The data extract will be for those facilities specified on the written request and will be based on institutional claims for Medicaid Members covered by WellCare. Reports will be distributed to the requestor via encrypted password protected email or FedEx.

Scope of Services

Overview
WellCare provides reimbursement to participating Providers for inpatient or outpatient hospital services. Care provided to eligible Members includes those services that are primarily for the treatment of acute illness, injury, impairment or for maternity care.

WellCare establishes reimbursement limitations as required by the Georgia state contract to ensure Medical Necessity of services rendered and utilization management.

Please refer to Section 14: Definitions for the definition of ‘Medical Necessity’.

Coverage is provided for eligible Members for preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. Care must be rendered under the direction of a doctor or by an institution which is licensed or formally approved as a hospital by an officially designated state standard-setting authority. The Provider must be qualified to participate under Title XIX (Medicaid) of the Social Security Act.

In compliance with Section 1902 (a) (57) of the Social Security Act, hospitals must:
- Provide written information to patients regarding their rights under state law to make decisions concerning their medical care, including the right to accept or
refuse medical or surgical treatment and the right to formulate advance directives;

- Provide written information to individuals regarding the institution's or program's written policies respecting the implementation of the right to formulate advance directives;
- Document in the patient's medical record whether or not an advance directive has been executed;
- Comply with all requirements of state law respecting advance directives;
- Provide (individually or with others) education for staff and the community on issues concerning advance directives; and
- Not condition the provision of care or otherwise discriminate against an individual who has executed an advance directive.

WellCare defines an **inpatient** as a patient who has been admitted to a participating hospital on recommendation of a licensed doctor and is receiving room, board and professional services in the hospital on a continuous twenty-four-(24)-hour-a-day basis. Transfers between units within the hospital are not considered new admissions, unless it is a transfer from a medical unit to a psychiatric unit.

WellCare defines an **outpatient** as a patient who is receiving professional services at a participating hospital, but who is not provided room, board and professional services on a continuous twenty-four-(24)-hour-a-day basis. Observation services are also considered outpatient. Observation services usually do not exceed twenty-four (24) hours.

Free-standing (satellite) clinics, which are not operated as part of a hospital, are considered doctors’ offices by WellCare. Services provided in these clinics and other away-from-hospital settings are not covered as hospital services.

Hospital-based clinics, which are operated as part of a hospital, are considered outpatient hospital-based facilities by WellCare. As such, these facilities must follow authorization rules for hospital-based services.

Level of care determinations will be based on InterQual™ Criteria and Medical Director review.

**Documentation and Coding Requirements**

WellCare’s requirements for documentation and coding dictate that written records must be maintained and fully disclose the extent, Medical Necessity and appropriateness of the setting for services provided. The records must identify the Member, support the diagnosis, justify the treatment and document the course of care and results accurately. Written records are subject to audit by WellCare, and coding will be evaluated against chart documentation for accuracy.

Inpatient medical record documentation must include at least the following:

- Identification data including the patient's name, address, date of birth, next of kin and a number that identifies the patient and the patient's medical record;
• Medical history completed within twenty-four (24) hours of admission, including the chief complaint, details of the present illness, relevant past, social and family histories, and an inventory of body systems;
• Relevant obstetrical records and prenatal information;
• Report of the physical examination, completed within twenty-four (24) hours of admission;
• A statement of conclusions or impressions drawn from the admission history and physical examination;
• A statement of the course of action planned for the patient while in the hospital including a periodic review of the planned course of action, as appropriate;
• Diagnostic and therapeutic orders written by medical staff members (verbal orders must be authenticated);
• Appropriate informed consent;
• Clinical observations, including the results of therapy;
• Progress notes by the medical staff which give a chronological report of the patient's course in the hospital and reflect changes in condition and the results of treatment;
• Consultation reports that contain the consultant's written opinion and reflect, when appropriate, an actual examination of the patient and the patient's medical record;
• Nursing notes and entries by non-physicians that contain medically relevant observations and information;
• Reports of procedures, tests and their results;
• A preoperative diagnosis recorded prior to surgery by the individual responsible for the patient;
• Operative report dictated or written on the medical record immediately after surgery containing a description of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis and the name of the primary surgeon and any assistants;
• Reports of pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatment, anesthesia records and any other diagnostic or therapeutic procedures;
• Clinical summary at termination of hospitalization which recapitulates the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient upon discharge and any significant instructions given to the patient and family;
• In teaching hospitals, the medical record must make it clear that the attending physician is providing professional services independently of the student or resident and that the notes of the student or resident only reflect his or her role as student or resident. At a minimum, the medical record must contain signed or countersigned notes which clearly specify that the physician personally reviewed the history, gave a physical examination and confirmed or revised the diagnosis and prescribed treatment. The attending physician must be recognized by the Member as the Member's personal physician;
• Documentation on the discussion of advance directives and/or a completed advance directive form; and
• Signature and date of each entry.
WellCare requires all participating hospitals to properly code all relevant diagnoses and surgical and obstetrical procedures on all inpatient and outpatient claims submitted. WellCare uses the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM or its successors) for all coding. In addition, the Physicians’ Current Procedural Terminology, Fourth Edition (CPT-4) coding and/or HCPCS is required for all outpatient surgical, obstetrical, injectable drugs, diagnostic laboratory and radiology procedures. When coding, the hospital must select the code(s) that most closely describe(s) the diagnosis(es) and procedure(s) performed. When a single code is available for reporting multiple tests or procedures, that code must be used rather than reporting the tests or procedures individually.

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

See Section 6: Claims (for more information regarding how to file claims)

Prior Authorization for Inpatient Services

Prior Authorization is the process of obtaining authorization in advance of rendering a service which may or may not require a medical record review and is required for elective or non-urgent services designated by WellCare. Prior Authorization is conducted prior to a Member’s admission, stay, other service or course of treatment in a hospital or other facility. The attending physician is responsible for obtaining the Prior Authorization of the elective and/or non-urgent admission. An authorization is the approval necessary for payment to be granted for Covered Services and is provided only after WellCare agrees the treatment is necessary and a Covered Benefit.

Hospitals should use inpatient-qualifying criteria such as InterQual™ to determine the appropriateness of an inpatient admission and conduct concurrent review of the patient’s condition. The patient should remain hospitalized until the same criteria indicate hospitalization is no longer necessary. WellCare will notify Providers at least thirty (30) days prior to the date of any changes in the criteria or version of criteria being used to certify inpatient admissions via posting to WellCare’s website or other means.

In determining if a Member’s condition requires inpatient care, WellCare looks to the Medical Necessity using inpatient-qualifying criteria such as those published by InterQual™. If the Member is admitted, he or she must remain hospitalized until concurrent review performed by the hospital indicates discharge is necessary.

There is no limit on the number of days Medicaid allows for Medically Necessary inpatient hospital care with the exception of a limitation for psychiatric care. If a Member is re-admitted to the hospital for the same or related problem within three (3) days of discharge, it is considered the same admission. All admissions are subject to medical justification and WellCare may request documentation to substantiate Medical Necessity and appropriateness of setting. Documentation must be provided upon request in pre-
payment or post-payment review. Failure to show appropriate medical justification may be cause for denial, reduction or recoupment of reimbursement.

For additional reimbursement for cost outliers or unusually expensive admissions, WellCare follows DCH guidelines when determining payment for each submitted case.

Hospital admission for diagnostic purposes is covered only when the services cannot be performed on an outpatient basis.

Certain services may only be reimbursed when performed on an outpatient basis unless Medical Necessity for an inpatient admission is documented and authorized. Diagnostic procedures such as chest X-rays are covered as part of the inpatient admitting process only when:

- The test is specifically ordered by a physician responsible for the patient’s care;
- The test is Medically Necessary for the diagnosis or treatment of the individual patient’s condition;
- The test does not unnecessarily duplicate the same test done on an outpatient basis before admission, or done in connection with a recent admission; or
- The test is billed with the admission.

If a hospital determines that an outpatient hospital setting would have met the medical needs of a Member after the services were provided in an inpatient setting, the services may be billed to WellCare as outpatient if the claim is received within one hundred eighty (180) days of the ending date of the service month. If the claim is received more than one hundred eighty (180) days after the ending date, the services are not covered.

To substantiate the determination, a physician’s order must document the Member’s status at the time of admission and any changes in the Member’s status.

Reimbursement for psychiatric services is limited to short-term acute care. The maximum length of stay considered for reimbursement by WellCare, or WellCare’s Delegated Behavioral Health Agent, is thirty (30) days. Psychiatric admissions that have a length of stay in excess of thirty (30) days will be denied reimbursement.

Intermediate care (i.e., step-down units) is reimbursable at the semiprivate room rate.

If a Member is admitted as an inpatient for less than twenty-four (24) hours in duration, the admission is subject to a Medical Necessity of admission review by WellCare. A length of stay less than twenty-four (24) hours is considered observation and is therefore considered an outpatient service. Outpatient services billed as inpatient are subject to denial or recoupment after review for Medical Necessity. Refer to the Observation Section below for more information.

Prior Authorization requirements by service type may be found on the Quick Reference Guide on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid or on the searchable Authorization Lookup Tool at: www.wellcare.com/Georgia/Providers/Authorization-Lookup. Providers will need to register and log in to use this secure tool.
Observation Services
WellCare defines observation services as those services furnished by a hospital, including the use of a bed and periodic monitoring by a hospital's nursing or other staff. Observation services are covered when it is determined they are reasonable and necessary to evaluate a patient's condition or to determine the need for a possible admission to the hospital as an inpatient.

Such services are covered only when provided by the order of a physician or another individual authorized to admit patients to the hospital or to order outpatient tests. Observation services usually do not exceed twenty-four (24) hours; however, some patients may require forty-eight (48) hours of outpatient observation services.

In only rare and exceptional cases, outpatient observation services span more than forty-eight (48) hours.

When a Member is placed under observation by a hospital, the patient is considered an outpatient until the patient is admitted as an inpatient. While under observation, the hospital may determine the patient needs further care as an inpatient admission or the patient may improve and be released. When Medical Necessity dictates an inpatient admission of a patient in observation, this should be billed under revenue code 762, which reflects this transaction. Please refer to the Quick Reference Guide on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid for more information.

WellCare does not cover outpatient observation services in the following situations:

- Complex cases requiring inpatient care;
- Post-operative monitoring during the standard recovery period;
- Routine preparation services furnished prior to diagnostic testing in the hospital outpatient department and the recovery afterwards; or
- Observation billed concurrently with therapeutic services such as chemotherapy, physical therapy, etc.

A Member may only transfer from outpatient status to inpatient status if it is determined that inpatient services are Medically Necessary and meet InterQual™ criteria. In order for the services to be covered, authorization must be obtained within one (1) business day of the beginning date of this episode of care. To receive authorization for an inpatient admission, WellCare must receive documentation indicating the admission is Medically Necessary and appropriate.

The date of the inpatient admission will be the actual date the patient is formally admitted as an inpatient and will count as the first inpatient day. When a patient is admitted to the hospital from outpatient observation, all observation charges must be combined and billed with the inpatient charges beginning from the date of initial observation. Outpatient observation services should not be used for services for which

Please refer to Section 5: Utilization Management, Care Management, and Disease Management for more information regarding Prior Authorization.
an overnight stay is normally expected. Services, such as complex surgery which clearly requires inpatient care, may not be billed as outpatient.

WellCare only covers services that are Medically Appropriate and Necessary. Failure to obtain the required authorization will result in denial of reimbursement of all services provided and extends to all professional services, not just the hospital services.

Medical appropriateness and necessity including that of the medical setting must be clearly substantiated in the Member’s medical record. If it is determined the outpatient observation is not covered, then all services provided in the observation setting are also not covered. Services provided for the convenience of the patient or physician and that are not reasonable or Medically Necessary for the diagnosis are not covered.

**Hospital-Based Physicians, Certified Registered Nurse Anesthetists, and Nurse Practitioners**

All inpatient and outpatient professional services must be billed on the physician's claim form. Hospital-based physicians, Certified Registered Nurse Anesthetists (CRNAs), specified nurse practitioners, and Physician Assistants (PAs) may designate the hospital as payee by agreement. The hospital must maintain each agreement authorizing such payments on file.

Services rendered to eligible Members by hospital-based physicians, CRNAs, designated nurse practitioners and PAs will be covered both on an inpatient and outpatient basis as long as the services are Medically Necessary and within the contractual or financial agreement with the hospital. These services are subject to Retrospective Review by WellCare or its authorized agents.

**Transplant Services**

WellCare covers all services and supplies related to covered transplant services for eligible Members. All transplants for eligible WellCare Members under the age of twenty-one (21) are covered as required by the DCH contract.

Heart, lung and heart/lung transplants are not covered for Members ages twenty-one (21) and older.

Prior Authorization is required for all transplants regardless of the Member's age.

**Dialysis**

Services for dialysis do not require Prior Authorization when rendered at a contracted facility.

**Rehabilitation Services**

Rehabilitation services as defined by federal regulation are not covered by WellCare. However, short-term rehabilitation services are covered by WellCare for Members if services are received immediately following treatment for acute illness, injury or impairment. Like other services covered under EPSDT, rehabilitative services need not actually cure a disability or completely restore an individual to a previous functional level.
Rather, such services are covered when they ameliorate a physical or mental disability, as discussed above. Short-term rehabilitation services include physical therapy, occupational therapy and speech therapy and are covered when the conditions listed below are met:

- The Member’s physician must establish a written treatment plan that includes the services received as well as identifies the rehabilitation potential, sets realistic goals, and measures progress. The plan must also include the type of modalities and procedures, frequency of visits, estimated duration, diagnosis, functional goals, and recovery potential; WellCare’s UM reviewers review all cases, adult and children, every 7 days (5 business days). The inpatient team receives clinical information from hospitals, nursing homes, long-term acute care facilities. Authorizations must be obtained by the physician every five (5) business days to ensure the services rendered are necessary. When requesting an extended authorization, the physician must include the date of the initial acute illness, injury or impairment, the diagnosis, and an estimate of the duration of service;
- The services must be of such a level of complexity and sophistication or the Member’s condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified therapist;
- The physician’s prognosis must include an expectation that the Member's condition will improve significantly in a reasonable period of time, or the development of an effective maintenance program relies on the services being provided to treat a specific disease state; and
- The plan for the Member’s treatment must include an amount, frequency and duration of services that are reasonable under accepted standards of practice.

**Hospitalist Program**
Hospitalists provide attending physician coverage in selected markets for Members admitted to contracted facilities. Hospitalists provide the following services:

- Emergency room assessment of a Member;
- Direct admissions to facilities where the PCP may not provide that service;
- Manages care as needed throughout the inpatient medical admission for Members, excluding obstetrical and gynecological cases;
- Refers Members to the PCP upon discharge for follow-up care; and
- Communicates the treatment/discharge plan verbally within twenty-four (24) hours and in writing within seven (7) days.

**Emergency Room and Outpatient Services**
Emergency services shall be available twenty-four (24) hours a day, seven (7) days a week to treat an emergency medical condition. Please see Section 14: Definitions for the definition of an ‘emergency medical condition’.

WellCare provides payment for emergency services when furnished by a qualified Provider, regardless of whether that Provider is in the WellCare network. These services are not subject to Prior Authorization requirements. WellCare will pay for all emergency services that are Medically Necessary until the Member is stabilized. WellCare will also pay for any medical screening examination conducted to determine whether an emergency medical condition exists.
In accordance with Georgia law (O.C.G.A. § 33-21A-4), WellCare will consider the following criteria when processing claims for emergency services:

- The age of the patient;
- The time and day of the week the patient presented for services;
- The severity and nature of the presenting symptoms;
- The patient’s initial and final diagnosis; and
- Any other criteria prescribed by DCH, including criteria specific to patients less than eighteen (18) years of age.

The attending emergency room physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge.

WellCare will not retroactively deny a claim for an emergency medical screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature. The determining factor for payment liability shall be whether the Member had acute symptoms of sufficient severity at the time of presentation. Payment shall be at either the rate negotiated under the Provider Agreement, or the rate paid by WellCare under the Medicaid Fee-for-Service Agreement.

WellCare may establish guidelines and timelines for submittal of notification regarding the provision of emergency services, but will not refuse to cover an emergency service based on the emergency room Provider’s or hospital or fiscal agent’s failure to notify the Member’s PCP or WellCare representative of the Member’s screening and treatment within said time frames.

The Member cannot be billed for the screening and/or treatment needed for stabilization.

Once the Member’s condition is stabilized, unplanned urgent admissions must be followed by:

- Notification to WellCare by calling the Provider Hotline and reporting the urgent or emergent admission within twenty-four (24) hours of the admission. The caller should provide the following:
  - Member’s name;
  - WellCare Member ID number;
  - Name of admitting hospital;
  - Referring physician; and
  - Diagnosis of Member; and

- Additional clinical information must be submitted to WellCare by the next business day for use in making a final authorization determination. If available, clinical information may be provided at the time of notification.

Emergency room visits that cannot be documented as true medical emergencies or potential medical emergencies will be reimbursed at the applicable triage rate, or as otherwise specified in the hospital Agreement. The triage rate covers all ancillary services rendered as well as the fee for use of the emergency room. This triage rate may be subject to the hospital’s contracted reimbursement rate; in other words, the triage rate
may not be the reimbursement rate in all cases. This triage rate includes any applicable Member co-payment. The triage rate is for the medical screening examination and stabilization services provided in the emergency room without regard to Prior Authorization.

If the hospital believes the medical record supports the existence of a true emergency situation, but the initial presenting information on the claim may not be identified as a true emergency, the claim may be submitted by hard copy with documentation. The claim will suspend for medical review against the prudent layperson criteria, and additional criteria outlined previously, and applicable payment applied.

If a triage rate was received, and the presenting claim did not clearly provide information for determining the presence of an emergency, additional documentation may be submitted for a medical Retrospective Review. A single form can be submitted with one or multiple claims. Each claim submitted should contain new information which provides complete insight on the Member’s visit to the emergency room. All claims will be reviewed and a follow-up letter of determination (upheld or overturned) will be sent for each claim.

In the event a claim decision is overturned based on the additional documentation, WellCare will automatically reprocess the claim at the appropriate emergency room payment rate determined by the hospital contract. Submit all retrospective emergency room review requests using the ER Medical Review Request Form. In the event the emergency room triage decision is upheld through this informal emergency room reconsideration process, the Provider can still submit the claim for review under the formal appeals process using the Administrative Review Request Form. Both forms are located on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid/Forms.

If, after medical review, the determination is made that an emergency or potential emergency did in fact exist, the services will be reimbursed at the hospital’s specific outpatient contracted rate. Accurate coding is critical to ensure proper reimbursement.

**Non-Covered Inpatient Services**
WellCare does not cover the services and procedures listed below. In addition, any services related to, required in preparation for, or incurred as a result of non-Covered Services are also not covered:

- Services and supplies which are inappropriate or not Medically Necessary as determined by WellCare or other authorized agent;
- Services or procedures performed which are not in compliance with the policies and procedures contained in this Handbook;
- Miscellaneous and non-specific charges;
- Non-acute levels of care;
- Utilization review;
- Differential service charges, i.e., "STAT" or priority, after-hours or "callback" fees;
- Late charges defined as a portion of the charges for a given service omitted from the original billing, which included some of the charges for that given service, are
non-covered. If the total charges for a given service were omitted from the original billing, a positive adjustment may be requested;

- Services mandated to be performed only on an outpatient basis;
- Clinic services while the Member is an inpatient;
- Inpatient leave of absence;
- Patient or family education or supplies;
- Nursing services, including services traditionally accepted as nursing care even though provided by other ancillary departments;
- Private duty nurses, sitters or companions;
- Service charges for individual areas within the hospital, i.e., pharmacy dispensing fee, IV admixture fee (except for hyperalimentation), cover charge for central supply, charges for handling and distribution of supplies, transportation within the hospital, equipment installation, specimen collection, venipuncture, standby equipment, staff time, and evaluations;
- Resuscitation, code, cardiopulmonary resuscitation (CPR), etc., are non-covered. However, supplies associated with this service will be reimbursed;
- Investigational items and experimental services, drugs or procedures;
- Any services or items furnished for which the hospital does not normally charge;
- Services provided by an institution for mental disease or special disorders;
- Separately billed equipment and supplies which are integral parts of hospital care and the area in which care is being provided, i.e., cardiac monitor in ICU, light source in the operating room, call system, blood pressure cuffs and monitors, specimen collection devices and containers, etc.;
- Hospital-based therapy services for treatment of chronic conditions;
- Private rooms are non-Covered Services. However, if the Member has a condition that requires an isolation room or special care unit (ICU, CCU), those are reimbursable. All other accommodations are reimbursed at the semiprivate room rate. Upon admission, Members should be notified that private rooms are non-Covered Services. Members who request a private room after being informed of WellCare’s policy will be responsible for the difference between the hospital's semiprivate and private room rates. If the Member has a condition that requires an isolation room or special care unit or if the hospital only offers private rooms or only has private rooms available, the Member cannot be billed for the difference between the semiprivate room rate paid by WellCare and the private room rate;
- Services which are not Medically Necessary to the patient's well-being, i.e., television, telephone, combs, brushes, guest meals, cots, etc.;
- Non-consumable multiple supply items, i.e., bath basins, admission kits, disposable pillows, etc.;
- Take-home prescription drugs, medical supplies, durable medical equipment, and artificial limbs and appliances are non-covered;
- Cosmetic surgery or mammoplasties for aesthetic purposes;
- Infertility procedures and related services;
- Some situations concerning abortions, sterilizations and hysterectomies. See Limits to Abortions, Sterilizations and Hysterectomy Coverage in Section 5: Utilization Management, Care Management and Disease Management for details; and
• Tubal reanastomosis procedures pertaining to sterilizations and vasectomies.

**Non-Covered Emergency Room Outpatient Services**

Not all emergency room and outpatient services are Covered Benefits for WellCare Members.

Those listed below as well as any services related to these services are non-covered:

- Services or procedures performed which are not in compliance with the policies and procedures contained in this Handbook;
- Routine physical examinations;
- Investigational items and experimental services, drugs or procedures;
- Any services and supplies which WellCare or an authorized agent deems as inappropriate or not Medically Necessary (may be submitted for Prior Authorization consideration);
- Any services or items furnished for which the hospital does not normally charge;
- Services non-covered or denied by WellCare because they were provided on an inpatient basis;
- Non-acute levels of care;
- Separately billed equipment and supplies which are integral parts of hospital care and the area in which care is being provided, i.e., cardiac monitor in ICU, light source in the operating room, call system, blood pressure cuffs and monitors, specimen collection devices and containers, etc.;
- Late charges defined as a portion of the charges for a given service omitted from the original billing, which included some of the charges for that given service, are non-covered. If the total charges for a given service were omitted from the original billing, a positive adjustment may be requested;
- Take-home prescription drugs, medical supplies, appliances and durable medical equipment are also non-covered;
- Differential service charges; i.e., "STAT" or priority, after-hours or "callback" fees;
- Resuscitation, code, cardiopulmonary resuscitation (CPR), etc. are non-covered; However, supplies associated with this service will be reimbursed;
- Service charges for individual areas within the hospital, i.e., pharmacy dispensing fee, IV admixture fee (except for hyperalimentation), cover charge for central supply, charges for handling and distribution of supplies, transportation within the hospital, equipment installation, specimen collection, venipuncture, standby equipment, staff time, and evaluations;
- Nursing services, including services traditionally accepted as nursing care even though provided by other ancillary departments;
- Some situations concerning abortions, sterilizations and hysterectomies. See *Limits to Abortions, Sterilizations and Hysterectomy Coverage in Section 5: Utilization Management, Care Management and Disease Management* for more details;
- Tubal reanastomosis procedures pertaining to sterilizations and vasectomies;
- Infertility procedures and related services;
- Patient or family education or supplies; and
- Cosmetic surgery or mammoplasties for aesthetic purposes.
Out-of-State Providers and Service Limitations
For some areas in Georgia, the closest Providers are located in another state. Enrolled Providers within a 50-mile radius of the state border are considered to be in the Georgia Provider network. Out-of-state hospital Providers not contracted with WellCare will be reimbursed for Covered Services provided to eligible WellCare Members while out-of-state if the claim is received within one hundred eighty (180) days from the date of service, and if at least one of the following conditions is met:

• The hospital Provider preauthorized the service through WellCare; or
• The service was provided to the WellCare Member as a result of an emergency or life-endangering situation occurring out of state. If the out-of-state Provider believes the medical record supports the existence of an emergency situation but the diagnosis does not justify an emergency, the claim must be submitted with a copy of the medical record.

The Medicaid program does not reimburse Providers located outside the continental United States.

Routine healthcare or elective surgery provided by out-of-state Providers is not covered unless Prior Authorization is obtained from WellCare. In order to receive Prior Authorization, the referring in-state Provider is required to request prior approval by documenting in writing the Medical Necessity of obtaining services out-of-state and providing the name and address of the out-of-state medical Provider. Provider reimbursement and coverage of out-of-state services are determined in accordance with current policies and procedures of WellCare and are contingent upon the patient's eligibility at the time services are provided.

Requests for prior approval or questions regarding out-of-state services must be directed to WellCare’s Provider Hotline. For contact information, please refer to the Quick Reference Guide on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid.

If services are pre-authorized, a copy of the authorization letter from WellCare must be attached to out-of-state claims submitted for reimbursement.

Services rendered due to an emergency or life-endangering situation do not have to be pre-authorized. Any emergency service, rendered by a non-participating Provider and identified by WellCare as emergent, is reimbursable at current Georgia Medicaid rates for these services.

Procedures for Obtaining Prior Authorization for All Medical Services, Except Dental Services and Transplants
The attending physician or hospital staff is responsible for obtaining Prior Authorization from WellCare and for providing the Prior Authorization number to each WellCare Provider associated with the case, i.e., assistant physician, hospital, etc. Failure to obtain Prior Authorization will result in denial of payment.
Requests for Prior Authorization should be submitted at least ten (10) business days prior to the planned admission or procedure. Once a procedure is approved, the approval is only valid for ninety (90) days from the date of issuance.

In cases when Prior Authorization has been obtained for an outpatient procedure, and during the procedure it is determined that the Member requires an additional or different procedure, the procedure will be considered an urgent procedure. The hospital’s request for an update of the Prior Authorization will be considered timely if received within one (1) business day of the date of the procedure.

When Prior Authorization has been obtained for an outpatient procedure, but after the procedure has been performed it is determined that the Member requires inpatient services, the admission should be considered an emergency. The hospital should notify WellCare of the admission within twenty-four (24) hours, and the request for a clinical update should be considered timely if received within one (1) business day of the beginning date of the episode of care.

Hospital requests for updates of authorization and retroactive authorizations of inpatient admissions following a procedure will be denied if it is determined that the procedure clearly required an inpatient level of care that should have been anticipated.

When it is determined that a Member with outpatient observation status requires inpatient services, the request for authorization must be received within one (1) business day of the beginning of the episode of care.

**Procedures for Obtaining Prior Authorization for Dental Services**

Prior Authorization is required for any dental service requiring inpatient or outpatient hospitalization. It is the responsibility of the attending dentist to obtain Prior Authorization and to provide the Prior Authorization number to the hospital. The failure of the attending dentist to obtain the correct Prior Authorization number will result in denial of payment.

For Prior Authorization of Dental Services requiring hospitalization, contact WellCare’s Utilization Management Department at the telephone number listed on the Quick Reference Guide on WellCare’s website at: [www.wellcare.com/Georgia/Providers/Medicaid](http://www.wellcare.com/Georgia/Providers/Medicaid).

**Procedures for Obtaining Prior Authorization for Transplants**

In order to receive Prior Authorization for a transplant, a written request with medical record documentation must be received by WellCare for review. This pertains to liver, bone marrow, kidney and cornea transplants as well as Medically Necessary heart, lung and heart/lung transplants for Members under the age of twenty-one (21). These records must include current medical history, pertinent laboratory findings, X-ray and scan reports, social history and test results that include viremia and other relevant information.

Transplant procedures and related services must be approved by WellCare prior to the transplant, regardless of the age of the Member. Once a transplant procedure is approved, a Prior Authorization number will be assigned. The Member must be eligible at the time services are provided, and these services cannot be approved retroactively.
For requests for approval of coverage of all transplant services, contact WellCare’s Utilization Management Department at the telephone number listed on the Quick Reference Guide on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid.

Procedures for Obtaining Prior Authorization for Observation Services
Observation should be considered if the patient does not meet acute care criteria, and any of the following apply:

- Diagnosis, treatment, stabilization and discharge can reasonably be expected within twenty-four (24) to forty-eight (48) hours;
- The clinical condition is changing and a discharge decision is expected within forty-eight (48) hours;
- Complications or extended observation post-ambulatory surgery/procedure;
- Symptoms are unresponsive to at least four (4) hours emergency room treatment; or
- Psychiatric crisis intervention/stabilization with observation every fifteen (15) minutes.

At forty-eight (48) hours, if the patient is not stable for discharge, acute care criteria will be applied.

The decision to admit a patient continues to be the responsibility of the treating Provider. If cases arise where the circumstances would pose a hazard to the patient’s health and/or safety and the appropriate setting is in question, then the case should be referred to secondary review.

Prior Authorization requirements by service type may be found on the Quick Reference Guide on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid. Providers may also use the searchable Authorization Lookup Tool at: www.wellcare.com/Georgia/Providers/Authorization-Lookup.

After-Hours Utilization Management
WellCare provides authorization of inpatient admissions twenty-four (24) hours a day, seven (7) days a week. Physicians requesting after-hours authorization for inpatient admission should refer to the Quick Reference Guide on WellCare’s website at: www.wellcare.com/Georgia/Providers/Medicaid for the number to contact an after-hours nurse. Discharge planning needs that may occur after normal business hours will be handled by WellCare’s after-hours nurse.
Section 14: Definitions

The following terms as used in this Provider Handbook shall be construed and/or interpreted as follows, unless otherwise defined in the participation Agreement the Provider has 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;
- The failure of WellCare to act within the time frames provided in §438.408(b); or
- For a resident of a rural area with only one (1) managed care entity, the denial of a Medicaid Enrollee's request to exercise his or her right under §438.52(b)(2)(ii) to obtain services outside the network.

“Administrative Law Hearing” means the Appeal process administered by the state in accordance with O.C.G.A. §49-4-153 and as required by federal law, available to Members, P4HB® Enrollees, and Providers after they exhaust WellCare’s Appeals process.

“Administrative Review” means the formal reconsideration of a Proposed Action, as a result of the proper and timely submission of a Provider’s request, Member’s request or a request by DCH.

“Administrative Service(s)” means the obligations of the contractor that include, but may not be limited to, utilization management, credentialing Providers, network management, quality improvement, marketing, enrollment, Member and P4HB® participant services, claims payment, management information systems, financial management, and reporting.

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

“Advanced Life Support” – Transportation by a ground ambulance vehicle which is equipped with the necessary supplies and services as defined by the State of Georgia. The ambulance must be staffed by an individual who is qualified in accordance with the State of Georgia and local laws as an emergency medical technician – intermediate (EMT-Intermediate) or EMT-Paramedic.

“Appeal” means a formal request from an Enrollee to seek a review of an action taken by WellCare pursuant to 42 CFR 438.400.
“Appeals Process” means the overall process that includes Appeals at the contractor level and access to the State Fair Hearing process (the State’s Administrative Law Hearing).

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

“Basic Life Support (BLS)” – Transportation by a ground ambulance vehicle which is equipped with the necessary supplies and services as defined by the State of Georgia. The ambulance must be staffed by an individual who is qualified in accordance with the State of Georgia and local laws as an emergency medical technician – basic (EMT-Basic).

“Benefits” or “Benefit Plan” means the healthcare services for which WellCare has agreed to provide, arrange, and be held fiscally responsible.

“Business Days” means Monday through Friday (9 a.m. to 5 p.m.), excluding state holidays.

“Calendar Days” means all seven (7) days of the week.

“Centers for Medicare & Medicaid Services (CMS)” means the agency within the U. S. Department of Health and Human Services with responsibility for Medicare, Medicaid and the State Children’s Health Insurance Program.

“Claim” means a bill for services, a line item of services, or all services for one recipient within a bill.

“Claim Adjustment” means a claim that has been incorrectly paid, incorrectly submitted or, as the result of an updated payment policy, the payment amount can be changed.

“Clean Claim” means a claim received by WellCare for adjudication, in a nationally accepted format in compliance with standard coding guidelines, which requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by WellCare. The following exceptions apply to this definition:

- A Claim for payment of expenses incurred during a period of time for which premiums are delinquent;
- A Claim for which fraud is suspected; and
- A Claim for which a third-party resource should be responsible.

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

“Co-payment” or “Co-pay” means the part of the cost-sharing requirement for Members in which a fixed monetary amount is paid for certain services/items received from the contractor’s Providers.
“Co-Surgeon” means one of multiple surgeons who work together as primary surgeons performing distinct part(s) of a surgical procedure.

“Covered Services” means those Medically Necessary healthcare services provided to Members, the payment or indemnification of which is covered by WellCare or those demonstration services provided to P4HB® Enrollees, the payment or indemnification of which is covered by WellCare.

“Department of Community Health (DCH)” means the Agency in the State of Georgia responsible for oversight and administration of the Medicaid Program, the PeachCare for Kids® Program, the Planning for Healthy Babies Program (P4HB®) and the State Health Benefits Plan (SHBP). For more information visit: www.dch.georgia.gov.

“Disenrollment” means the removal of a Member or enrollee from participation in WellCare’s plan but not necessarily from the Medicaid Program, PeachCare for Kids® Program, the Planning for Healthy Babies® Program (P4HB®) or the State Health Benefits Plan (SHBP).

“Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program” means a Title XIX mandated program that covers screening and diagnostic services to determine physical and mental deficiencies in Members younger than twenty-one (21) years of age, and healthcare, treatment, and other measures to correct or ameliorate any deficiencies and chronic conditions discovered. P4HB® Enrollees are not eligible to participate in the EPSDT Program.

“Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

An Emergency Medical Condition shall not be defined on the basis of lists of diagnoses or symptoms.

In addition to the conditions identified under federal law and the State of Georgia, WellCare considers the following symptoms to also be emergent in nature:

- Serious harm to self or others due to an alcohol or drug abuse emergency;
- Injury to self or bodily harm to others; or
- With respect to a pregnant woman having contractions:
  - That there is not adequate time to effect a safe transfer to another hospital before delivery; or
  - That transfer may pose a threat to the health or safety of the woman or the unborn child.
“Emergency Services and Care” means covered inpatient and outpatient services furnished by a qualified Provider needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard.

“Encounter” means a distinct set of health care services provided to a P4HB® Participant, Medicaid or PeachCare for Kids® Member enrolled with WellCare on the dates that the services were delivered.

“Encounter Data” means:
- All data captured during the course of a single healthcare encounter that specify the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the Member or P4HB® Participant receiving services during the encounter;
- The identification of the Member or P4HB® Participant receiving and the Provider(s) delivering the healthcare services during the single encounter; and
- A unique, i.e., unduplicated, identifier for the single encounter.

“Georgia Families® (GF)” means the risk-based managed care delivery program for Medicaid and PeachCare for Kids® in which the Department contracts with Care Management Organizations to manage the care of eligible Members and P4HB® Enrollees.

“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 or services provided;
- Aspects of interpersonal relationships such as rudeness of a Provider or employee; or
- Failure to respect the Enrollee’s rights.

“Healthcare” means care, services, or supplies related to the health of an individual. Healthcare includes, but is not limited to, the following:
- Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and
- Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

“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.

“Long-Term Acute Care (LTAC) Hospital” means care facilities including nursing homes, skilled nursing facilities, psychiatric residential treatment facilities and other facilities that provide long-term acute care.

“Medical Necessity” or “Medically Necessary” is based upon generally accepted medical practices in light of Conditions at the time of treatment. Medically Necessary Services are those that are:

- Required to correct or ameliorate a defect, physical or mental illness, or a Condition;
- Appropriate and consistent with the diagnosis and the omission of which could adversely affect the eligible Member’s medical Condition;
- Compatible with the standards of acceptable medical practice;
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for the convenience of the Member or the convenience of the Health Provider;
- Not primarily custodial care unless custodial care is a Covered Service or Benefit under the Member’s evidence of coverage; and
- Provided when there is no other effective and more conservative or substantially less costly treatment, service and setting available

“Member” means a Medicaid or PeachCare for Kids® recipient who is currently enrolled in a CMO plan.

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

“Members/Individuals with Special Healthcare Needs” means 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.

“Non-life-threatening Emergency” means an emergency situation where clinical evidence shows that a person requires immediate care but that lack of care would not lead to death.

“Out-of-state Provider” means a Provider who operates beyond a 50-mile radius of the Georgia border.

“PeachCare for Kids®” means the State of Georgia's Children's Health Insurance Program (CHIP) established pursuant to Title XXI of the Social Security Act.
“Periodicity” means the frequency with which an individual may be screened or re-screened.

“Periodicity Schedule” means the schedule which defines age-appropriate services and time frames for screenings within the Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) Program.

“Planning for Healthy Babies” means the name of the 1115 Demonstration Waiver Program in Georgia.

“Post-Stabilization Services” means Covered Services related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member’s Condition.

“Pre-service Appeal” is a Member request to change an Adverse Benefit Determination for care or services that must be prior approved in advance of the Member obtaining care or services.

“Preventive Services” means services provided by a physician or other licensed health practitioner within the scope of his or her practice under State law to:
- Prevent disease, disability, and other health conditions or their progression;
- Treat potential secondary conditions before they happen or at an early remediably stage;
- Prolong life; and
- Promote physical and mental health and efficiency.

“Primary Care” means all healthcare services and laboratory services, including periodic examinations, preventive healthcare and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and initiation of referrals to specialty Providers, required for maintaining continuity of patient care. These services are customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, and may be furnished by a nurse practitioner to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

“Primary Care Provider (PCP)” means a licensed medical doctor (M.D.) or doctor of osteopathy (D.O.) or certain other licensed medical practitioner who, within the scope of practice and in accordance with State certification licensure requirements, standards, and practices, is responsible for providing all required primary care services to Members or P4HB® Enrollees. A PCP shall include general/family practitioners, pediatricians, internists, physician's assistants, CNMs or NP-Cs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with licensure requirements.

“Prior Authorization” means the act of authorizing specific services before they are rendered (also referred to as “pre-authorization” or “prior approval”).
“Proposed Action” means the proposal of an Action for 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 part of payment for a service; the failure to provide services in a timely manner; or the failure of WellCare to act within the time frames provided in 42 CFR 438.408(b).

“Provider” means any person (including physicians or other healthcare professionals), partnership, professional association, corporation, facility, hospital, or institution certified, licensed, or registered by the State of Georgia to provide healthcare services that has contracted with a Care Management Organization to provide healthcare services to Members and P4HB® Enrollees.

“Provider Complaint” means a written expression by a Provider which indicates dissatisfaction or dispute with the contractor’s policies, procedures, or any aspect of a contractor’s administrative functions.

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

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

“(Claims) Reprocessing” means upon determination of the need to correct the outcome of one or more claims processing transactions, the subsequent attempt to process a single claim or batch of claims.

“Retrospective Administrative Review” is a Provider request to change an adverse action for care or services that have already been received by the Member.

“Routine Care” means that treatment of a condition that would have no adverse effects if not treated within twenty-four (24) hours or could be treated in a less acute setting (e.g., physician’s office) or by the patient.

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

“Urgent Care” means Medically Necessary treatment for an injury, illness, or another type of Condition (usually not life-threatening) which should be treated within twenty-four (24) hours.

“WellCare Companion Guide” means the transaction guide that sets forth data requirements and electronic transaction requirements for Clean Claims and Encounter Data submitted to WellCare or its Affiliates, as amended from time to time. The WellCare Claims/Encounter Companion Guides are part of the Provider Handbook.
Section 15: WellCare Resources

WellCare of Georgia's Home Page
www.wellcare.com/en/Georgia

Provider Home Page
www.wellcare.com/Georgia/Providers

Quick Reference Guide
www.wellcare.com/Georgia/Providers/Medicaid

Provider Orientation
www.wellcare.com/Georgia/Providers
The Provider must be a registered user of WellCare’s secure online Provider Portal to access.

Forms and Documents
www.wellcare.com/Georgia/Providers/Medicaid/Forms

Clinical Practice Guidelines
www.wellcare.com/Georgia/Providers/Clinical-Guidelines/CPGs

Clinical Coverage Guidelines
www.wellcare.com/Georgia/Providers/Clinical-Guidelines/CCGs

Pharmacy Services
www.wellcare.com/Georgia/Providers/Medicaid/Pharmacy

Claims Information
www.wellcare.com/Georgia/Providers/Medicaid/Claims

Resource Guides
www.wellcare.com/Georgia/Providers/Medicaid
Quality care is a team effort.
Thank you for playing a starring role!

WellCare proudly serves the Georgia Medicaid and PeachCare for Kids® members enrolled in the Georgia Families® program and women enrolled in the Planning for Healthy Babies® program.