# Table of Contents

2013 New Jersey Medicaid Provider Manual Table of Revisions ........................................ 6  
Resolution of an Expedited Appeal .................................................................................. 7  

## Section 1: Overview ...................................................................................................... 9  
About WellCare .................................................................................................................. 9  
Purpose of this Manual ...................................................................................................... 9  
Quick Reference Guide ..................................................................................................... 9  
Provider Services ............................................................................................................. 9  
WellCare’s Medicaid/NJ FamilyCare Managed Care Plan ............................................. 10  
Covered Services and Benefits ....................................................................................... 10  
Website Resources ......................................................................................................... 20  

## Section 2: Provider and Member Administrative Guidelines ........................................ 22  
Provider Administrative Overview ................................................................................. 22  
Excluded or Prohibited Services ..................................................................................... 23  
Responsibilities of All Providers ..................................................................................... 24  
Payment in Full/Prohibition on Balance Billing .............................................................. 25  
Individuals with Special Health Care Needs .................................................................. 25  
Responsibilities of Primary Care Providers .................................................................... 26  
Access Standards ............................................................................................................ 27  
Specialist Providers/Specialty Care Services ................................................................ 29  
New Jersey’s Early and Periodic Screening, Diagnosis, and Treatment Program .......... 30  
Domestic Violence and Substance Abuse Screening ..................................................... 33  
PCPs should identify indicators of substance abuse or domestic violence. .................... 33  
Smoking Cessation .......................................................................................................... 33  
Adult Health Screening ................................................................................................... 33  
Laboratory and Radiology Test Results ......................................................................... 33  
Termination of a Member ................................................................................................ 33  
Member Administrative Guidelines ................................................................................. 34  
Member Identification Cards ........................................................................................... 34  
Member Eligibility Verification ....................................................................................... 34  
Member Rights and Responsibilities .............................................................................. 34  
Assignment of Primary Care Physician ......................................................................... 36  
Women’s Health Specialists ............................................................................................ 36  
Hearing-Impaired, Interpreter and Sign Language Services .......................................... 36  

## Section 3: Quality Improvement .................................................................................... 38  
Overview .......................................................................................................................... 38  
Medical Records ............................................................................................................. 38  
Provider Participation in the Quality Improvement Program ......................................... 39  
Member Satisfaction ....................................................................................................... 39  
Patient Safety to include Quality of Care (QOC) and Quality of Service (QOS) ........... 39  
Clinical Practice Guidelines ............................................................................................ 40  
HEDIS® ............................................................................................................................. 40  
Web Resources ............................................................................................................... 41  

## Section 4: Utilization Management (UM), Care Management (CM) and Disease  
Management (DM) ......................................................................................................... 42  
Utilization Management ................................................................................................. 42  

Overview ........................................................................................................... 42
Medically Necessary Services ........................................................................... 42
Criteria for Utilization Management Decisions .................................................... 43
Utilization Management Process ....................................................................... 43
Notification ......................................................................................................... 44
Referrals ............................................................................................................... 44
Prior Authorization ............................................................................................. 44
Concurrent Review ............................................................................................. 45
Discharge Planning ............................................................................................. 46
Retrospective Review ......................................................................................... 46
Services Not Requiring Authorization ................................................................ 47
WellCare Proposed Actions ............................................................................... 47
Second Medical Opinion ...................................................................................... 48
Individuals with Special Health Care Needs (ISHCH) .......................................... 48
Conditions Considered to be Both Medical and Dental ....................................... 51
Service Authorization Decisions ......................................................................... 51
Emergency/Urgent Care and Post-Stabilization Services ...................................... 52
Continuity of Care ............................................................................................... 53
Transition of Care ............................................................................................... 53
Care Management Program ............................................................................... 53
Overview ............................................................................................................. 53
Role of the Care Manager ..................................................................................... 54
Care Management ............................................................................................... 55
Behavioral Health ............................................................................................... 55
Special Heath Care Needs .................................................................................... 55
Care Monitoring ................................................................................................... 56
Transition of Care ............................................................................................... 56
Referrals ............................................................................................................... 56
Disease Management Program ........................................................................... 56
Overview ............................................................................................................. 56
Candidates for Disease Management ................................................................... 57
Members with HIV / AIDS .................................................................................. 57
Access to Care and Disease Management Programs ........................................... 57

Section 5: Claims ................................................................................................. 59
Overview ............................................................................................................. 59
Timely Claims Submission .................................................................................. 59
Tax Identification (TIN) and National Provider Identification (NPI) Requirements .. 59
Taxonomy ............................................................................................................ 59
Preauthorization number ..................................................................................... 60
National Drug Codes (NDC) ............................................................................... 60
Strategic National Implementation Process ......................................................... 60
Claims Submission Requirements ....................................................................... 60
Electronic Claims Submissions .......................................................................... 60
HIPAA Electronic Transactions and Code Sets ..................................................... 61
Paper Claims Submissions ............................................................................... 61
Claims Processing ............................................................................................... 62
Encounters Data ................................................................................................. 63
Balance Billing .................................................................................................... 65
Provider-Preventable Conditions (PPCs) .................................................................65
Reopening and Revising Determinations .............................................................66
Disputed Claims.................................................................................................66
Corrected Claims or Voided Claims .................................................................67
Reimbursement.................................................................................................68
Surgical Payments ............................................................................................68
Modifiers ...........................................................................................................69
Allied Health Providers ....................................................................................69
Recoupment Policy and Procedures – Overpayment Recoveries ......................69
Benefits during Disasters and Catastrophic Events ..........................................70

Section 6: Credentialing ...................................................................................71
Overview...........................................................................................................71
Practitioner Rights ...........................................................................................72
Baseline Criteria ...............................................................................................73
Liability Insurance ............................................................................................73
Site Inspection Evaluation ...............................................................................74
Covering Physicians .........................................................................................74
Allied Health Professionals .............................................................................74
Ancillary Health Care Delivery Organizations .................................................75
Re-Credentialing ..............................................................................................75
Updated Documentation ....................................................................................75
Office of Inspector General Medicare/Medicaid Sanctions Report .................75
Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials ........................................................................75
Provider Appeal through the Dispute Resolution Peer Review Process ..........75
Delegated Entities ............................................................................................77

Section 7: Complaints, Grievances and Appeals .............................................78
Overview...........................................................................................................78
Actions ..............................................................................................................78
Complaints and Grievances .............................................................................78
Provider Complaints and Grievances ..............................................................78
Provider Grievance Appeals ...........................................................................79
Member Complaints and Grievances ...............................................................79
Member Grievance Resolution .......................................................................80
Medicaid Fair Hearings ....................................................................................80
Provider Claim Resolution/Appeals ...............................................................81
Medicaid/NJ FamilyCare Provider on Behalf of Self Appeals Process .............81
Binding Arbitration - External Review Alternative Dispute Resolution ..........82
Appeals .............................................................................................................83
Member Appeals Overview .............................................................................83
Administrative (Post-Service) Appeal Process ..............................................83
Medical Necessity/Utilization Management Appeals Process .......................84
Continuation of Benefits .................................................................................85
Informal Internal Utilization Management Appeals (Stage 1) .........................85
Formal Internal Utilization Management Appeals (Stage 2) ...........................86
Expedited Medical Necessity Appeal Process (Stage 1 and 2 Appeals Process) 88

Section 8: Compliance .....................................................................................90
WellCare’s Compliance Program ......................................................................90

WellCare Health Plans, Inc.
Medicaid/NJ FamilyCare Provider Manual
Effective: July 1, 2014
NJ025803_PRO_MAN_ENG State Approved 0730201 59200
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Page 3 of 123
Addendum A: Managed Long Term Care (MLTSS) Overview .................................................. 115
Benefits .............................................................................................................................. 115
Provider and Member Administrative Guidelines ............................................................ 115
Training ............................................................................................................................ 115
Unable to Contact .......................................................................................................... 116
Quality Improvement ...................................................................................................... 116
Overview .......................................................................................................................... 116
Medical Records ............................................................................................................ 117
Patient Safety to include Quality of Care (QOC) and Quality of Service (QOS) .... 117
Critical Incidents ............................................................................................................ 118
Clinical Practice Guidelines ......................................................................................... 119
HEDIS® ............................................................................................................................ 120
Utilization Management (UM), Care Management (CM), Disease Management .... 120
Critical Incident Reporting for MLTSS Providers ......................................................... 120
Care Management Program .......................................................................................... 121

WellCare Health Plans, Inc.
Medicaid/NJ FamilyCare Provider Manual
Effective: July 1, 2014
NJ025803 PRO_MAN ENG State Approved 0730201 59200
©WellCare 2014 NJ_03_14
Page 4 of 123
POC Development .......................................................... 121
Claims ........................................................................... 121
Credentialing ................................................................ 122
Complaints, Grievances and Appeals ............................. 122
Compliance ..................................................................... 122
Delegated Entities............................................................ 122
Behavioral Health ........................................................... 122
Pharmacy ........................................................................ 123
## Table of Revisions

<table>
<thead>
<tr>
<th>Date</th>
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<th>Comments</th>
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<td>Over the Counter Medications List Updated</td>
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<td>Section 11: Pharmacy</td>
<td>Coverage Limitations Updated</td>
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Section 11: Pharmacy

Pharmacy Lock-In Program Subsection Added
Section 1: Overview

About WellCare
WellCare Health Plans, Inc. (WellCare) provides managed care services targeted exclusively to government-sponsored health care programs, focused on Medicaid and Medicare, including prescription drug plans and health plans for families, and the aged, blind and disabled. WellCare’s corporate office is located in Tampa, Florida. As of December 31, 2013, we served approximately 2.8 million members. Our experience and exclusive commitment to these programs enable us to serve our members and providers as well as manage our operations effectively and efficiently.

Purpose of this Manual
This Provider Manual is intended for WellCare Participating Providers providing health care services to WellCare Members enrolled in a WellCare Medicaid/NJ FamilyCare Managed Care plan. This Manual serves as a guide to the policies and procedures governing the administration of WellCare’s Medicaid/NJ FamilyCare plans and is an extension of and supplements the Provider Participation Agreement (Agreement) between WellCare and health care Providers, who include, without limitation: physicians, hospitals and ancillary providers (collectively, Providers). This Manual replaces and supersedes any previous versions dated prior to July 1, 2014 and is available on the website at https://newjersey.wellcare.com/provider/resources. A paper copy, at no charge, may be obtained upon request by contacting Customer Service (Provider Services) or your Provider Relations representative.

Participating Providers must abide by all applicable provisions contained in this Manual. Revisions to this Manual reflect changes made to WellCare’s policies and procedures. Revisions shall become binding 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 subsequent versions of this Manual. Provider Bulletins that are state specific may override the policies and procedures in this Manual.

Quick Reference Guide
WellCare provides additional information online via Quick Reference Guides “QRG”. QRGs list important addresses, phone and fax numbers, and authorization requirements. Quick Reference Guides are available on WellCare’s website at https://newjersey.wellcare.com/provider/resources.

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 investigating 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 our Provider Relations representatives.

Provider Relations representatives are available to assist with requests from Participating Providers. Contact your local market office for assistance or call the Provider Services number located on your Quick Reference Guide to request a Provider Relations representative to contact you. Provider Services is available Monday–Friday, 8 a.m. to 6 p.m.

Providers may contact the appropriate departments at WellCare by referring to the Quick Reference Guide on WellCare's website at https://newjersey.wellcare.com/Provider/resources.

**WellCare's Medicaid/NJ FamilyCare Managed Care Plan**

WellCare has contracted with the State of New Jersey Department of Human Services Division of Medical Assistance and Health Services (DMAHS) to provide Medicaid/NJ FamilyCare and CHIP managed care services to eligible Members. WellCare serves adults and children eligible to participate in New Jersey's Medicaid/NJ FamilyCare program. Eligibility is determined solely by the Agency. These plans 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.

**Covered Services and Benefits**
The following services are provided as Medically Necessary to eligible WellCare Medicaid and NJ FamilyCare Plan A, B, and C Members:

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicaid, NJ FamilyCare A and Alternative Benefit Plan (ABP)</th>
<th>NJ Division of Developmental Disabilities (DDD)</th>
<th>NJ FamilyCare B</th>
<th>NJ Family Care C</th>
<th>NJ FamilyCare D</th>
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<tbody>
<tr>
<td>Audiology</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓ (Members under 16 years old)</td>
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<tr>
<td>Chiropractic services</td>
<td>(limited to spinal manipulation)</td>
<td>(limited to spinal manipulation)</td>
<td>(limited to spinal manipulation with $5 co-pay)</td>
<td>Not covered</td>
<td></td>
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<tr>
<td>Dental</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>($5 co-pay except for preventive dental visits)</td>
</tr>
<tr>
<td>Diabetic supplies and equipment</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>($5 co-pay except for preventive dental visits)</td>
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<tr>
<td>Durable medical equipment (DME)</td>
<td>✓</td>
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<td>✓</td>
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<td>Limited benefit</td>
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<th>NJ Division of Developmental Disabilities (DDD)</th>
<th>NJ FamilyCare B</th>
<th>NJ Family Care C</th>
<th>NJ FamilyCare D</th>
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<td>Emergency services</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✗</td>
<td>✔ (with $10 co-pay for ER services, except when referred by PCP for services that should have been provided in PCP’s office or when admitted to the hospital)</td>
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<td>EPSDT (Early and Periodic Screening, Diagnostic and Treatment) services</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✗</td>
<td>✔ (limited to well-child care, newborn hearing screenings, immunizations, lead screenings and treatment)</td>
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<td>Family Planning</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✗</td>
<td>✔ (includes medical history and physical exams, diagnostic and lab tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling); must use network providers)</td>
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<td>Hearing aids</td>
<td>✔</td>
<td>✔</td>
<td>✗</td>
<td>✗</td>
<td>✔ (Members under 16 years old)</td>
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<td>Home health</td>
<td>✔</td>
<td>✔</td>
<td>✗</td>
<td>✗</td>
<td>✔ (limited to skilled nursing for home-bound members who are provided care or supervised by an RN and home health aide; includes medical social services needed for treatment of the Member’s medical condition)</td>
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<td>✗</td>
<td>✗</td>
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<td>Yes (covered by Medicaid)</td>
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WellCare Health Plans, Inc.
Medicaid/NJ FamilyCare Provider Manual

Effective: July 1, 2014
NJ025803_PRO_MAN_ENG  State Approved 0730201 59200
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Page 12 of 123
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<td>(limitations may apply)</td>
<td>(limitations may apply)</td>
<td>visit, except for preventive care services)</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Nursing facility care</td>
<td></td>
<td></td>
<td>visit during normal office hours, except for preventive care services; $10 co-pay for non-office hours and home visits)</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Optometrist services:</td>
<td>•Includes one yearly eye exam for all ages</td>
<td>(with $5 co-pay)</td>
<td>(with $5 co-pay, except for newborns covered under Medicaid fee-for-service)</td>
<td>(with $5 co-pay)</td>
<td>(with $5 co-pay)</td>
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<tr>
<td>Optical appliances:</td>
<td>•Members can choose eyeglasses or contact lenses from select frames or contact lenses (limitations may apply)</td>
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<td></td>
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<tr>
<td>Outpatient diagnostic testing</td>
<td></td>
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<tr>
<td>Partial care services</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td></td>
</tr>
<tr>
<td>Partial hospital program services</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td></td>
</tr>
<tr>
<td>Personal care assistant services</td>
<td>(covered with limits)</td>
<td>(covered with limits)</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Podiatrist services:</td>
<td>•Excludes routine hygienic care of feet, including treatment of corns, calluses, trimming of nails and other</td>
<td></td>
<td></td>
<td>(with $5 co-pay)</td>
<td>(with $5 co-pay)</td>
</tr>
<tr>
<td>Service</td>
<td>Medicaid, NJ FamilyCare A and Alternative Benefit Plan (ABP)</td>
<td>NJ Division of Developmental Disabilities (DDD)</td>
<td>NJ FamilyCare B</td>
<td>NJ Family Care C</td>
<td>NJ FamilyCare D</td>
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<td>------------------------------------------------------------------------</td>
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<tr>
<td>hygiene care in the absence of a pathological condition</td>
<td>$1 co-pay on generic drugs (covered by WellCare); $5 co-pay on brand-name drugs (covered by WellCare)</td>
<td>$5 co-pay on drugs if supply is less than 34 days (covered by WellCare); $10 co-pay on drugs if supply is greater than 34 days (covered by WellCare)</td>
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</tr>
<tr>
<td>Prescription drugs (retail pharmacy):</td>
<td>$1 co-pay per visit; no co-pay for well-child visits, lead screenings or treatment, necessary immunizations, prenatal care, or</td>
<td>$5 co-pay per visit during normal office hours; $10 co-pay for non-office hours and home visits; no co-pay for well-child visits,</td>
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<tr>
<td>• ABD members with Medicare are covered under Medicare Part D</td>
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<tr>
<td>• Erectile dysfunction drugs, antiobesity and cosmetic agents not covered</td>
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<tr>
<td>• Certain cough/cold and topical items not covered for certain ages</td>
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<tr>
<td>Prescription drugs (given by doctor):</td>
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<tr>
<td>• Covered by Medicare Part B</td>
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<tr>
<td>• Co-pays for Medicare Part B covered drugs considered DME and used in home covered by Medicaid (i.e., insulin given through an insulin pump)</td>
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<tr>
<td>Primary care, specialty care and women's health services</td>
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<tr>
<td>Service</td>
<td>Medicaid, NJ FamilyCare A and Alternative Benefit Plan (ABP)</td>
<td>NJ Division of Developmental Disabilities (DDD)</td>
<td>NJ FamilyCare B</td>
<td>NJ Family Care C</td>
<td>NJ FamilyCare D</td>
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<tr>
<td>Prosthetics</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
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<tr>
<td>Radiology services (diagnostic and therapeutic)</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅ (with $5 co-pay when not part of an office visit)</td>
</tr>
<tr>
<td>Rehabilitation services (cognitive, physical occupational and speech therapies)</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
</tr>
<tr>
<td>Transportation - ground emergency</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
</tr>
<tr>
<td>Transportation - non-emergency</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

- PAP tests
- lead screenings or treatment, necessary immunizations or preventive dental services for children under 19 years old; $5 co-pay for first prenatal visit only
- (limited to the initial delivery of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired due to disease, injury or congenital defect; repair services and replacement are covered only when needed due to congenital growth)
- (with $5 co-pay; limited to 60 visits per therapy, per incident, per calendar year)
- (limited to 60 visits per therapy, per incident, per calendar year)
- (with a $5 co-pay; limited to 60 visits per therapy, per incident, per calendar year; speech therapy for developmental delay not covered unless resulting from disease, injury or congenital defects)
<table>
<thead>
<tr>
<th>Service</th>
<th>Medicaid, NJ FamilyCare A and Alternative Benefit Plan (ABP)</th>
<th>NJ Division of Developmental Disabilities (DDD)</th>
<th>NJ FamilyCare B</th>
<th>NJ Family Care C</th>
<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td>(mobile assisted vehicles (MAVs) and non-emergency basic life support)</td>
<td>Medicaid</td>
<td>Medicaid</td>
<td>Medicaid</td>
<td>Medicaid</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Transportation—livery (taxi, bus, car service) • Includes reimbursement for mileage</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

- Routine physicals required for work, school, camp, or other entities/programs that require such examinations as a condition of employment or participation;
- Primary and Specialty Care by Physicians and, within the scope of practice and in accordance with State certification/licensure requirements, standards and practices, by Certified Nurse Midwives, Certified Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants;
- Preventive Health Care and Counseling and Health Promotion;
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program Services. For NJ FamilyCare Plan B and C Members, coverage includes early and periodic screening and diagnostic medical examinations, dental, vision, hearing, and lead screening services. It includes only those treatment services identified through the examination that are available under WellCare’s benefit package or specified services under the Fee-For-Services (FFS) program;
- Emergency Medical Care;
- Inpatient Hospital Services including acute care hospitals, rehabilitation hospitals, and special hospitals;
- Outpatient Hospital Services;
- Laboratory Services;
- Radiology Services – diagnostic and therapeutic;
- Prescription Drugs (legend and non-legend covered by the Medicaid/NJ FamilyCare program including physician administered drugs) – WellCare will continue to cover physician-administered drugs for all Members in accordance with the list of applicable codes provided by DMAHS. Includes drugs which may be excluded from Medicare Part D coverage under section 1927(d)(2) referred to in the Medicare Modernization Act 2003. Excludes drugs not covered by a third party Medicare Part D formulary. Atypical antipsychotic and anticonvulsant drugs ordered by a non-participating or Participating Provider will always be covered by WellCare regardless of the treatment plan established by WellCare. WellCare’s formulary and Prior Authorization requirements will apply only when the initial medication treatment plan is changed;
• Family Planning Services and Supplies;
• Audiology;
• Inpatient Rehabilitation Services;
• Podiatrist Services;
• Chiropractor Services;
• Optometrist Services;
• Optical Appliances;
• Hearing Aid Services;
• Home Health Agency Services;
• Hospice Services are covered in the community as well as in institutional settings. Room and board services are included only when services are delivered in an institutional (non-private residence) setting. Hospice care for children under twenty-one (21) years of age includes both palliative and curative care;
• Durable Medical Equipment (DME)/Assistive Technology Devices;
• Medical Supplies;
• Prosthetics and Orthotics including certified shoe Provider;
• Dental Services;
• Organ Transplants includes donor and recipient costs. Exception: WellCare is not responsible for transplant-related donor and recipient inpatient hospital costs for an individual placed on a transplant list while in the Medicaid FFS program prior to initial enrollment into WellCare’s plan;
• Transportation Services – emergency ground transportation only;
• Nursing Facility Services – limited to Medicaid and NJ FamilyCare Plan A for the first thirty (30) days of admission to a nursing facility for nursing care. If the admission to an acute hospital is required during the first thirty (30) days, the thirty (30) day count is suspended and resumes on readmission back to the nursing facility. The inpatient rehabilitation service benefit for Medicaid and NJ FamilyCare Plan A, B, and C Members may be provided in this setting, when appropriate;
• Mental Health/Substance Abuse Services only for Members who are clients of the Division of Developmental Disabilities (DDD). Exception: partial care and partial hospitalization services are not covered by WellCare;
• Personal Care Assistant Services limited to forty (40) hours per week (not covered for NJ FamilyCare Plan B and C Members). Exception – Personal Preference Program services are not covered by WellCare;
• Medical Day Care (not covered for NJ FamilyCare Plan B and C Members);
• Outpatient Rehabilitation – physical therapy, occupational therapy, and speech pathology services. (For Medicaid/NJ FamilyCare Plan B and C Members, limited to sixty (60) visits per therapy per calendar year.); and
• Treatment for conditions altering mental status, including the following diagnoses:
  o 290.0 Senile dementia, uncomplicated;
  o 290.1 Presenile dementia;
  o 290.10 Presenile dementia, uncomplicated;
  o 290.11 Presenile dementia with delirium;
  o 290.12 Presenile dementia with delusional features;
  o 290.13 Presenile dementia with depressive features;
  o 290.2 Senile dementia with delusional or depressive features;
  o 290.20 Senile dementia with delusional features;
o 290.21 Senile dementia with depressive features;
o 290.3 Senile dementia with delirium;
o 290.4 Vascular dementia;
o 290.40 Vascular dementia, uncomplicated;
o 290.41 Vascular dementia with delirium;
o 290.42 Vascular dementia with delusions;
o 290.43 Vascular dementia with depressive mood;
o 290.8 Other specific senile psychotic conditions;
o 290.9 Unspecified senile psychotic condition;
o 291.1 Alcohol induced persisting amnestic disorder;
o 291.2 Alcohol induced persisting dementia;
o 292.82 Drug induced persisting dementia;
o 292.83 Drug induced persisting amnestic disorder;
o 292.9 Unspecified drug induced mental disorder;
o 293.0 Acute delirium due to conditions classified elsewhere;
o 293.1 Subacute delirium;
o 293.8 Other specified transient organic mental disorders due to conditions classified elsewhere;
o 293.81 Transient organic psychotic condition, paranoid type;
o 293.82 Transient organic psychotic condition, hallucinatory type;
o 293.83 Transient organic psychotic condition, depressive type;
o 293.84 Organic anxiety syndrome;
o 294.0 Amnestic syndrome;
o 294.1 Dementia in conditions classified elsewhere;
o 294.8 Other persistent mental disorders due to conditions classified elsewhere;
o 294.9 Unspecified persistent mental disorders due to conditions classified elsewhere;
o 305.1 Tobacco use disorder;
o 310.0 Frontal lobe syndrome;
o 310.2 Postconcussional syndrome;
o 310.8 Other specified nonpsychotic mental disorder following organic brain damage; and
o 310.9 Unspecified nonpsychotic mental disorder following organic brain damage.

The following services are provided as Medically Necessary to eligible Medicaid/NJ FamilyCare Plan D Members:

- Primary Care:
  - All physicians services, primary and specialty;
  - In accordance with state certification/licensure requirements, standards, and practices, PCPs shall also include access to certified nurse midwives, certified nurse practitioners, clinical nurse specialists, and physician assistants;
  - Services rendered at independent clinics that provide ambulatory services; and
  - Federally Qualified Health Center primary care services;

- Emergency Room Services;
• Family Planning Services, including medical history and physical examinations (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the Medicaid/NJ FamilyCare program;

• Home Health Care Services - Limited to skilled nursing for a home bound Member which is provided or supervised by a registered nurse, and home health aide when the purpose of the treatment is skilled care; and medical social services which are necessary for the treatment of the Member's medical condition;

• Hospice Services - Hospice care for children under the age of nineteen (19) must cover both palliative and curative care;

• Inpatient Hospital Services, including general hospitals, special hospitals, and rehabilitation hospitals. WellCare is not responsible when the primary admitting diagnosis is mental health or substance abuse related;

• Outpatient Hospital Services, including outpatient surgery but excluding mental health visits;

• Laboratory Services - All laboratory testing sites providing services under this contract must have either a Clinical Laboratory Improvement Act (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those Providers with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory services;

• Radiology Services - Diagnostic and therapeutic;

• Optometrist Services, including one (1) routine eye examination per year;

• Optical appliances - Limited to one (1) pair of glasses (or contact lenses) per twenty-four (24) month period or as medically necessary;

• Organ transplant services which are non-experimental or non-investigational;

• Prescription drugs, excluding over-the-counter drugs. Exception: Protease Inhibitors and other antiretrovirals;

• Dental Services for children under the age of nineteen (19);

• Podiatrist Services - Excludes routine hygienic care of the feet, including the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, in the absence of a pathological condition;

• Prosthetic appliances - Limited to the initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury, or congenital defect. Repair and replacement services are covered when due to congenital growth;

• Private duty nursing - Only when authorized by WellCare;

• Transportation Services - Limited to ambulance for medical emergency only;

• Well-child care including immunizations, lead screening and treatments;

• Maternity and related newborn care (including hearing screening);

• Diabetic supplies and equipment;

• Hearing Aid Services - Limited to children under the age of sixteen (16) years;

• Audiology - Limited to children under the age of sixteen (16) years;
- Durable Medical Equipment - Limited benefit;
- Medical Supplies - Limited benefit;
- Outpatient Rehabilitation Services - Physical therapy, occupational therapy, and speech pathology services for non-chronic conditions and acute illnesses and injuries limited to sixty (60) visits per therapy per calendar year. Speech pathology services rendered for treatment of delays in speech development are not covered unless resulting from disease, injury or congenital defects.

**Website Resources**
WellCare’s website, [https://newjersey.wellcare.com](https://newjersey.wellcare.com), offers a variety of tools to assist Providers and their staff.

Available resources include:
- Provider Manuals;
- Quick Reference Guides;
- Clinical Practice Guidelines;
- Clinical Coverage Guidelines;
- Forms and documents;
- Provider search tool (directories);
- Authorization look-up tool;
- Training materials and job aids;
- Newsletters;
- Member rights and responsibilities; and
- Privacy statement and notice of privacy practices.

**Secure Provider Portal - Benefits of Registering**
Our secure online Provider Portal offers immediate access to an assortment of useful tools. Providers can create a login and password using their WellCare Provider Identification Number (PIN).

WellCare’s secure Provider Portal offers the following features:
- **Ability to create sub-accounts for office staff:** Providers have the ability to create sub-accounts so that office staff may login.
- **Claims submission status and inquiry:** Submit a new claim, check the status of an existing claim, and customize and download reports.
- **Member eligibility and co-payment information:** Verify Member eligibility and obtain specific Co-payment information.
- **Prior Authorization requests:** Submit Prior Authorization requests, attach clinical documentation and check Prior Authorization status. Providers can also print and/or save copies of Prior Authorization forms.
- **Training:** Take required training courses and complete attestations online.
- **Reports:** Access reports such as active Members, Prior Authorization status, claims status, eligibility status, HEDIS® care gaps, and more.
- **Provider news:** View the latest important announcements and updates.
- **Personal inbox:** Receive notices and key reports regarding your claims, eligibility inquiries and authorization requests.

**How to Register**

After registering for WellCare’s website, Providers should retain their login and password information for future reference.

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

**Additional Resources**

The New Jersey Medicaid Resource Guide contains information about our secure online Provider Portal, Member eligibility, authorizations, filing paper and electronic claims, appeals, and more. For specific instructions on how to complete day-to-day administrative tasks, please see the New Jersey Medicaid Resource Guide found on our website at https://newjersey.wellcare.com/provider/job_aids.

Another valuable resource is the Quick Reference Guide (QRG), which contains important addresses, phone/fax numbers and authorization requirements. Providers can find the QRG at https://newjersey.wellcare.com/provider/resources.
Section 2: Provider and Member Administrative Guidelines

Provider Administrative Overview

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

Participating 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 as amended, the Age Discrimination Act of 1975 as amended, the Americans with Disabilities Act of 1990 as amended, and the Rehabilitation Act of 1973 as amended;
- Agree to cooperate with WellCare in its efforts to monitor compliance with its Medicaid/NJ FamilyCare contract(s) and/or Agency rules and regulations, and assist us in complying with corrective action plans necessary for us to comply with such rules and regulations;
- Retain all agreements, books, documents, papers, and medical records related to the provision of services to WellCare Members as required by state and federal laws;
- Provide Covered Services in a manner consistent with professionally recognized standards of health care;
- Use physician extenders appropriately. Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNP) should provide direct Member care within the scope or practice established by the rules and regulations of the Agency 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: MD, DO, ARNP, PA) to Members and to other health care professionals;
- Honor, at all times, any Member request to be seen by a physician rather than a physician extender;
- Administer, within the scope of practice, treatment for any Member in need of health care services;
- Maintain the confidentiality of Member information and records;
- Respond promptly to WellCare’s request(s) for medical records in order to comply with regulatory requirements;
- Maintain accurate medical records and adhere to all WellCare’s policies governing content and confidentiality of medical records as outlined in Section 3: Quality Improvement and Section 8: Compliance;
- Ensure that: (a) all employed physicians and other health care practitioners and providers comply with the terms and conditions of the Agreement between the
Provider and WellCare; (b) the physician maintains written agreements with contracted physicians, health care practitioners, or other providers, employed physicians and other health care practitioners and providers, and that such agreements contain similar provisions to the Agreement.

- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene;
- Communicate timely clinical information between providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to WellCare, the Member or the requesting party at no charge, unless otherwise agreed;
- Preserve Member dignity and observe the rights of Members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimens;
- Not discriminate in any manner between WellCare Medicaid/NJ FamilyCare Members and members of other plans, commercial or otherwise;
- Ensure that the hours of operation offered to WellCare Medicaid/NJ FamilyCare Members is 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 health care; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; or (g) disability;
- Freely communicate with and advise Members regarding the diagnosis of the Member’s condition and advocate on the Member’s behalf for the Member’s health status, medical care and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services;
- Identify Members who are in need of services related to children’s health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation or substance abuse. If indicated, Providers must refer Members to WellCare-sponsored or community-based programs;
- Must document the referral to WellCare-sponsored or community-based programs in the Member’s medical record and provide the appropriate follow-up to ensure the Member accessed the services; and
- Assure the use of the most current diagnosis and treatment protocols and standards established by DOH and the medical community.

**Excluded or Prohibited Services**

Providers must verify Member 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-emergency transportation, are administered outside of the managed care program.

Excluded Services are services that Members may obtain under the Medicaid/NJ FamilyCare plan for which WellCare is not financially responsible. Excluded Services may be paid for by the Agency on a fee-for-service basis or other basis. In the event the
service(s) is (are) an Excluded Service, Providers must submit reimbursement for those services directly to the Agency. In the event the service(s) is (are) prohibited, neither WellCare nor the Agency is financially responsible.

**Responsibilities of All Providers**
The following is a summary of the responsibilities of all Providers who render services to WellCare Members. These are intended to supplement the terms of your Participating Provider Agreement, not replace them. In the event of a conflict between this Provider Manual and the Participating Provider Agreement (“Agreement”), the terms of the Agreement shall govern.

**Living Will and Advance Directive**
All Members have the right to control decisions relating to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life.

Each WellCare Member (age eighteen (18) years or older and of sound mind), should receive information regarding living will and advance directives. This allows Members to designate another person to make a decision should they become mentally or physically unable to do so.

Information regarding living will and advance directives should be made available in Provider offices and discussed with the Members, or their authorized representatives. Completed forms should be documented and filed in Members’ medical records.

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

**Provider Billing and Address Changes**
Prior notice to your Provider Relations representative or Provider Services is required for any of the following changes:
- 1099 mailing address;
- Tax Identification Number (TIN) or Entity Affiliation (W-9 required);
- Group name or affiliation;
- Physical or billing address; and
- Telephone and fax number.

Failure to notify WellCare prior to these changes will result in a delay in claims processing and payment.

**Provider Termination**
In addition to the Provider termination information included in the Agreement, you must adhere to the following terms:
- Any contracted Provider must give at least ninety (90) days prior written notice to WellCare before terminating your relationship with WellCare “without cause,” unless otherwise agreed to in writing. This ensures adequate notice may be given to WellCare Members regarding your participation status with WellCare. Please refer to your Agreement for the details regarding the specific required days for
providing termination notice, as you may be required by contract to give more notice than listed above; and

- Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month.

Please refer to Section 6: Credentialing in this Manual 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 PCP, hospital, specialist or significant ancillary Provider within the service area as required by New Jersey program requirements, and applicable federal and state statutes, rules, and/or regulations.

Out-of-Area Member Transfers
Providers should assist WellCare in arranging and accepting the transfer of all 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.

Payment in Full/Prohibition on Balance Billing
Providers must accept WellCare’s payments for services, goods, and supplies as payment in full on behalf of the Member. No additional amount can be charged to the Member, his or her family, representative or others on his or her behalf for the Covered Services, goods, and supplies furnished to the Member. Providers also may not seek reimbursement from Members for any missed appointments.

Providers may not seek reimbursement from Members because the services provided are determined not to be Medically Necessary. A Provider may seek reimbursement from a Member for services, goods, or supplies that are not Covered Services if the Member knows in advance that the good, service, or supply is not a Covered Service and that the Member will be responsible for payment to the Provider.

Individuals with Special Health Care Needs
Individuals with Special Health Care Needs (ISHCN) include but are not limited to Members with serious or chronic physical, developmental, behavioral, or emotional conditions such as:

- Developmental disabilities or related conditions;
- Serious chronic illnesses such as Human Immunodeficiency Virus (HIV), schizophrenia or degenerative neurological disorders;
- Disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes; or
- Children and adults with certain environmental risk factors such as homelessness or family problems that may lead to the need for placement in foster care.

The following is a summary of responsibilities specific to Providers who render Covered Services to WellCare Members who have been identified with special health care needs:

- Assess Members and develop plans of care for those Members determined to need courses of treatment or regular care;
• Coordinate treatment plans with Members, family and/or specialists caring for Members;
• The 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.

Responsibilities of Primary Care Providers
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 timeframes indicated in the Access Standards section below;
• Provide or arrange for coverage of services, consultation or approval for referrals twenty-four (24) hours per day, seven (7) days per week;
• To ensure accessibility and availability, PCPs must provide one of the following:
  o A twenty-four (24) hour answering service that connects the Member to someone who can render a clinical decision or reach the PCP;
  o An answering system with an option to page the physician for a return call within a maximum of thirty (30) minutes; or
  o An advice nurse with access to the PCP or on-call physician within a maximum of thirty (30) minutes;
• Assure Members are aware of the availability of public transportation where available;
• Provide access to WellCare or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity. A related organization or entity is defined as having influence, ownership or control and either a financial relationship or a relationship for rendering services to the primary care office;
• Submit an Encounter for each visit where the Provider sees the Member or the Member receives a HEDIS® service;
• Submit Encounters - for more information on Encounters, refer to Encounters in Section 5: Claims;
• Ensure Members utilize WellCare’s Participating Providers. If a Provider is unable
to locate a Participating Provider, contact Provider Services for assistance. Refer to the Quick Reference Guide on WellCare’s website at newjersey.wellcare.com/provider/resources for contact information; and

- Comply with and participate in corrective action and performance improvement plan(s).

Primary Care Office Resources
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, Marketing and Sales departments, as well as the tools and resources available on WellCare’s website at https://newjersey.wellcare.com/provider; and

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

Closing of Physician Panel
When requesting closure of your panel to new and/or transferring WellCare Members, PCPs must:

- Submit the request in writing at least 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 to 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 and credentialled Provider to provide services on their behalf, unless there is an emergency.

Covering physicians are required to be credentialled by WellCare, and are required to sign an agreement which, among other terms and conditions sets forth the negotiated rate prohibits the balance billing of WellCare Members. For additional information, please refer to Section 6: Credentialing in this Manual.

In non-emergency cases, should you have a covering physician/provider who is not contracted and credentialled with WellCare, contact WellCare for approval. For more information, refer to the QRG on WellCare’s Provider website.

Access Standards
Providers must adhere to standards of timeliness that take into consideration the immediacy of the Member’s needs for appointments, in-office waiting times, and telephone response times as set forth in the table below. WellCare shall monitor Providers against these standards to ensure Members can obtain needed health services within the acceptable timeframes. Providers not in compliance with 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><strong>Emergency Services</strong></td>
<td>Immediately upon presentation</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>&lt; 24 hours</td>
</tr>
<tr>
<td><strong>Symptomatic Acute Care</strong> - an encounter with a health care provider associated with the presentation of medical signs, but not requiring immediate attention</td>
<td>&lt; 72 hours</td>
</tr>
<tr>
<td><strong>Routine</strong> - non-symptomatic visits, including annual gynecological examinations or pediatric and adult immunization visits</td>
<td>&lt; 28 days</td>
</tr>
<tr>
<td><strong>Specialist Referrals</strong></td>
<td>&lt; 4 weeks</td>
</tr>
<tr>
<td><strong>Urgent Specialty Care</strong></td>
<td>Within 24 hours of referral</td>
</tr>
<tr>
<td><strong>Baseline physicals for new adult members</strong></td>
<td>Within 180 calendar days of initial enrollment</td>
</tr>
<tr>
<td><strong>Baseline physicals for new children members and adult clients of the DDD</strong></td>
<td>Within 90 days of initial enrollment, or in accordance with EPSDT guidelines</td>
</tr>
<tr>
<td><strong>Prenatal Care</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Physicals</strong></td>
<td>Within 4 weeks</td>
</tr>
<tr>
<td><strong>Lab and radiology services – routine</strong></td>
<td>Within 3 weeks</td>
</tr>
<tr>
<td><strong>Lab and radiology services – urgent</strong></td>
<td>Within 48 hours</td>
</tr>
<tr>
<td><strong>Initial Pediatric appointments</strong></td>
<td>Within 3 months of enrollment</td>
</tr>
<tr>
<td><strong>Dental – emergency (including in an emergency room)</strong></td>
<td>No later than 48 hours, or earlier if the condition warrants, of injury to sound natural teeth and surrounding tissue</td>
</tr>
<tr>
<td><strong>Dental – urgent</strong></td>
<td>Within 3 days of referral</td>
</tr>
<tr>
<td><strong>Dental – routine</strong></td>
<td>Within 30 days of referral</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse - Emergency</strong></td>
<td>Immediately upon presentation</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse – Urgent</strong></td>
<td>&lt; 24 hours</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse - Routine</strong></td>
<td>&lt; 10 days</td>
</tr>
<tr>
<td><strong>Maximum Number of Intermediate/Limited Patient Encounters - Adult</strong></td>
<td>4 per hour</td>
</tr>
<tr>
<td><strong>Maximum Number of Intermediate/Limited Patient Encounters - Children</strong></td>
<td>4 per hour</td>
</tr>
</tbody>
</table>
In-office wait times shall not exceed forty-five (45) minutes.

Providers are required to respond to telephone inquiries in a timely manner and to prioritize appointments. Providers should triage medical and dental conditions and special behavioral needs for non-compliant Members who are mentally deficient. While scheduling an appointment, Providers should identify any special needs of Members, such as interpretive linguistic needs.

Providers should schedule a series of appointments and follow-up appointments as the Member’s needs dictate.

Providers should develop processes to identify and reschedule missed appointments.

<table>
<thead>
<tr>
<th>Type of Telephone Call</th>
<th>Response Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>After hours non-emergent, symptomatic issues</td>
<td>Within 30 to 45 minutes</td>
</tr>
<tr>
<td>Non-symptomatic concerns</td>
<td>Same day</td>
</tr>
<tr>
<td>Crisis situations</td>
<td>Within 15 minutes</td>
</tr>
</tbody>
</table>

**Specialist Providers/Specialty Care Services**

Selected specialty services by a specialist Provider or specialty care center require a proper referral from the Member’s PCP. The specialist may order diagnostic tests without PCP involvement by following WellCare’s referral guidelines. However, the specialist Provider may not refer the Member to other specialists or admit the Member to a hospital without the referral of a PCP, except in the case of an emergency. The specialist Provider must abide by WellCare’s Prior Authorization requirements when ordering diagnostic tests. The PCP should arrange for a standing referral to a specialist Provider from WellCare when a Member requires ongoing specialty care.

The specialist Provider must maintain contact with the Member’s PCP. This could include telephone contact, written reports on consultations, or verbal reports if an emergency situation exists.

All specialist Providers must:
- Obtain referral or Prior Authorization from the Member’s PCP before providing services;
- Coordinate the Member’s care with the PCP;
- Provide the PCP with consult reports and other appropriate records within five (5) business days;
- Be available for or provide on-call coverage through another source twenty-four (24) hours a day; and
- Maintain confidentiality of the Member’s medical information.

WellCare recognizes that in certain cases, it may be beneficial for a Member’s specialist Provider to act as the Member’s PCP. Members who have special needs that require very complex, highly specialized health care services over a prolonged period of time, a
life-threatening condition or disease, or a degenerative and/or disabling condition or disease may be offered the option of selecting an appropriate specialist Provider (where available) instead of a traditional PCP. Such specialist providers must have the appropriate clinical skills, capacity, accessibility, and availability. They must be specially credentialed and are contractually obligated to:

- assume the responsibility for the overall health care coordination of the Member;
- assure that the Member receives all necessary specialty care related to his or her special needs; and
- provide for or arrange all routine preventive care and health maintenance services, even if they are not customarily provided by or be the responsibility of the specialist Provider.

The specialist Provider acting as PCP must be available or provide on-call coverage twenty-four (24) hours per day, seven (7) days per week.

**New Jersey’s Early and Periodic Screening, Diagnosis, and Treatment Program**

New Jersey’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is a comprehensive preventive health care program designed to improve the overall health of Medicaid/NJ FamilyCare eligible infants, children, and adolescents. The goal of the EPSDT program is to identify health problems and treat them early to reduce the risk of costly treatment or hospitalization later. WellCare’s Participating Providers who perform PCP services are required to participate in the EPSDT program.

Medical check-ups must be performed in accordance with the Pediatric Preventive Health Standards Schedule that is based on the American Academy of Pediatrics (AAP) recommendations.

All initial screenings are to be performed by the Member’s PCP and include at a minimum:

- Family history (physical and mental development);
- Comprehensive unclothed physical examination;
- Dental assessment (as appropriate);
- Measurements (height, weight, and infant head circumference);
- Nutritional assessment;
- Developmental assessment;
- Mental health assessment;
- Sensory screening (vision and hearing);
- Laboratory tests (including blood lead level assessments appropriate for age and risk factors);
- Tuberculosis test;
- Lead screening;
- Immunizations;
- Health education;
- Visual assessment;
- Anticipatory guidance; and
- Referral services, i.e., family planning, and dental services.

Any Provider attending the birth of a baby must require testing for phenylketonuria (PKU), galactosemia, hypothyroidism, homocystinuria, hemoglobinopathies (including sickle cell
anemia), electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss, and congenital adrenal hyperplasia on all newborns as required by New Jersey law.

**Member Notification**
WellCare informs all eligible Members of all testing/screenings due according to the federal periodicity schedule pursuant to state and federal agency contracts. WellCare contacts Members to encourage them to obtain health assessment and preventative care. Upon enrollment, all Members will receive a Member Handbook, which includes information about needed child health screenings, preventive services, age appropriate immunizations, and dental screenings (if applicable). Age-appropriate eligible Members are sent reminder notices when upcoming assessments or needed services are due. WellCare offers scheduling assistance in order to assist Members in keeping appointments.

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. Members are sent reminder notices according to the following schedule:
- Within forty-five (45) days of enrollment with WellCare if there has been no visit to PCP for EPSDT visit;
- Age one (1) month;
- Age two (2) months;
- Age four (4) months;
- Age six (6) months;
- Age nine (9) months;
- Age twelve (12) months;
- Age fifteen (15) months;
- Age eighteen (18) months;
- Age twenty-four (24) months;
- Age thirty (30) months; and
- Ages three (3) through twenty-one (21) years annually.

**Provider Notification and Responsibilities**
WellCare will send all Providers a monthly membership list of EPSDT-eligible children, who have not had a screen within one hundred twenty (120) days of enrolling in WellCare or are not in compliance with the EPSDT periodicity schedule. The PCP shall contact these Members’ parents or guardians to schedule an appointment.

Providers are responsible for monitoring, tracking and following up with all Members who have not had a health assessment screening. Providers will ensure all Members receive the proper referrals to treat any conditions or problems identified during the health assessment and tracking, monitoring and following up with all Members to ensure they receive the Medically Necessary services. Providers are to assist all Members with transition to other appropriate care for children who age-out of EPSDT services.

Providers are required to follow up with all Members who miss EPSDT appointments. Appropriate and reasonable outreach must consist of a minimum of three (3) attempts to reach the Member through:
WellCare

eHealth Plans, Inc.

Medicaid/NJ FamilyCare Provider Manual

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Page 32 of 123

- mailers;
- certified mail if necessary;
- telephone calls;
- the use of the MEDM system provided by the State; and
- contact with the Medical Assistance Customer Center (MACC), DDD, or Division of Youth and Family Services of the Department of Children and Families (DYFS/DCF) regional offices to confirm addresses and/or to request assistance in locating a Member.

Documentation of the Provider’s attempts to contact all Members and coordinate care must be in the medical record.

Medical record reviews are conducted to assess the quality of care delivered and services documented. The process includes, but may not be limited to, evaluation of adherence to EPSDT requirements. In general, documentation in the medical office record is reviewed for the following elements:

- Compliance with professional practice standards, as well as any preventive health guidelines;
- Appropriate and timely assessments;
- Use of appropriate tools to identify early, timely and age-appropriate interventions;
- Early and timely referrals to appropriate intervention programs in the Member’s area;
- Appropriate utilization of services;
- Coordination of care and services
- Inclusion of the Member in the development of the treatment process; and
- General compliance with state and federal requirements.

Vaccines for Children
PCPs must enroll with the New Jersey Department of Health’s (DOH) Vaccines for Children (VFC) Program and use the vaccines for all eligible Members if the vaccines are covered by VFC. PCPs can receive vaccines for immunizations free of charge through DOH. You must have a provider identification number (PIN) to order. If you are not enrolled, call (609) 826-4862 for more information on how to enroll.

WellCare requires all Members under the age of eighteen (18) to be immunized by their PCP unless medically contraindicated or against parental religious beliefs.

Blood Lead Screening
PCPs are required to perform a verbal risk assessment and screen for blood lead levels in children six (6) months through six (6) years of age as part of the EPSDT visit. This screening must be done through a blood lead level determination. The EP test is no longer acceptable as a screening test for lead poisoning, although it is still valid as a screening for iron deficiency anemia. PCPs must report all blood lead screening results, both positive and negative, to the County Lead Poisoning Center at the local health department. If a screening identifies a child with blood lead levels equal to or greater than ten (10) micrograms per deciliter, PCPs must immediately report the findings to the County Lead Poisoning Center.
Domestic Violence and Substance Abuse Screening
PCPs should identify indicators of substance abuse or domestic violence.

Smoking Cessation
PCPs should direct Members who wish to quit smoking to call Customer Service and ask to be directed to the Case 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.

Adult Health Screening
An adult health screening should be performed by a physician to assess the health status of all WellCare Members. The adult Member should receive an appropriate assessment and intervention as indicated or upon request. Please refer to the adult preventive health guidelines located on WellCare’s website at https://www.wellcare.com/provider/CPGs.

Laboratory and Radiology Test Results
The Provider should notify all Members of laboratory and/or radiology test results within twenty-four (24) hours of receipt of the results in urgent care or emergent care cases. The Provider should notify all Members of laboratory and/or radiology results within ten (10) business days of receipt of the results in non-urgent or non-emergent cases.

The Provider shall notify a Member’s mental health/substance abuse Provider of physical examination and laboratory and/or radiology test results within twenty-four (24) hours of receipt of the results in urgent care cases and within five (5) business days in non-urgent cases.

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. In the event that a Participating Provider desires to terminate her or his relationship with a WellCare Member, the Provider should submit adequate documentation to support that although the Provider has 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.

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, “The Member has been transferred from the Provider’s practice, and such transfer has occurred”.

The Provider should complete a Request for Transfer of Member Form, attach supporting documentation, and fax the form to Customer Service. A copy of the form is available on WellCare’s website at https://newjersey.wellcare.com/provider/forms.
Member Administrative Guidelines

Member Identification Cards
Member identification cards are intended to identify WellCare Members, the type of plan they have, and facilitate their interactions with 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 confirming the current eligibility of the Member.

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

Providers may do one of the following to verify eligibility:
- Access the secure, online Provider Portal of the WellCare website at https://newjersey.wellcare.com/provider;
- Access WellCare’s Interactive Voice Response (IVR) system; and/or
- Contact Provider Services.

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

Member Rights and Responsibilities
WellCare Members, both adults and children, have specific rights and responsibilities. These are included in the Member Handbook.

WellCare Members have the right to:
- Receive information about WellCare’s plans, services, doctors and other health care providers;
- Receive information about their rights and responsibilities;
- Know the names and titles of the doctors and other health providers caring for them;
- Be treated with respect and dignity;
- Have their privacy protected;
- Choose their PCP from WellCare’s Participating Providers;
- Decide with their Provider on the care they receive;
- Have services provided that promote a meaningful quality of life and autonomy, and support independent living in both the Member’s home and other community-based settings so long as such services are medically and socially feasible, and preserve and support of the Members natural support systems;
- Talk openly about the care they need, no matter the cost or benefit coverage,
treatment options and the risks involved (this information must be given in a way they understand);
• Have the benefits, risks and side effects of medications and other treatments explained to them;
• Know about their health care needs after they leave a Provider’s office or the hospital;
• A second medical opinion;
• Refuse care, as long as they agree to be responsible for their decision;
• Refuse to take part in any medical research;
• File an Appeal or grievance about their plan or the care provided; also, to know that if they do, it will not change how they are treated;
• Not be responsible for WellCare’s debts in the event of bankruptcy and not be held liable for:
  − Covered services provided to them for which the government does not pay us;
  − Covered services provided to them for which the government or WellCare does not pay the Provider who furnished the services; and
  − Payment of Covered Services under a contract, referral or other arrangement to the extent those payments are in excess of the amount they would owe if WellCare provided the services directly;
• Be free from hazardous procedures or 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 (requests must be received in writing from the Member or the person they choose to represent them; the records will be provided at no cost; they will be sent within 14 days of receipt of the request);
• Have their records kept private;
• Make their health care wishes known through advance directives;
• Have a say in WellCare’s Member rights and responsibilities policies and recommend changes to other policies and services that WellCare covers;
• Appeal medical or administrative decisions by using WellCare’s Appeals and Grievances process;
• Exercise these rights no matter their sex, age, race, ethnicity, income, education or religion;
• Have WellCare staff observe their rights;
• Have all of these rights apply to the person legally able to make decisions about their health care; and
• Be furnished quality services in accordance with 42 CFR 438.206 through 438.210, which include:
  − Accessibility
  − Authorization standards
  − Availability
  − Coverage
  − Coverage outside of network

WellCare members also have certain responsibilities. These include the responsibility to:
• Read their Member Handbook to understand how WellCare’s health care plan works;
• Carry their Member Identification card and Medicaid card at all times;
• Give information that WellCare and their Providers need to provide care to them;
• Follow plans and instructions for care that they have agreed on with their Provider;
• Understand their health problems;
• Help set treatment goals that they and their Provider agree upon;
• Show their Member Identification card to each Provider when they receive services;
• Schedule appointments for all non-emergency care through their Provider;
• Get a referral from their PCP for specialty care;
• Cooperate with the people who provide their health care;
• Be on time for appointments;
• Tell their Provider’s office if they need to cancel or change an appointment;
• To pay their co-pays to Providers;
• Respect the rights and property of all Providers;
• Respect the rights of other patients;
• Not be disruptive at their Provider’s office;
• Know the medicines they take, what they are for and how to take them the right way;
• Make sure their Provider has copies of all of their previous medical records;
• Let WellCare know within 48 hours, or as soon as possible, if they are admitted to the hospital or get emergency room care; and
• Be responsible for cost sharing only as specified under Covered Services co-pays.

Assignment of Primary Care Physician
WellCare ensures that Members are informed and have access to enroll with traditional and safety net providers. WellCare makes every effort to ensure that Members are assigned to their existing PCP.

If the Member does not choose a PCP within ten (10) calendar days of the Member’s effective date of enrollment, the Member will be assigned to her or his PCP of record, based on prior information, if that Provider is in WellCare’s network. Otherwise, the Member will be assigned a PCP based on proximity to the Member and the Member’s language and/or cultural needs (if known).

A Member can change his or her PCP by contacting WellCare’s Customer Service. The reassignment will become effective by the first of the month following a full month after the request.

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

Hearing-Impaired, Interpreter and Sign Language Services
Hearing-impaired, interpreter and sign language services are available to WellCare Members through Customer Service. PCPs should coordinate these services for WellCare
Members and contact Customer Service if assistance is needed. Please refer to the QRG on WellCare’s website at https://newjersey.wellcare.com/provider/resources for the Provider Services telephone numbers.
Section 3: Quality Improvement

Quality Improvement

Overview
WellCare’s Quality Improvement Program (QI Program) is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral health care services. Strategies are identified and activities are implemented in response to findings. 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 health care settings/services;
- Cultural competency;
- Quality of care/service;
- Preventative health;
- Service utilization;
- Complaints/Grievances;
- Network adequacy;
- Appropriate service utilization;
- Disease and Case Management;
- Member and Provider satisfaction;
- Components of operational service; and
- Regulatory/federal/state/accreditation requirements.

The QI Program activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, HEDIS® measures, and/or medical record audits. WellCare’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.

Medical Records
Medical records should be comprehensive and reflect all aspects of care for each Member. Records are to be maintained in a secured, timely, legible, current, detailed and organized manner which conforms to good professional medical practice. Records should be maintained in a manner that permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Complete medical records include, but are not limited to: medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals’ findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of service provided. Medical records must be signed and dated.
Confidentiality of Member information must be maintained at all times. Records are to be stored securely with access granted only to authorized personnel. 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 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 records to WellCare upon request at no cost to WellCare. Information from the medical record review may be used in the re-credentialing process as well as quality activities.

For more information on medical records compliance, including but not limited to, confidentiality of Member information and release of records, refer to Section 8: Compliance in this Manual.

Provider Participation in the Quality Improvement Program
Participating Providers are contractually required to cooperate with quality improvement activities. Providers are invited to volunteer for participation in the QI Program. Avenues for participation include committee representation, quality/performance improvement projects, and feedback/input via satisfaction surveys, grievances, and calls to Customer Service. Provider participation in quality activities helps facilitate integration of service delivery and benefit management.

Information regarding the QI Program, available upon request, includes a description of the QI Program and a report on progress in meeting goals. WellCare evaluates the effectiveness of the QI Program on an annual basis. An annual report is published which reviews completed and continuing QI activities that address the quality of clinical care and service, trends measures to assess performance in quality of clinical care and quality of service, identifies any corrective actions implemented or corrective actions which are recommended or in progress, and any modifications to the QI Program. This report is available as a written document and is posted to the provider portal annually.

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

Patient Safety to include Quality of Care (QOC) and Quality of Service (QOS)
Programs promoting patient safety are a public expectation, a legal and professional standard, and an effective risk-management tool. As an integral component of health care delivery by all inpatient, and outpatient Providers, WellCare supports identification and implementation of a complete range of patient safety activities. These activities include medical record legibility and documentation standards, communication and coordination of care across the health care network, medication allergy awareness/documentation, drug interactions, utilization of evidence-based clinical guidelines to reduce practice variations, tracking and trending adverse events/quality of care issues/quality of service issues, and grievances related to safety.
Patient safety is also addressed through adherence to clinical guidelines that target preventable conditions. Preventive services include:

- Regular checkups;
- Immunizations; and
- Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, sexually transmitted diseases, pap smears, and mammograms.

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

**Clinical Practice Guidelines**

WellCare adopts validated evidence-based Clinical Practice Guidelines (CPGs) and utilizes the guidelines as a clinical decision support tool. While clinical judgment by a treating physician or other provider may supersede CPGs, the guidelines provide clinical staff and providers with information about medical standards of care to assist in applying evidence from research in the care of both individual Members and populations. The CPGs are based on peer-reviewed medical evidence and are relevant to the population served. Approval of the CPGs occurs through the Quality Improvement Committee. Clinical Practice Guidelines, to include Preventative Health Guidelines, may be found on WellCare’s website at [https://www.wellcare.com/provider/CPGs](https://www.wellcare.com/provider/CPGs).

**HEDIS®**

HEDIS® (Healthcare Effectiveness Data and Information Set) 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 2014 tool is comprised of eighty-one (81) measures across five (5) domains of care, including:

- Effectiveness of care;
- Access and availability of care;
- Experience of care;
- Utilization and Relative Resource Use; and
- Health Plan Descriptive Information.

HEDIS is a mandatory process that occurs annually. The results of WellCare’s compliance with the measures are reported annually to the National Committee for Quality Assurance, the Center for Medicaid and Medicare Services and the State of New Jersey. Providers can request a copy of the results. It is an opportunity for WellCare and its Providers to demonstrate the quality and consistency of care that is available to Members. Medical records and claims data are reviewed to ensure the required data are captured. Compliance with HEDIS® standards is reported on an annual basis with results available to Providers upon request. Through compliance with HEDIS® standards, Members benefit...
from the quality and effectiveness of care received and Providers benefit by delivering industry recognized standards of care to achieve optimal outcomes.

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

Utilization Management

Overview
WellCare’s Utilization Management (UM) program is designed to meet contractual requirements with federal regulations and the Agency while providing Members access to high quality, cost-effective, Medically Necessary care.

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

Medically Necessary Services
In order for services to be considered Covered Services, the service(s) must meet Medical Necessity criteria. Please see Section 12: Definitions for the definition of Medically Necessary services.

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

In accordance with 42 CFR 440.230, each Medically Necessary service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

WellCare's UM program includes components of Prior Authorization, prospective, concurrent, and Retrospective Review activities. Each component is designed to provide for the evaluation of health care and services based on the WellCare Member's coverage, the appropriateness of such care and services, and to determine the extent of coverage and payment to Providers of care.
WellCare does not reward its associates or any practitioners, physicians, other individuals, or entities performing UM activities for issuing denials of coverage, services or care. WellCare does not provide financial incentives to encourage or promote under-utilization.

**Criteria for Utilization Management Decisions**

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

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

- InterQual™,
- WellCare Clinical Coverage Guidelines;
- Medical Necessity;
- State Medicaid/NJ FamilyCare Contract;
- State Provider Handbooks, as appropriate;
- Local and federal statutes and laws;
- Medicaid/NJ FamilyCare and Medicare guidelines; and
- Hayes Health Technology Assessment.

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

The review criteria and guidelines are available to the Providers upon request. Providers may request a copy of the criteria used for specific determination of Medical Necessity by contacting the Utilization Management department via Provider Services. The phone number is listed on the Quick Reference Guide on WellCare’s website at [https://newjersey.wellcare.com/provider/resources](https://newjersey.wellcare.com/provider/resources).

**Utilization Management Process**

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

- Notifications;
- Referrals;
- Prior Authorizations;
- Concurrent Review; and/or
- Retrospective Review.

Decision and notification timeframes are determined by NCQA® requirements, contractual requirements, or a combination of both.

WellCare forms for the submission of notifications and authorization requests can be found on WellCare’s website at [https://newjersey.wellcare.com/provider/forms](https://newjersey.wellcare.com/provider/forms).
Notification
Notifications are communications to WellCare with information related to a service rendered to a Member or a Member’s admission to a facility. Notification is required for:

- Prenatal services. This enables WellCare to identify pregnant Members for inclusion into the care coordination program. Obstetrical Providers are required to notify WellCare of a Member’s pregnancy via fax using the Prenatal Notification Form as soon as possible after the initial visit. This process will expedite care management and claims reimbursement.
- A Member’s admission to a hospital. This enables WellCare to log the hospital admission and follow-up with the facility on the following business day to receive clinical information. The notification should be received by fax or telephone and include Member demographics, facility name, and admitting diagnosis.

Referrals
A referral is a request by a PCP for a Member to be evaluated and/or treated by a specialty Provider. A written or faxed script to the specialist is required. The specialist must document receipt of the request for a consultation and the reason for the referral in the medical record. No communication with WellCare is necessary. A copy of the medical consultation and diagnostic results should be submitted to the Member’s mental health or substance abuse Provider, if applicable. WellCare does not require authorization for the initial or subsequent visits when the Member is evaluated by a Participating Provider.

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

- Review for Medical Necessity;
- Appropriateness of rendering Provider;
- Appropriateness of setting; and/or
- 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 QRG on WellCare’s website at https://newjersey.wellcare.com/provider/resources or on the searchable Authorization Look-up Tool.

Some Prior Authorization guidelines to note are:

- The Prior Authorization request should include the diagnosis to be treated and the CPT code describing the anticipated procedure.
- A Prior Authorization may be given for a series of visits or services related to an episode of care. The Prior 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. Post-service requests for Prior Authorization will be reviewed only if the service was provided urgently and submitted within a few days of the
service. In all other circumstances, Providers are expected to meet standard non-urgent Prior Authorization guidelines and late submission of a request for Prior Authorization will result in a denial.

Prior Authorization requirements by service type may be found on the Quick Reference Guide on WellCare’s website at https://newjersey.wellcare.com/provider/resources or on the searchable authorization Look-up Tool.

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

- **Inpatient Authorization Request Form** is used to request Prior Authorization for elective/non-urgent inpatient, observation, skilled nursing facility and rehabilitation admissions.
- **Outpatient Authorization Request Form** is used to request Prior Authorization for services such as genetic testing, select outpatient hospital procedures, out-of-network services and transition of care.
- **Durable Medical Equipment (DME) and Orthotic-Prosthetic Request Form** is used to request Prior Authorization for durable medical equipment, orthotics and prosthetics, and items such as motorized wheelchairs, insulin pumps, and Dynasplint® systems.
- **Skilled Therapy Services Request Form** is used to request Prior Authorization for physical therapy (PT), occupational therapy (OT) and speech therapy (ST) services.
- **Home Health Services Request Form** is used to request Prior Authorization for home health services including skilled nursing, physical therapy and other services rendered in a home setting.

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

- Have all required fields completed;
- Be typed or printed in black ink for ease of review; and
- Contain a clinical summary or have supporting clinical information attached.

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

All forms are located on WellCare’s website at https://newjersey.wellcare.com/provider/forms. All forms should be submitted via fax to the number listed on the form.

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

Concurrent Review
Concurrent review activities involve the evaluation of a continued hospital, long-term acute care (LTAC) hospital, skilled nursing or acute rehabilitation stay for medical
appropriateness, utilizing appropriate criteria. The concurrent review nurse follows the clinical status of the Member through telephonic or onsite 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 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™ criteria to assess the quality and appropriate level of care for continued medical treatment. Reviews are performed by licensed clinical reviewers under the direction of the WellCare Medical Director.

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

**Discharge Planning**

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

**Retrospective Review**

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

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

- Retrospective review initiated by Providers:
  - WellCare will review post-service requests for authorization of inpatient admissions or outpatient services. The review includes making coverage
determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions and taking into account the Member’s needs at the time of service. WellCare will also identify quality issues, utilization issues and the rationale behind failure to follow WellCare’s Prior Authorization/pre-certification guidelines.

WellCare will give a written notification to the requesting Provider and Member within thirty (30) calendar days of receipt of a request for a UM determination. If WellCare is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once for up to fourteen (14) calendar days of the post-service request.

The Member or Provider may request a copy of the criteria used for a specific determination of Medical Necessity by contacting the UM department via Provider Services. Refer to the QRG on WellCare’s website at https://newjersey.wellcare.com/provider/resources.

**Peer-to-Peer Reconsideration of Adverse Determination**

In the event of an adverse determination following a medical necessity review, peer-to-peer Reconsideration is offered to the treating and/or requesting Provider via faxed notification. The Provider is provided a toll-free number to the Medical Director Hotline to request a discussion with the WellCare Medical Director who made the denial determination. Peer-to-peer reconsideration is offered within three (3) business days following the receipt of the faxed adverse determination notification.

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

**Services Not Requiring Authorization**

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

- Many routine services do not require Prior Authorization. A searchable authorization look-up tool is available on WellCare’s Provider website.
- Clinical laboratory tests conducted in contracted laboratories, hospital outpatient laboratories, and Provider offices under a Clinical Laboratory Improvement Amendment (CLIA) waiver do not require Prior Authorization. There are exceptions to this rule for specialty laboratory tests which require Prior Authorization regardless of place of service:
  - Reproductive laboratory tests;
  - Molecular laboratory tests; and
  - Cytogenetic laboratory tests;
- Certain tests described as CLIA-waived may be conducted in the Provider’s office if the Provider is authorized through the appropriate CLIA certificate, a copy of which must be submitted to WellCare.

All services performed without Prior Authorization are subject to Retrospective Review by WellCare.

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

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

**Second Medical Opinion**

A second medical opinion may be requested in any situation where there is a question related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. A second opinion may be requested by any member of the health care team, 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 Participating Provider, 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.

**Individuals with Special Health Care Needs (ISHCH)**

ISHCN are adults and children/adolescents who face physical, mental or environmental challenges daily that place their health and ability to fully function in society at risk. Factors include:

- individuals with mental retardation or related conditions;
- individuals with serious chronic illnesses, such as HIV, schizophrenia or degenerative neurological disorders;
- individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes;
- children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to placement in foster care.

ISHCN Members will be identified for referral for a Comprehensive Needs Assessment (CNA) by a review of hospital and pharmacy utilization. Additionally, Providers can refer Members and Members can self-refer.

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

- Allow the Members needing a course of treatment or regular care monitoring to have direct access through standing authorization or approved visits, as appropriate for the Member’s condition or needs:
To obtain a standing authorization, the provider should complete the appropriate authorization request form and document the need for a standing authorization request under the pertinent clinical summary area of the form; The authorization request should outline the plan of care including the frequency, total number of visits and the expected duration of care.

- Coordinate with WellCare to ensure each Member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the Member; and
- Ensure that members requiring specialized medical care over a prolonged period of time have access to a specialty care provider. Members will have access to a specialty care provider through standing authorization requests, if appropriate.

Members are identified for Care Management through the CNA. Additional triggers which may indicate the need for a CNA may be obtained from the following data sources:

- Claims and/or encounter data;
  - SNP Member identification from enrollment reports;
  - Hospital discharge;
  - Pharmacy;
  - Utilization Management;
  - Data supplied by Member and/or caregiver (Health Risk Assessments);
  - Data supplied by practitioners, if applicable.

Referral sources for identification and consideration of members appropriate for Care Management Services include, but are not limited to, the following:

- Utilization Management;
- Disease Management;
- Behavioral Health;
- Intake;
- Practitioners/Provider;
- Members or their caregivers (self-referral);
- Hospital Discharge Planners;
- Health Information Line;
- State Regulators.

Care plans will be developed to address the specific service requirements (such as durable medical equipment, skilled therapy services, home health care and transportation) of Members identified as having complex needs.

The specific needs of referred Members are assessed during the CNA, including condition-specific issues. The CNA includes the following:

- Initial assessment of the Member's medical, dental, and behavioral health status, including condition specific issues;
- Assessment of co-morbidities;
- Documentation of clinical history including current and past medications, disease onset, key events such as acute phases, inpatient stays, and treatment history;
• Documentation of frequency and quantity of drug and/or alcohol use;
• Initial assessment of the activities of daily living such as eating, bathing and mobility;
• Initial assessment of mental health status, including cognitive functions and psychosocial factors such as the ability to communicate, understand instructions and process information about their illness;
• Initial assessment of life-planning activities (if the Member is greater than eighteen (18) years old);
• If expressed life-planning activities are not on record, the care manager determines if such a decision is appropriate during the first contact, based on the Member’s circumstances and provides life-planning information if appropriate;
• Evaluation of cultural and linguistic needs, preferences or limitations;
• Evaluation of dental, visual, and hearing needs, preferences or limitations;
• Evaluation of caregiver resources and involvement, such as involvement in and decision making about the care plan;
• Evaluation of available benefits within the organization and from community resources; and
• Assessment of care gaps.

Members will be referred to Behavioral Health Care Management based on the outcome of the Patient Health Questionnaire (PHQ-9) screening. Members with a PHQ-9 score of twenty (20) or greater are referred to Behavioral Health Care Manager for anticipated referral to psychiatrist for an evaluation, if Member is not currently under treatment by a psychiatrist. The Care Manager will conduct the CNA in the medical management system.

Care Managers will collaborate with Providers, Members, parents, caregivers, or guardians to ensure that access to all Covered Services are available for Members with special needs whose disabilities substantially impeded activities of daily living.

Care Management will follow all policies and procedures to allow for the continuation of existing relationships with non-participating providers, when appropriate Participating Providers are not available within network or it is otherwise considered by the contractor to be in the best medical interest of the Member with special needs.

If WellCare or the PCP, in consultation with WellCare’s Medical Director and a specialist, if any, determines that the Member’s care would be most appropriately be coordinated by such specialist/specialty care center, WellCare shall refer the Member. Care Managers will collaborate in order to facilitate the Member’s care by a specialty care center.

Members, parents, caregivers, or guardians are provided the Nurse Advice Line (1-800-919-8807) after hours. This number is provided in Member letters, Member handbooks, the Quick Reference Guide, and care management correspondence.

The Nurse Advice Line will be available to answer phone calls of Members, guardians, parents, or caregivers who need to speak with a nurse. The Care Management team is sent referrals from the Nurse Advice Line to follow-up and assess for Care Management needs.
Members also have access to a toll free behavioral crisis hotline that is staffed twenty-four (24) hours a day. The crisis hotline phone number is printed on the Member’s card and is available on our website.

Care Managers will assist Members, parents, caregivers, or guardians in scheduling dental appointments with a dental Provider with expertise in the dental management of Members with developmental disabilities. WellCare will consider all current Providers of dental services to Members with developmental disabilities to be Participating Providers.

For Children with Special Healthcare Needs, the Care Managers will collaborate with the child’s Providers, parent, caregiver, or guardian to ensure access to health promotion, disease prevention, well child care, and specialty care. Further, Care Management will follow all policies and procedures to allow for the continuation of existing relationships with non-participating providers, when appropriate Participating Providers are not available within network or it is otherwise considered by the Care Manager to be in the best medical interest of the child with special needs.

**Conditions Considered to be Both Medical and Dental**
PCPs can refer WellCare Members to oral surgeons or physician specialists for the diagnosis and treatment of a condition that can be considered either dental or medical in nature. Examples include, but are not limited to, treatment of a fractured jaw or surgical removal of oral cysts. The referred services must be performed by a Participating Provider and require a referral by the Member’s PCP.

All services performed at an inpatient facility for oral surgery require Prior Authorization. To verify if a Prior Authorization is necessary or to obtain a Prior Authorization for outpatient services, please refer to the QRG on WellCare’s Provider website.

All assistant surgeons’ procedures including those on the assistant surgeon’s list are subject to Retrospective Review for Medical Necessity.

A Provider’s medical staff by-laws requiring that an assistant surgeon be present for a designated procedure are not grounds for reimbursement. Medical staff by-laws alone do not constitute Medical Necessity, nor is reimbursement guaranteed when the Member or family requests an assistant surgeon be present for the procedure. Coverage and subsequent reimbursement for an assistant surgeon’s service is based on the Medical Necessity of the procedure itself and the assistant surgeon’s presence at the time of the procedure.

**Service Authorization Decisions**

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<tr>
<th>Type of Authorization</th>
<th>Decision</th>
<th>Extension</th>
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<tbody>
<tr>
<td>Standard Pre-service</td>
<td>10 business days?</td>
<td>14 calendar days</td>
</tr>
<tr>
<td>Expedited Pre-service</td>
<td>Within 24 hours of receipt of necessary information but no later than 72 hours after receipt of request for service</td>
<td>48 hours</td>
</tr>
<tr>
<td>Urgent Concurrent</td>
<td>24 hours</td>
<td>48 hours</td>
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Standard Service Authorization
WellCare will provide a service authorization decision as expeditiously as the Member’s health condition requires and within the state-established timeframe which will not exceed ten (10) business days. WellCare will provide an authorization response to the Provider verbally or in writing by faxing the response to the fax number(s) included on the Prior Authorization request form. An extension may be granted for an additional fourteen (14) calendar days if the Member or the Provider requests an extension, or if WellCare justifies a need for additional information and the extension is in the Member’s best interest.

Expedited Service Authorization
In the event the Provider indicates, or WellCare determines, that following the standard time frame could seriously jeopardize the Member’s life or health, WellCare will make an expedited authorization determination and provide notice within twenty-four (24) hours of receipt of necessary information but no later than seventy-two (72) hours of the request. An extension may be granted for an additional forty-eight (48) hours if the Member or the Provider requests an extension, or if WellCare justifies a need for additional information and the extension is in the Member’s best interest.

Members and Providers may file a verbal request for an expedited decision. Requests for expedited decisions for Prior Authorization should be requested by telephone, not fax, or WellCare’s online Provider Portal. Please refer to the QRG on WellCare’s Provider website to contact the UM Department via Provider Services.

Urgent Concurrent Authorization
A Prior 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.

Emergency/Urgent Care and Post-Stabilization Services
Emergency services, including both medical and dental services, are not subject to Prior Authorization requirements and are available to Members twenty-four (24) hours a day, seven (7) days a week. Urgent care services should be provided within one (1) day. See Section 12: Definitions for definitions of “Emergency Services” and “Urgent Care”. Urgent Care services are provided as necessary and are not subject to Prior Authorization or pre-certification.

If a Provider calls WellCare’s Provider Services Department to obtain Prior Authorization for emergency medical and/or dental services, WellCare will inform the Provider Prior Authorization is not required. Providers may contact the Provider Services Department by referring to the Quick Reference Guide on WellCare’s website at https://newjersey.wellcare.com/Provider/resources.

Post-Stabilization services are services related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or improve, or resolve the Member’s condition. Post-Stabilization services are covered.
without Prior Authorization up to the point WellCare is notified that the Member’s condition has stabilized.

**Continuity of Care**
WellCare will allow Members in active treatment to continue care with a terminated treating Provider, when such care is Medically Necessary, in accordance with N.J.A.C 11:24-3.5, as amended, and the terms of the Agreement.

**Transition of Care**
WellCare may receive referrals to assist Members with the transition of care between clinical settings, levels of care, health plans, or providers. Provider engagement and cooperation are essential in supporting the Member’s plan of care. Care Managers and coordinators are in place to assist the interdisciplinary care teams in facilitating these transition efforts. To do so, they will outreach to the most appropriate person/agency/entity to secure the information required for utilization management, Care Management, or resource planning is obtained. For assistance in transitional planning, the Provider may contact the Care Management toll free line.

During the first thirty (30) days of enrollment, Prior Authorization is not required for certain Members with previously approved services by the state or another managed care plan. WellCare will continue to be responsible for the costs of continuation of such Medically Necessary Covered Services, without any form of prior approval and without regard to whether such services are being provided within or outside WellCare’s network until such time as WellCare can reasonably transfer the Member to a service and/or network Provider without impeding service delivery that might be harmful to the Member’s health. However, notification to WellCare is necessary to properly document these services and determine any necessary follow-up care.

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

When WellCare becomes aware that a covered Member will be dis-enrolled from WellCare and will transition to another managed care plan, 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.

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 Agency/CMO approval for reconsideration. Providers can refer to the QRG on WellCare’s Provider website for the appeals department contact information.

**Care Management Program**

**Overview**
Care Management refers to a set of Member-centered, goal-oriented, and culturally relevant steps to assure that a Member receives needed health care services. The Care
Management Program emphasizes prevention, health promotion, continuity of care and coordination of care, as necessary across Providers and settings to achieve the least restrictive and most integrated setting of care. The goals of the Care Management program include:

- Provide access to timely, appropriate, accessible, and Member-centered health care;
- Improve the quality of care and health outcomes for Members;
- Tailor care to the Members’ needs by using evidence-based treatment, best practices, and practice-based evidence to manage services by duration, scope, and severity;
- Ensure health plans involve Members and their family in the care process;
- Reduce emergency room visits and avoidable hospitalizations;
- Promote effective and ongoing health education and disease prevention activities;
- Provide cost-effective care;
- Promote information sharing and transparency.

In an effort to achieve optimal Member outcomes, the aim of the Care Management program is to provide supportive, effective, resourceful, and timely service coordination in the most cost efficient manner available. Therefore, the following Care Management functions are provided:

- Early identification of Members who have or may have special needs;
- Assessment of a Member’s risk factors, utilizing the New Jersey specific tools for assessment of Members;
- Development of an individualized plan of care;
- Referrals and assistance to ensure timely access to Providers;
- Coordination of care linking the Member to Providers, medical services, dental services, residential, social, behavioral, and other support services where needed;
- Monitoring; continuity of care; Follow-up and documentation.

**Role of the Care Manager**

The Interdisciplinary Care Team (ICT) is a group comprised of individuals and Providers who have an impact on the health and wellbeing of the Member. The team is comprised of the Member, Care Manager, PCP, and other caregivers, specialists, and home care providers. The role of the Care Manager is to provide communication and collaboration among the health care team for optimal coordination of care, and goal attainment. As the facilitator, the Care Manager will:

- Conduct a Comprehensive Needs Assessment (CNA) that identifies Member needs and barriers to care;
- Develop an individualized Care Plan with the Member/Caregiver and the PCP, establish and prioritize self-management goals, and identify needed resources, plan interventions and review outcomes;
- Coordinate with the ICT to facilitate seamless communication, coordination, and delivery of services with all relevant participants in the care of the medically fragile Member;
- Appropriately generate referrals to health care professional services such as...
behavioral health, pharmacy, medical, dental, and other specialized practitioners when needed;
- Coordinate transitions of care for Member by assisting with navigating today’s complex healthcare system and accessing provider, public and private community-based resources;
- Educate and assist Members with understanding diseases/conditions and resources necessary to address medical needs;
- Assess and monitor Member’s adherence with the Provider's plan of care.

**Care Management**
Care Management activities, a component of care management, is a set of activities tailored to meet a Member’s situational health-related needs. Situational health needs are time-limited episodes of instability. Care Managers will expedite access to services, both clinical and non-clinical, by connecting the Member to resources that support him/her in playing an active role in the self-direction of his/her health care needs.

Care Management activities also emphasize prevention, continuity of care, and coordination of care. Care Management activities are driven by quality-based outcomes such as: improved/maintained functional status; enhanced quality of life; increased Member satisfaction; adherence to the care plan; improved Member safety; and to the extent possible, increased Member self-direction.

**Behavioral Health**
The state will retain a separate Mental Health/Substance Abuse (MH/SA) system for the coordination and monitoring of most mental health/substance abuse conditions for non-developmentally disabled members. As such, Care Management will not manage MH/SA services except partial care and partial hospitalization services for developmentally disabled Members.

Care Managers will be responsible for referring or coordinating referrals of members as indicated to Mental Health/Substance Abuse providers. Identification, coordination, and monitoring of behavioral and substance abuse conditions, in addition to those diagnoses which are categorized as altering the mental status of an individual (but are of organic origin), are integrated into the care management process.

**Special Health Care Needs**
Adults, Adolescents, and Children with Special Health Care Needs, as defined by the State of New Jersey contract with WellCare includes Members with chronic conditions or complex health risks that impact their daily function in society due to challenges with physical, mental, or environmental challenges.

- Adult Members with Special Health Care Needs may include: Members with complex/chronic medical conditions requiring specialized health care services;
- Members with physical, mental/substance abuse, and/or developmental disabilities;
- Members who are homeless
- Members with any other condition specified by the State of New Jersey.
Children with Special Health Care Needs (CSHCN) are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Special Health Care Needs Members are coordinated under the scope of complex Care Management by experienced ICT care team members. The ICT focuses on coordination and planning for both adults and children.

**Care Monitoring**
In the event a Member cannot be reached, or in the case of a Member that must be managed (i.e. Developmental Disability (DDD, or Member’s scoring 5+ on Initial Health Screening [IHS]) but does not consent to participate in the Care Management Program, the Member is placed in a care monitoring status. Care monitoring affords the Care Manager the ability to monitor the Member’s status for trigger events (i.e. frequent emergency room visits, claims, pharmacy trends, and other predictive model indicators) and identify potential health plan resources to the PCP, specialist, and/or community agencies involved in the care of the Member. All Department of Children Protection and Permanency (DCP&P) Members must be care managed.

**Transition of Care**
WellCare may receive referrals to assist Members with the transition of care between clinical settings, levels of care, health plans, or Providers. Provider engagement and cooperation is essential in supporting the Member’s plan of care. Care Managers and coordinators are in place to assist the interdisciplinary care teams in facilitating these transition efforts. To do so, they will outreach to the most appropriate person, Provider, agency or entity to secure the information required for utilization management, care management, or resource planning. For assistance in transitional planning, the Provider may contact the Care Management toll free line.

**Referrals**
If you would like to refer a Member to the Care Management Program, please call 1-866-635-7045, 8 a.m. to 5 p.m. or refer to the QRG which is available on WellCare’s Provider website.

**Disease Management Program**

**Overview**
Disease Management (DM) is a population-based strategy that involves consistent care across the continuum for Members with certain disease states. Elements of the program include education of the Member about the particular disease and self-management techniques, monitoring of the Member for adherence to the treatment plan and the consistent use of validated, industry-recognized evidence-based Clinical Practice Guidelines by the treatment team as well as the Disease Manager. WellCare’s Disease Management Program is an Opt-Out Program; therefore all Members with the diagnosis listed below are automatically assigned to the Program. Once a Member is assigned to the Disease Management Program, WellCare begins Member outreach to provide disease management education.
The DM 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;
- HIV/AIDS;
- Hypertension;
- Depression; and
- Smoking Cessation.

WellCare's DM Program educates Members and their caregivers regarding the standards of care for chronic conditions, triggers to avoid, and appropriate medication management. The Program also focuses on educating the Provider 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 https://newjersey.wellcare.com/provider/quality.

**Candidates for Disease Management**
WellCare encourages referrals from Providers, Members, hospital discharge planners and others in the health care community.

Interventions for Members identified vary depending on the Member’s level of need and stratification level. Interventions are based on industry-recognized CPGs. Members identified at the highest stratification levels receive a Comprehensive Needs Assessment by a DM nurse, disease-specific educational materials, identification of a care plan and goals, and follow-up assessments to monitor adherence to the plan and attain goals.

Disease-specific CPGs adopted by WellCare are on WellCare’s website at www.wellcare.com/provider/cpgs.

**Members with HIV / AIDS**
Providers should ensure that all pregnant women receive HIV education and counseling and HIV testing with their consent as part of their regular prenatal care. A refusal of testing should be documented in the Member’s medical record. Additionally, counseling and education regarding perinatal transmission of HIV and available treatment options for the mother and the newborn infant should be made available during pregnancy and/or to the infant within the first months of life.

Providers should access WellCare’s CPGs or other resources to ensure that the most current diagnosis and treatment protocols and standards established by DOH and the medical community are available to Members.

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

For more information on the Care Management Referral Line, refer to the QRG on WellCare’s Provider website.
Section 5: Claims

Overview
The focus of the Claims department is to process claims in a timely manner. WellCare has established toll-free telephone numbers for Providers to access a representative in our Customer Service department. For more information on claims submission, refer to the QRG on WellCare’s Provider website.

Timely Claims Submission
Unless otherwise stated in your Provider Participation Agreement (Agreement), Provider must submit claims (initial, corrected and voided) within one hundred eighty (180) calendar days from the date of service or the date of discharge for inpatient services. Unless prohibited by New Jersey state law or the Agency, WellCare may deny payment for any claims that fail to meet WellCare’s submission requirements for Clean Claims or that are received after the time limit in the Agreement for filing Clean Claims.

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

- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by WellCare; or
- 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:

- Strategic National Implementation Process (SNIP) Rejection Letter; and
- A copy of the Provider’s billing screen.

Tax Identification (TIN) and National Provider Identification (NPI) Requirements
WellCare requires the payer-issued Tax Identification Number (Tax ID / TIN) and National Provider Identifier (NPI) on all claims submissions, with the exception of atypical providers. Atypical Providers must pre-register with WellCare before submitting claims to avoid NPI rejections. WellCare will reject claims without the Tax ID and NPI. More information on NPI requirements, including HIPAA’s NPI Final Rule Administrative Simplification, is available on the Centers for Medicare and Medicaid Services (CMS) website at http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html.

Taxonomy
Providers should submit claims with the correct taxonomy code consistent with Provider Demographic Information for the Covered Services being rendered in order to be reimbursed at the appropriate rate. WellCare may pay the claim at the lower reimbursement rate if the taxonomy code is incorrect or omitted.
Preauthorization number
If a preauthorization number was obtained, Providers must include this number in the appropriate data field on the claim.

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

Strategic National Implementation Process
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 timely filing limits. For more information on Encounters, see the Encounters section of this Manual.

Claims Submission Requirements
When presenting a claim for payment to WellCare, the Provider understands that:
- The Provider has an affirmative duty to supervise the provision of, and be responsible for, the Covered Services identified on the claim form;
- The Provider must supervise and be responsible for preparation and submission of the claims; and
- The Provider must present a claim that is true and accurate and that is for Covered Services that:
  o have actually been furnished to the Member by the Provider prior to submitting the claim; and
  o are Medically Necessary.

Providers using electronic submission shall submit all claims to WellCare or its designee, as applicable, using the HIPAA compliant 837 electronic format, or a CMS 1500 and/or UB-04, or their successors. Claims shall include the Provider’s NPI, Tax ID and the valid Taxonomy code that most accurately describes the services reported on the claim. The Provider acknowledges and agrees that no reimbursement is due for a Covered Service and/or no claim is complete for a Covered Service unless performance of that Covered Service is fully and accurately documented in the Member’s medical record prior to the initial submission of any claim. The Provider also acknowledges and agrees that at no time shall Members be responsible for any payments to the Provider with the exception of Member expenses and/or non-covered services. Covered Services are established by the Member’s benefit plan. For more information on paper submission of claims, refer to the Quick Reference Guide which on WellCare’s website at https://newjersey.wellcare.com/provider/resources.

Electronic Claims Submissions
WellCare accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to WellCare must be in the ANSI ASC X12N format, version 5010A or its successor. For more information on EDI implementation with WellCare, refer to the \textit{WellCare Companion Guides} on WellCare’s website at \url{https://newjersey.wellcare.com/provider/claims_updates}.

Because most clearinghouses can exchange data with one another, providers should work with their existing clearinghouse, or a WellCare contracted clearinghouse, to establish EDI with WellCare. For a list of WellCare contracted clearinghouse(s), for information on the unique WellCare Payer Identification (Payer ID) numbers used to identify WellCare on electronic claims submissions, or to contact WellCare’s EDI team, refer to the \textit{Provider Resource Guide} available on WellCare’s website.

\textbf{HIPAA Electronic Transactions and Code Sets}

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

Specific WellCare requirements for claims and encounter transactions, code sets and SNIP validation are described herein. \textit{To promote consistency and efficiency for all claims and encounter submissions to WellCare, it is WellCare’s policy that these requirements also apply to all paper and DDE transactions.}

For more information on EDI implementation with WellCare, refer to the \textit{WellCare Companion Guides} on WellCare’s website at \url{https://newjersey.wellcare.com/provider/claims_updates}.

\textbf{Paper Claims Submissions}

For timely processing of claims, Providers are encouraged to submit claims electronically. Claims not submitted electronically may be subject to penalties in outlined the Agreement. For assistance in creating an EDI process, contact WellCare’s EDI team by referring to the QRG on WellCare’s Provider website.

- Paper claims must only be submitted on an original (red ink on white paper) claim forms.
- Any missing, illegible, incomplete or invalid information in any field will cause the claim to be rejected or processed incorrectly.
- Per CMS guidelines, the following process should be used for clean claims submission:
  - The information must be aligned within the data fields and must be:
    - On an original red-ink-on-white-paper claim forms;
    - Typed. Do not print, hand-write, or stamp any extraneous data on the form;
    - In black ink;
    - Large, dark font such as, PICA, ARIAL 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 UB-04 Fact Sheet:

CMS 1500 Fact Sheet:

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 records if requested from the Provider) WellCare will make all necessary adjustments to the claim, including recovery of payments which are not supported by the medical record. Providers who do not submit the requested medical records, or who do not remit the overpayment amount identified by WellCare, may be subject to a recoulement.

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), the National Physician Fee Schedule Database, the American Medical Association (AMA) and Specialty Society correct coding guidelines, and state specific regulations. These software programs may result in claim edits for specific procedure code combinations. These claims editing software programs may result in an adjustment of the payment to the Provider for the services or in a request, prior to payment, for the submission for review of medical records that relate to the claim. Providers may request reconsideration of any adjustments produced by these claims editing software programs by submitting a timely request for reconsideration to WellCare. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.

Prompt Payment
WellCare will pay Clean Claims within thirty (30) days after receipt when submitted electronically, or forty (40) days after receipt when submitted in a manner other than electronically. Note that a health care Provider’s submission of a Clean Claim to WellCare’s billing agent or clearinghouse does not constitute receipt by WellCare.
If WellCare is late in paying a Clean Claim under the terms of a health benefits plan, WellCare is required to pay simple interest on that Clean Claim at twelve percent (12%) per annum, with such interest calculated from the date that the Clean Claim should have been paid. Any such interest owed will be included with the claim payment.

**Coordination of Benefits**

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

The following applies for Members covered under more than one insurance policy at a time:

- If a claim is submitted for payment consideration secondary to primary insurance carrier, other primary insurance information, such as the primary carrier’s EOB, must be provided with the claim. WellCare has the capability of receiving EOB information electronically. To submit other insurance information electronically, refer to the **WellCare Companion Guides** which may be found on WellCare’s website at [https://newjersey.wellcare.com/provider/claims_updates](https://newjersey.wellcare.com/provider/claims_updates);
- If WellCare has information on file to suggest the Member has other insurance, WellCare may deny the claim;
- If the primary insurance has terminated, the Provider is responsible for submitting the initial claim with proof that coverage was terminated. In the event a claim was denied for other coverage, the Provider must resubmit the claim with proof that coverage was terminated;
- If benefits are coordinated with another insurance carrier as primary and the payment amount is equal to or exceeds WellCare’s liability, no additional payment will be made; and/or
- If the primary carrier pays less than WellCare’s liability, WellCare will pay the difference up to the allowed amount, not to exceed any amount that constitutes the Member’s responsibility.

**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, federal agencies have 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 should submit complete and accurate Encounter files to WellCare as follows:

- 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 requirements apply to both corrected claims (error correction Encounters) and cap-priced Encounters.

Accurate Encounters Submission
All Encounter transactions submitted via DDE or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines per the federal 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.

More information on WEDI SNIP Edits can be found at the WEDI white paper link at http://www.wedi.org/knowledge-center/white-papers-articles

For more information on submitting Encounters electronically, refer to the WellCare Companion Guides on WellCare’s website at https://newjersey.wellcare.com/provider/claims_updates.

Vendors are required to comply with any additional Encounters validations as defined by New Jersey and/or CMS, as applicable.

Encounters Data Types
There are four (4) Encounter types that delegated vendors and Providers are required to submit 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 a new, voided or a replaced/overlaid Encounter. The definitions of the types of Encounters are as follows:

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

**Encounters Submission Methods**
Delegated vendors and Providers may submit Encounters using several methods: electronically, through WellCare’s contracted clearinghouse(s), via DDE or using WellCare’s Secure File Transfer Protocol (SFTP) process. SFTP is the preferred submission method.

**Submitting Encounters Using WellCare’s SFTP Process (Preferred Method)**
WellCare accepts electronic Encounters submission through EDI as its preferred method of submission. Encounters may be submitted using WellCare's SFTP process. Refer to WellCare’s ANSI ASC X12 837I, 837P and, 837D Health Care Claim / Encounter Institutional, Professional and Dental Guides for detailed instructions on how to submit Encounters electronically using SFTP. For more information on EDI implementation with WellCare, refer to WellCare’s website at [https://newjersey.wellcare.com/provider/claims_updates](https://newjersey.wellcare.com/provider/claims_updates).

Because most clearinghouses can exchange data with one another, Providers should work with their existing clearinghouse, or a WellCare contracted clearinghouse, to establish EDI with WellCare. For a list of WellCare contracted clearinghouse(s), for information on the unique WellCare Payer Identification (Payer ID) numbers used to identify WellCare on electronic claims submissions, or to contact WellCare’s EDI team, refer to the *New Jersey Medicaid Provider Resource Guide*, which may be found on WellCare’s website.

**Submitting Encounters Using Direct Data Entry**
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 [newjersey.wellcare.com/provider](https://newjersey.wellcare.com/provider). For more information on free DDE options, refer to the *New Jersey Medicaid Provider Resource Guide* on WellCare’s website at [https://newjersey.wellcare.com/provider/job_aids](https://newjersey.wellcare.com/provider/job_aids).

**Balance Billing**
Providers shall accept payment from WellCare for Covered Services provided to WellCare Members in accordance with the compensation terms outlined in the Agreement. Payment made to Providers constitutes payment in full by WellCare for Covered Services, 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.

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

Never Events are defined as a surgical or other invasive procedure to treat a medical condition when the practitioner erroneously performs:

- a different procedure altogether;
- the correct procedure but on the wrong body part; or
- the correct procedure on the wrong patient.

Hospital Acquired Conditions are additional non-payable conditions listed on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html?redirect=/HospitalAcqCond/06_Hospital-Acquired_Conditions.

Health care 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.

**Reopening and Revising Determinations**

A reopening request must be made in writing, clearly stating the specific reason for requesting the reopening. It is the responsibility of the Provider to submit the requested documentation within ninety (90) days of the denial to re-open the case.

All decisions to grant reopening are at the sole discretion of WellCare.

**Disputed Claims**

The claims Appeal process is designed to address claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Provider shall have the right to contest the denial of any claim in accordance with N.J.A.C. 11:22-1.6. Claim payment disputes must be submitted to WellCare in writing within ninety (90) calendar days of the date of denial on the Explanation of Payment (EOP).

Documentation must include:

- 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 records).

To initiate the process, please mail to the address, or fax to the fax number, listed in the QRG on WellCare’s website at https://newjersey.wellcare.com/provider/resources.
Corrected Claims or Voided Claims
Corrected and/or voided claims are subject to timely claims submission (i.e., timely filing) guidelines.

To submit a corrected or voided claim electronically:

- For Institutional claims, the Provider must include the original WellCare claim number for the claim adjusting or voiding in the REF*F8 (loop and segment) for any 7 (Replacement for prior claim) or 8 (Void/cancel of prior claim) in the standard 837 layout.
- For Professional claims, the Provider must have the Frequency Code marked appropriately as 7 (Replacement for prior claim) or 8 (Void/cancel of prior claim) in the standard 837 layout.

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

To submit a corrected or voided claim via paper:

- For Institutional claims, 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>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>FED. TAX NO.</td>
<td>STATEMENT COVERS PERIOD FROM TO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1171</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>DOCUMENT CONTROL NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>290370064</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:

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

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

The correction or void process involves two (2) 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 appear on a later EOP than the EOP that is sent out for the newly submitted corrected claim.

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

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

- **Incidental Surgeries/Complications** - A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for extra payment. Any complicated procedure that warrants consideration for extra payment should be identified with an operative report and the appropriate modifier. A determination will be made by a WellCare Medical Director regarding whether the proposed complication merits additional compensation above the usual allowable amount.

- **Admission Examination** - One (1) charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.

- **Follow-up Surgery Charges** - Charges for follow-up surgery visits are considered to be included in the surgical service charge and are not reimbursed separately. Follow-up days included in the global surgical period vary by procedure and are based on Agency policy.

- **Multiple Procedures** - Payment for multiple procedures is based on current CMS or Agency percentages methodologies, as applicable. The percentages apply when eligible multiple surgical procedures are performed under one continuous medical service, or when multiple surgical procedures are performed on the same day and by the same surgeon.

- **Assistant Surgeon** - Payment for an assistant surgeon and/or a non-physician practitioner for assistant surgery is based on current CMS percentages methodologies. WellCare uses the American College of Surgeons (ACS) as the primary source to determine which procedures allow an assistant surgeon. For procedures that the ACS lists as “sometimes”, CMS is used as the secondary source.

- **Co-Surgeon** - Payment for a co-surgeon is based on current CMS percentages methodologies. In these cases, each surgeon should report her or his 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.

**Modifiers**
WellCare follows CMS guidelines regarding modifiers and only reimburses modifiers reimbursed by CMS. Pricing modifier(s) should be placed in the first position(s) of the claim form.

**Allied Health Providers**
WellCare follows the Agency’s reimbursement guidelines regarding Allied Health Professionals. If the Agency does not have such reimbursement guidelines, WellCare will follow CMS reimbursement guidelines for Allied Health Providers.

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

WellCare will proactively identify and attempt to correct inappropriate payments. In situations where the inappropriate payment caused an overpayment, WellCare will adhere to New Jersey Law, L. 2005, c. 352 ([http://www.njleg.state.nj.us/2004/Bills/PL05/352_.HTM](http://www.njleg.state.nj.us/2004/Bills/PL05/352_.HTM)) and limit its notice of retroactive denial to eighteen (18) months from the original payment date. These time frames do not apply to fraudulent or abusive billing for which there is no deadline for WellCare to seek recovery from the Provider. WellCare or its designee will provide a written notice to the Provider identifying the specific claims, 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 forty-five (45) days for the Provider to send in the refund, request further information, Appeal or dispute the retroactive denial.

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

If the Provider independently identifies an overpayment it can either a) send a corrected claim (refer to the corrected claim section of the Manual), b) contact WellCare Customer Service to arrange an off-set against future payments, or c) send a refund and explanation of the overpayment to:
Benefits during Disasters and Catastrophic Events
In the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services – but absent an 1135 waiver by the Secretary – WellCare will:

- Waive in full, requirements for Prior Authorization or pre-notification;
- Temporarily reduce plan-approved out-of-network cost sharing to in-network cost sharing amounts; and/or
- Waive the thirty (30) calendar day notification requirement to Members as long as all the changes (such as reduction of cost sharing and waiving authorization) benefit the Member.

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency timeframe has not been closed thirty (30) calendar days from the initial declaration, and if CMS has not indicated an end date to the disaster or emergency, WellCare should resume normal operations thirty (30) calendar days from the initial declaration.

For institutional claims, the condition code will be DR or modifier CR. For professional claims, the modifier will be CR Code.
Section 6: Credentialing

Overview
Credentialing is the process by which the appropriate WellCare staff evaluates the credentials and training qualifications of practitioners including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities, and other ancillary facilities/health care delivery organizations. For purposes of this Credentialing section, all references to “practitioners” shall include providers 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/health care delivery organizations.

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

Practitioners are required to be credentialed prior to being listed as Participating 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 practitioner’s credentialing application must be attested to by the applicant as being correct and complete. The application captures professional credentials and contains a questionnaire section that asks for information regarding professional liability claims history and suspension or restriction of hospital privileges, criminal history, licensure, Drug Enforcement Administration (DEA) certification, or Medicare/Medicaid sanctions.

Please take note of the following credentialing process highlights:
- Primary source verifications are obtained in accordance with state and federal regulatory agencies, accreditation, and WellCare policy and procedure requirements, and include a query to the National Practitioner Data Bank.
- Physicians, allied health professionals, and ancillary facilities/health care delivery organizations are required to be credentialed in order to be Participating Providers of services to WellCare Members.
- Satisfactory site inspection evaluations are required to be performed in accordance with state and federal accreditation requirements.
- After the credentialing process has been completed, a timely notification of the credentialing decision is forwarded to the Provider.
Credentialing may be done directly by WellCare or by an entity approved by WellCare for delegated credentialing. In the event that credentialing is delegated to an outside agency, the agency shall be required to meet WellCare’s criteria to ensure that the credentialing capabilities of the delegated entity clearly meet federal and state accreditation (as applicable) and WellCare requirements. The delegated entity’s contract may be subject to review and approval by the Agency prior to the entity performing any delegated services.

All Participating Providers or entities delegated for credentialing are to use the same standards as defined in this section and as set forth in the Agreement. 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 are included in WellCare’s credentialing application and re-credentialing application and cover letter.

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

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

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

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

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

**Practitioner’s Right to Correct Erroneous Information and Receive Notification of the Process and Timeframe**

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

WellCare’s written notification to the practitioner includes:

- The nature of the discrepant information;
• The process for correcting the erroneous information submitted by another source;
• The format for submitting corrections;
• The timeframe for submitting the corrections;
• The addressee in Credentialing to whom corrections must be sent;
• WellCare’s documentation process for receiving the correction information from the Provider; and
• WellCare’s review process.

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

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

• **DEA 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 Controlled Dangerous Substance (CDS) or Controlled Substance Registration (CSR) certificate (applicable for MD/DO/DPM/DDS/DMD).

• **Work History** – Practitioners must provide a minimum of five (5) years of relevant work history as a health professional.

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

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

• **Ability to Participate in Medicaid/NJ FamilyCare and Medicare** – Providers must have the ability to participate in Medicaid/NJ FamilyCare and Medicare. Any individual or entity excluded from participation in any government program is not eligible for participation in any WellCare Company plan. 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.

Liability Insurance
WellCare Participating Providers (all disciplines) are required to carry and continue to maintain professional liability insurance in the minimum limits required by the state of New Jersey and as set forth in the Agreement, unless otherwise agreed by WellCare in writing.

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

WellCare will make an exception to our Professional Liability Insurance guidelines for Board Certified physicians who reside in rural areas or if there is a network deficiency. The exception still requires $1 million/$2 million instead of $1 million/$3 million.
Site Inspection Evaluation

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

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

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

Covering Physicians

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

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 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;
- Physical therapist;
- Occupational therapist;
- Audiologist; and
- Speech/language therapist/pathologist.
Ancillary Health Care 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, Medicaid/NJ FamilyCare certification (as applicable), regulatory status, and liability insurance coverage, prior to accepting the applicant as a WellCare Provider.

Re-Credentialing
In accordance with applicable federal and state laws, rules, and regulations, accreditation organizations, and WellCare’s policies and procedures, re-credentialing is required at least once every three (3) years.

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

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

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 currently available information on sanctioned providers. This information is cross-checked against the network of WellCare Providers. If a network Provider is identified as being currently under sanction, appropriate action is taken in accordance with WellCare policy and procedure. If the sanction imposed is revocation of license, the Provider is subject to immediate termination. Notifications of termination are given in accordance with contract and WellCare policies and procedures.

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

Provider Appeal through the Dispute Resolution Peer Review Process
WellCare may immediately suspend, pending investigation, the participation status of a participating Provider who, in the opinion of the Medical Director, is engaging in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of Members. In such instances, the Medical Director investigates on an expedited basis.
WellCare has a Participating Provider dispute resolution peer review panel process in the event WellCare chooses to alter the conditions of participation of a Provider based on issues of quality of care, conduct or service, and if such process is implemented, may result in reporting to regulatory agencies.

The Provider dispute resolution peer review process has two (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 that 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. 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 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, the practitioner’s rights, and the process for obtaining the first and or second level dispute resolution peer review panel, are provided to the practitioner. Notification to the practitioner will be mailed by overnight recorded or certified return-receipt mail.

The practitioner has up to 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. WellCare then notifies the practitioner of the schedule for the review panel hearing.

The practitioner and WellCare are entitled to legal representation at the hearing. The practitioner has the burden of proof 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 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 panel by following the notice information contained in the letter notifying the practitioner of the adverse determination of the first level panel.

Within ten (10) calendar days of the request for a second level panel hearing, the Medical Director or her or his designee shall notify the practitioner of the date, time, and access number for the second level panel hearing.

The second level 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 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 panel result in an adverse determination for the practitioner, the findings of the second level 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 and the terms of the Agreement. Compliance is monitored on a monthly/quarterly basis and formal audits are conducted annually. For further details, please refer to Section 9: Delegated Entities.
Section 7: Complaints, Grievances and Appeals

Overview

WellCare offers a telephone helpline for Providers to call and make informal verbal complaints, ask questions, and get resolution to problems. The toll-free helpline will be available during business hours and the number can be found on the QRG available on WellCare’s Provider website. Helpline staff are trained and educated on how to accept complaints, resolve complex issues, and address standard inquiries related to Member eligibility, claims, and authorization status inquiries.

Actions
Action, at a minimum, means any of the following:

- An adverse determination under a utilization review program;
- Denial of access to specialty and other care;
- Denial of continuation of care;
- Denial of a choice of provider;
- Denial of coverage of routine Member costs in connection with an approved clinical trial;
- Denial of access to needed drugs;
- Imposition of arbitrary limitation on medically necessary services;
- Denial, in whole or in part, of payment for a benefit;
- Denial or limited authorization of a requested service, including the type or level of services;
- Reduction, suspension, or termination of a previously authorized service;
- Failure to provide services in a timely manner; and/or
- Denial of a service based on lack of Medical Necessity.

Complaints and Grievances

Provider Complaints and Grievances
Providers may contact WellCare’s Provider Services Department to initiate informal verbal Complaints, to ask questions, and resolve problems without going through the formal, written Grievance or Appeal process.

Providers have the right to file a formal written Grievance for issues such as dissatisfaction with WellCare’s policies and procedures or a decision made by WellCare that is not related to billing, payments or other administrative disputes.

Formal written grievances must be filed no later than thirty (30) days from the date of the occurrence that caused the Provider’s dissatisfaction. Upon receipt of a Provider’s formal Grievance, WellCare will contact the Provider to acknowledge receipt of the Grievance. Provider grievances will be resolved and a written notification provided within forty-five (45) days of receipt by WellCare.
**Provider Grievance Appeals**

Providers who remain dissatisfied with the resolution of their formal Grievance may initiate a Grievance Appeal. The Appeal of the Grievance must be submitted in writing to:

WellCare Health Plans  
Attention: Grievance Department  
PO Box 31384  
Tampa, FL 33631-3368

All Grievance Appeals shall be reviewed by a review panel. The Provider will have an opportunity to attend the meeting in person, or participate via conference call. Emergent/urgent Grievance Appeals will be resolved within forty-eight (48) hours. All other Appeals will be resolved and a written notification of the resolution of the Appeal will be provided within thirty (30) days of receipt by WellCare and are final.

Providers may not file a Grievance on behalf of a Member without written consent from the Member as the Member’s representative.

The Provider Grievance process is not applicable to any disputes that may arise between WellCare and any Provider regarding the terms, conditions, or termination or any other matter arising under the Agreement between the Provider and WellCare.

**Member Complaints and Grievances**

Members have the right to file Complaints. A Complaint is filed verbally and is generally of a less serious or formal nature than a Grievance described below. A Complaint may be filed by contacting WellCare’s Customer Services Department. Providers shall not discriminate against a Member for filing a Complaint or Grievance. If WellCare is unavailable for any reason or the matter cannot be readily resolved during the initial contact, WellCare will call the Member within twenty-four (24) hours of the initial contact. If WellCare can resolve the Member’s Complaint satisfactorily, the Member can expect a verbal resolution to her or his Complaint within five (5) business days. If WellCare cannot resolve the Complaint via the telephone call that initiated the Complaint, it shall be treated as a Grievance and a letter of acknowledgment will be mailed to the Member within ten (10) business days, of the date the original Complaint was received. If additional information is needed, a letter will be mailed to the Member outlining the additional information required and the reason for the additional information.

A Member or Member’s representative acting on the Member’s behalf may file a Grievance. Examples of Grievances that can be submitted include, but are not limited to:

- Provider service including, but not limited to:
  - Rudeness by Provider or office staff;
  - Refusal to see a 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.

A written description or summary of the Appeals and Grievances policy and procedure is available upon request to any Member, Provider, or facility rendering service. WellCare will not discriminate against a Member or attempt to disenroll a Member for filing a Complaint or Grievance.

A Member or a Member’s representative may file a standard Grievance request either verbally or in writing.

If the Member wishes to use a representative, then she or he 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 https://newjersey.wellcare.com/provider/forms.

**Member Grievance Resolution**
A Member or Member’s representative shall be notified of the decision as expeditiously as the case requires, based on the Member’s health status, but no later than thirty (30) calendar days after the date WellCare receives the verbal or written Grievance, consistent with applicable laws and regulations. WellCare will send a written decision letter upon completion of the Member’s grievance.

The Grievance Department will inform the Member of the determination of the Grievance. All Grievances submitted, either verbally or in writing, will be responded to in writing.

WellCare provides all Members with written information about the Grievance and Complaint procedures/processes available to them. WellCare also provides written information to Members and/or their appointed representative(s) about the Grievance procedure at:
- Initial enrollment;
- Upon involuntary disenrollment initiated by WellCare;
- Upon the denial of a Member’s request for an expedited review of a determination or Appeal;
- Upon the Member’s request; and
- Annually thereafter.

**Medicaid Fair Hearings**
Medicaid/NJ FamilyCare Plan A and some Plan D members have the right to request a fair hearing pursuant to N.J.S.A. 10:74-11.2 and N.J.S.A. 10:49-10 in the event the Member believes her or his Medicaid/NJ FamilyCare benefits have been erroneously terminated, reduced or suspended.

Providers may request a fair hearing on any valid complaint or issue arising out of the Medicaid/NJ FamilyCare claims payment process, exclusive of WellCare’s claims...
processing procedures or issues arising under the Agreement between WellCare and the Provider. A request for a fair hearing must be made within twenty (20) days from the date of the notice of the decision by WellCare or the Agency.

If a Member requests a Fair Hearing and wishes to request a continuation of benefits, he or she must do so in writing within ten (10) days of the date of the denial letter. If the Member requests continuation of benefits under the Medicaid Fair Hearing process and the Appeal is denied, the Member may be required to pay for the cost of these services.

A Member’s or Provider’s written request for a fair hearing should be mailed to:

Department of Human Services  
Division of Medical Assistance and Health Services  
Fair Hearing Section  
PO Box 712  
Trenton, NJ 08625-0712

Provider Claim Resolution/Appeals

Medicaid/NJ FamilyCare Provider on Behalf of Self Appeals Process
A Provider may request a standard reconsideration on his or her own behalf by mailing or faxing a letter of Appeal and/or an Appeal form with supporting documentation, such as medical records, to WellCare. Appeal forms are located on WellCare’s website at https://newjersey.wellcare.com/provider/forms.

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

WellCare has thirty (30) calendar days to review the case for Medical Necessity and conformity to WellCare guidelines.

Cases received without the necessary documentation will be denied for lack of information. It is the responsibility of the Provider to provide the requested documentation within sixty (60) calendar days of the denial to re-open the case. Records and documents received after that timeframe will not be reviewed and the case will remain closed.

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

Reversal of Adverse Provider Claim Determination
Once all of the relevant information is received, WellCare will make a determination within thirty (30) calendar days. If it is determined during the review that the Provider has
complied with WellCare protocols and that the Appealed services were Medically Necessary, the denial will be overturned. The Provider will be notified of this decision in writing.

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

**Affirmation of Adverse Provider Claim Determination**

If it is determined during the review that the Provider did not comply with WellCare protocols and/or Medical Necessity was not established, the denial will be upheld. The Provider will be notified of this decision in writing within thirty (30) calendar days.

For denials based on Medical Necessity, the criteria used to make the decision may be provided in the letter. The Provider may also request a copy of the clinical rationale used in making the Appeal decision by sending a written request to the appeals address listed in the decision letter. The written determination will also include notice to the Provider of the Provider’s right to submit to binding arbitration of the matter that was the subject of the formal claim resolution procedure. The Provider must submit this request within thirty (30) calendar days of the receipt of WellCare’s written determination.

In the event WellCare fails to deliver a written determination to the Provider within thirty (30) calendar days of the initial receipt of the Appeal, such failure on the part of WellCare shall have the effect of a denial by WellCare. The Provider will then have the right to submit the matter to binding arbitration (external review alternative dispute resolution).

**Binding Arbitration - External Review Alternative Dispute Resolution**

Binding arbitration or an external review alternative dispute resolution (ADR) must be conducted in accordance with the rules and regulations of the American Health Lawyers Association, pursuant to the Uniform Arbitration Act as adopted in the State of New Jersey N.J.A.C. 11:22-10.8, unless the Provider and WellCare mutually agree to some other binding resolution process.

The Provider must submit a written request for an ADR review within thirty (30) calendar days of the receipt of the adverse determination letter.

A claim that is finally determined through WellCare’s claim resolution procedure (including ADR) to contain sufficient supporting documentation shall be processed by WellCare within thirty (30) days after the final determination. A claim that is finally determined through WellCare’s claim resolution procedure (including ADR) to lack sufficient supporting documentation shall be processed by WellCare within thirty (30) days after the Provider submits to WellCare the requisite supporting documentation. The Provider shall have thirty (30) days after receipt of written notice of the final determination establishing that the claim lacked sufficient supporting documentation to submit the requisite supporting documentation. If supporting documentation is not received within the established timelines, the denial will be upheld and final.
WellCare will maintain a log of all formally filed Provider claim disputes. The logged information will include a Provider’s name, date of dispute, nature of dispute, and disposition. WellCare will submit annual reports to the Department of Human Services regarding the number and type of Provider disputes.

**Appeals**

**Member Appeals Overview**
WellCare and its providers comply with N.J.A.C. 11:24-3.7, as applicable, when receiving and handling Medicaid/NJ FamilyCare Member Complaints and Appeals. The Appeals process consists of two separate processes. The first process is the administrative review process and the second process is the utilization management Appeals process.

For Member Appeals, the Member, Member’s representative, or a Provider acting on behalf of the Member and with the Member’s consent, may file for an Appeal. Providers do not have Appeal rights through the Member Appeals process. However, Providers have the ability to file a Prior Authorization or claim-related Appeal on her or his own behalf.

The Member, Member’s representative, or a Provider acting on the Member’s behalf, may file for an expedited, standard pre-service or retrospective Appeal determination. The request can come from the Provider or office staff working on behalf of the Provider. A Provider can only request a standard retrospective Appeal on the Provider’s own behalf.

If the Member wishes to use a representative, then she or he must complete an AOR statement. The Member, and the person who will be representing the Member, must sign the AOR statement and return the signed form to WellCare at the address in the QRG available on WellCare’s Provider website. The AOR form is located on WellCare’s website at [https://newjersey.wellcare.com/Provider/forms](https://newjersey.wellcare.com/Provider/forms). Prior to the service(s) being rendered, Providers may Appeal on behalf of the Member if they have the Member’s consent in their records.

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

Examples of actions that can be appealed include, but are not limited to:
- 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; and/or
- The failure to provide services in a timely manner, as defined by the Agency.

**Administrative (Post-Service) Appeal Process**
Administrative Appeals are typically requests for payment for care or services that the Member has already received. Accordingly, a post-service Appeal would never result in the need for an expedited review.
A Member or a Member’s representative may file a post-service Appeal request either orally or in writing within ninety (90) calendar days of the date of the adverse determination. Members are also provided reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing.

**Reversal of Denial of an Administrative (Post-Service) Appeal**

If, upon Appeal, WellCare overturns its adverse determination denying a Member’s request for payment, then WellCare will issue its reconsidered determination and send payment for the service.

WellCare will also pay for Appealed services, in accordance with state policy and regulations, if the services were furnished while the Appeal was pending and the disposition reverses a decision to deny, limit or delay services.

**Affirmation of Denial of an Administrative (Post-Service) Appeal**

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

- Issue a Notice of Adverse Action to the Member and/or appellant; and
- Include in the Notice the specific reason for the Appeal decision in easily understandable language with reference to the benefit provision, guideline, protocol or other similar criteria on which the Appeal decision was based.

**Medical Necessity/Utilization Management Appeals Process**

A Member, or Provider acting on behalf of a Member with the Member’s written consent, may Appeal any utilization management (UM) determination resulting in a denial, termination, or other limitation of Covered Services.

WellCare’s UM Appeals process consists of three (3) progressive stages. The first stage consists of an informal internal review by WellCare (Stage 1 Appeal). This form of Appeal can be initiated by calling WellCare at the phone number listed on the Member’s ID card. If the issue is not resolved at this stage, the next step is a formal internal review by WellCare (Stage 2 Appeal). If the issue is not resolved at this point, the decision can be referred for a formal external review (Stage 3 Appeal) by an Independent Utilization Review Organization (IURO) under the Department of Banking and Insurance and/or through the Medicaid/NJ FamilyCare Fair Hearing process in accordance with N.J.A.C 10:49-10 et seq. Only NJ FamilyCare B, C and D members have the right to request a Stage 3 Appeal.

The Stage 3 Medicaid/NJ FamilyCare Fair Hearing (Fair Hearing) process is available to Medicaid/NJ FamilyCare A Beneficiaries, and NJ FamilyCare D Beneficiaries with a program status code of 380. The Fair Hearing must be requested with the DMAHS and/or DOBI within 20 days of the date of the notice of adverse action.

The Member, or Provider acting on behalf of a Member with the Member’s written consent, also has the right to request an Expedited Appeal in situations where applying the standard procedure could seriously jeopardize the Member’s life, health or ability to regain maximum function.

WellCare ensures that the initial decision-maker(s) are not involved in reconsiderations of previous levels of review. When deciding an Appeal of a denial based on lack of Medical
Necessity, a Grievance regarding the denial of expedited resolution of an Appeal, or a Grievance or Appeal involving clinical issues, the Appeal reviewers will be health care professionals with clinical expertise in treating the Member's condition/disease or will have sought advice from providers with expertise in the field of medicine related to the request.

A written description or summary of the policy and procedure is available upon request to any Member, Provider, or facility rendering service.

WellCare gives Members reasonable assistance in completing forms and other procedural steps for an Appeal including, but not limited to, providing interpreter services and toll-free telephone numbers with TTY/TDD and interpreter capability.

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

WellCare's UM Appeals process requires pertinent medical information that supports the reason for the Appeal. If an Appeal is submitted without valid and/or pertinent medical information, WellCare will assist the Member, or Provider acting on behalf of the Member, by requesting the pertinent medical records or documentation.

All Stage 1 and 2 appeals can be addressed orally or in writing by contacting WellCare at:

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

Pharmacy Appeals:
WellCare Health Plans
Attn: Pharmacy Appeals Department
P.O. Box 31398
Tampa, FL 33631-3398
Fax: 1-888-865-6531

All UM Appeals will be reviewed at the Appeals and Grievance Committee Meeting held weekly and/or as needed. All Pharmacy Appeals will be reviewed at the daily Pharmacy Appeals Committee Meeting. All Appeals and Grievance Committees are chaired by WellCare's Medical Director or his or her physician designee and are comprised of a variety of health care professionals.

Continuation of Benefits
During any stage of the Appeal process, WellCare shall continue the Member's benefits if all of the following is met:

- The Member or the Provider files the Appeal timely;
- The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized Provider (i.e. a network Provider); and
- For those eligible Members who request the Medicaid Fair Hearing Process, continuation of benefits must be requested in writing within 10 days of the date of the denial letter or prior to the intended effective date of WellCare's proposed action, whichever is later.

Informal Internal Utilization Management Appeals (Stage 1)
Any Member, or any Provider acting on behalf of a Member with the Member’s consent, who is dissatisfied with any UM determination of WellCare, including determinations on drug utilization, is allowed the opportunity to speak with the WellCare Medical Director and/or physician designee who rendered the determination within ninety (90) calendar days from the date of the determination. At this time, the Member may informally Appeal the determination. All informal internal (Stage 1) Appeals are reviewed by WellCare’s Medical Director or her or his physician designee and will be concluded within ten (10) calendar days, or within seventy-two (72) hours in the case of urgent or emergent cases.

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<tr>
<th>Responsible Party</th>
<th>Action Step</th>
<th>Timeframe</th>
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<tbody>
<tr>
<td>Any Member (or Provider acting on behalf of a Member with the Member’s consent) who is dissatisfied with any UM determination of WellCare</td>
<td>Appeal the initial determination by speaking with the WellCare Medical Director, and/or physician designee who rendered the determination</td>
<td>Appeal must be submitted within 90 calendar days from the date the Member received the initial adverse utilization management decision. In all cases, the Appeal will be concluded within ten (10) calendar days. In urgent or emergency cases, and for all cases in which the Member is an inpatient, an expedited resolution of Appeal will be concluded within 72 hours.</td>
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**Reversal of Initial Adverse Utilization Management Determination**

If, upon review of the Stage 1 Appeal, WellCare overrules its adverse UM decision denying a Member’s request, then WellCare will issue an authorization for the service request.

In instances where a Member was receiving a Covered Service prior to the determination, WellCare shall continue to provide the same level of service while the determination is in Appeal.

**Affirmation of Initial Adverse Utilization Management Determination**

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

- Issue a Notice of Adverse Action to the Member and/or appellant; and
- Include in the Notice of Adverse Action the specific reason for the Appeal decision in easily understandable language with reference to the benefit provision, guideline, protocol or other similar criteria on which the Appeal decision was based, as well as inform the Member of her or his right to request a formal internal Appeal (Stage 2) and how to do so.

**Formal Internal Utilization Management Appeals (Stage 2)**

If a Member, or a Provider acting on the Member’s behalf, is not satisfied with the Stage 1 UM Appeal determination, the Appeal may be taken to Stage 2 within ninety (90) calendar days of the date of the Stage 1 Appeal decision. At Stage 2, WellCare will have the case...
reviewed by a panel that will include one or more health care provider(s) of the type who
would normally provide services similar to the original provider. All Stage 2 Appeal
determinations will be issued within twenty (20) business days.

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<th>Responsible Party</th>
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<th>Timeframe</th>
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<tr>
<td>Any Member (or Provider acting on behalf of a Member with the Member’s consent) who is dissatisfied with the results of the Stage 1 Appeal</td>
<td>Request a formal internal Appeal following the determination at Stage 1 to be reviewed before a panel of physicians and/or other health care professionals* selected by WellCare, who were not previously involved in the UM determination at issue</td>
<td>Appeal must be submitted within 90 calendar days from the date the Member received the Stage 1 adverse determination. In all cases, the Appeal will be concluded within twenty (20) business days, except in urgent or emergency cases, and for all cases in which the Member is inpatient. An expedited resolution of Appeal will be concluded within seventy-two (72) hours.</td>
</tr>
<tr>
<td>WellCare</td>
<td>Present consultant practitioner(s) to be selected to appeals panel, as follows:</td>
<td>WellCare will send acknowledgment of receipt of the Appeal within ten (10) business days of receipt of the Stage 2 Appeal</td>
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<td>• One or more consultant practitioner(s) trained or practicing in the same specialty who could typically manage the case at issue</td>
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<td>• Other licensed health care professional(s), to be mutually agreed upon by the Member, or Provider, and WellCare</td>
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<tr>
<td>Member or Provider who filed the Appeal</td>
<td>Request or select consultant practitioner(s) from those presented as available by WellCare</td>
<td>Prior to convening of the Stage 2 review panel</td>
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</table>

*Panel will not include any physicians who were previously involved in the specific UM determination at issue.

**Reversal of Stage 2 Appeal Determination**
If, upon review of the formal internal (Stage 2) Appeal, WellCare overrules its Stage 1 Appeal determination, then WellCare will issue an authorization for the service request.
In instances where a Member was receiving a Covered Service prior to the determination, WellCare shall continue to provide the same level of service while the determination is in Appeal.

**Affirmation of Stage 2 Appeal Determination**

If, upon review of the formal internal (Stage 2) Appeal, WellCare affirms its Stage 1 Appeal determination (in whole or in part), it will:

- Issue a Notice of Adverse Action to the Member and/or appellant; and
  - Include in the Notice the specific reason for the Appeal decision in easily understandable language with reference to the benefit provision, guideline, protocol or other similar criteria on which the Appeal decision was based, as well as inform the Member of his or her right to request a Medicaid Fair Hearing.

In the event WellCare fails to comply with any of the deadlines for completion of the internal UM appeals set forth above, in accordance with N.J.A.C. 11:24-8.5 or 8.6, or in the event that WellCare for any reason expressly waives its rights to an internal review of any Appeal, then the Member and/or Provider will be relieved of the obligation to complete WellCare’s internal review process and may, at his or her option, proceed directly to the external appeals process in accordance with N.J.A.C. 11:24-8.7.

**Expedited Medical Necessity Appeal Process (Stage 1 and 2 Appeals Process)**

To request an Expedited Appeal, a Member or a Provider (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 determination will be considered in situations where applying the standard procedure could seriously jeopardize the Member’s life, health, or ability to regain maximum function, including cases in which WellCare makes a less than fully favorable decision to the Member. In light of the short timeframe for deciding Expedited Appeals, a Provider does not need to be an authorized representative to request an Expedited Appeal on behalf of the Member.

Members who orally request an Expedited Appeal are not required to submit a written Appeal request.

**Resolution of an Expedited Appeal**

Upon an Expedited Appeal of an adverse determination, WellCare will complete the Expedited Appeal and give the Member (and the Provider involved, as appropriate) notice of its decision as expeditiously as the Member’s health condition requires, but no later than seventy-two (72) hours after receiving a valid complete request for the Expedited Appeal. WellCare will make reasonable efforts to provide verbal notice to the Member with the Expedited Appeal determination.

In the event the request for an Expedited Appeal is denied, WellCare will provide the Member, Member’s authorized representative, or Provider acting on behalf of the Member with oral notification of the denial. Written Notification will subsequently be mailed to the Member within two (2) calendar days of the oral notification explaining:

a. WellCare will transfer the Appeal to the standard time frame of no longer than ten (10) calendar days for a Level 1 Appeal beginning on the date WellCare received the original request for an Appeal; or
b. WellCare will transfer the Appeal to the standard time frame of no longer than twenty (20) business days for Level 2 appeals beginning on the date WellCare received the original request for an Appeal.

The Member has the right to resubmit a request for an Expedited Appeal. Any such request must include any physician’s support indicating that applying the standard time frame for making a decision could seriously jeopardize the Member’s life, health or ability to regain maximum function. The request will be expedited automatically.

**Medicaid Fair Hearing (Stage 3):**

In addition to the right to file an Appeal with WellCare, the Member, if eligible, has a right to file for a Medicaid Fair Hearing. NJ FamilyCare A members and NJ FamilyCare D members with a program status code of 380 have the right to a Medicaid Fair Hearing (which must be requested within 20 days of the adverse action) with DMAHS and the Appeal process through the DOBI for Medicaid and NJ FamilyCare members.

Individuals eligible solely through NJ FamilyCare B, C and D (except for D individuals with a program status code of 380), do not have the right to a Medicaid Fair Hearing.

A written request for a Medicaid Fair Hearing must be made within 20 days of the date of the denial letter to the following address:

State of New Jersey  
Division of Medical Assistance and Health Services  
Fair Hearing Section  
P.O. Box 712  
Trenton, NJ 08625-0712

The Member must include their name, address, telephone number, and a copy of the denial letter with their request for a Medicaid Fair Hearing.

The Medicaid Fair Hearing and Appeal will be concluded within ninety (90) days.
Section 8: Compliance

WellCare’s 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 Provider sub-contractors and their employees, are required to comply with WellCare compliance program requirements. WellCare’s compliance-related training requirements include, but are not limited to, the following initiatives:

- Corporate Integrity Agreement (CIA) Training
  - Effective April 26, 2011, WellCare’s CIA with the OIG of the United States Department of Health and Human Services (HHS) requires that WellCare maintain and build upon its existing Compliance Program and corresponding training.
  - Under the CIA, the degree to which individuals must be trained depends on their role and function at WellCare.

- HIPAA Privacy and Security Training
  - Summarizes privacy and security requirements in accordance with the federal standards established pursuant to 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 sub-contractors and their employees, to have appropriate policies and procedures to address fraud, waste, and abuse;
    - Process for reporting suspected fraud, waste and abuse;
    - Protections for employees and subcontractors who report suspected fraud, waste and abuse; and
    - Types of fraud, waste and abuse that can occur.

- Cultural Competency Training
  - Develop programs to educate and identify the diverse cultural and linguistic needs of the Members they serve.

- Disaster Recovery and Business Continuity
  - Development of a Business Continuity Plan that includes the documented process of continued operations of the delegated functions in the event of a short term or long term interruption of services.
Providers, including Provider employees and/or Provider sub-contractors, must report to WellCare any suspected fraud, waste or abuse, misconduct or criminal acts by WellCare, or any Provider, including Provider employees and/or Provider sub-contractors, or by WellCare members. Reports may be made anonymously through the WellCare fraud hotline at (866) 678-8355.

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

**Code of Conduct and Business Ethics**

**Overview**

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

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

**Fraud, Waste and Abuse (FWA)**

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

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

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

Participating Providers must be in compliance with all CMS rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicaid managed care organization meet annual compliance and education training requirements with respect to FWA. To meet federal regulation standards specific to fraud, waste and abuse (§ 423.504), Providers and their employees must complete an annual FWA training program.

To report suspected fraud and abuse, please refer to the Quick Reference Guide which may be found on WellCare’s website at https://newjersey.wellcare.com/provider/resources or call our confidential and toll-free WellCare compliance hotline. Details of the corporate ethics and compliance program, and how to contact the WellCare fraud hotline, may be found on WellCare’s website at https://www.wellcare.com/aboutus/compliance.

Confidentiality of Member Information and Release of Records

Medical records should be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules and regulations. All consultations or discussions involving the Member or his or her case should be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the privacy and security rules and regulations of the Health Insurance Portability and Accountability Act of 1996, as may be amended. All Provider practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure there is a procedure or process in place for maintaining confidentiality of members’ medical records and other PHI as defined under HIPAA; and the practice is following those procedures and/or obtaining appropriate authorization from Members to release information or records where required by applicable state and federal law.

Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

Every Provider practice is required to provide Members with information regarding their privacy practices and to the extent required by law, with their Notice of Privacy Practices (NPP). The NPP informs the patient or Member of their Member rights under HIPAA and how the Provider and/or WellCare may use or disclose the members’ PHI. HIPAA regulations require each covered entity to provide a NPP to each new patient or Member. Employees who have access to Member records and other confidential information are required to sign a Confidentiality Statement.

Examples of confidential information include, but are not limited to the following:

- Medical records;
- Communication between a Member and a physician regarding the Member’s medical care and treatment;
- All personal and/or PHI as defined under the federal HIPAA privacy regulations, and/or other state or federal laws;
Medical Records

Member medical records must be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. 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. Medical records must be signed and dated. Complete medical records include, but are not limited to:

- Medical charts;
- Prescription files;
- Hospital records;
- Provider specialist reports;
- Consultant and other health care professionals’ findings;
- Appointment records;
- Other documentation sufficient to disclose the quantity, quality appropriateness and timeliness of services provides under the Contract; and
- A signature by the Provider of service.

Confidentiality of Member information must be maintained at all times. The Member’s medical record is the property of the Provider who generates the record. However, each Member or her or his representative is entitled to one (1) free copy of his or her medical record. Additional copies shall be made available to Members at cost. Medical records shall generally be preserved and maintained for a minimum of five (5) years unless federal requirements mandate a longer retention period (i.e. immunization and tuberculosis records are required to be kept for a person’s lifetime).

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

- Member/patient identification information on each page;
- Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identification of language spoken, and guardianship information;
- Date of data entry and date of encounter;
- Documentation of late entries should include the date and time of the occurrence and the date and time of documentation;

WellCare Health Plans, Inc.
Medicaid/NJ FamilyCare Provider Manual

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- Provider identification by name and profession of the rendering Provider (e.g., MD, DO, OD);
- Allergies and/or adverse reactions to drugs shall be noted in a prominent location;
- Documentation of past medical history, including serious accidents, operations, illnesses;
- Identification of current problems;
- Documentation of the consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering Provider’s initials or other documentation indicating review;
- Current list of immunizations pursuant to 42 CFR 456;
- Identification and history of nicotine, alcohol use or substance abuse;
- Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 42 CFR 456;
- Documentation of follow-up visits provided secondary to reports of emergency room care;
- Hospital discharge summaries;
- Advanced Medical Directives, for adults;
- Documentation that Member has received the Provider’s office policy regarding office practices compliant to HIPAA;
- Documentation regarding permission to share protected health information with specific individuals has been obtained; and
- The record must be legible to at least a peer of the writer and written in Standard English. Any record judged illegible by one reviewer shall be evaluated by another reviewer.

A Member’s medical record shall include the following minimal detail for individual clinical encounters:
- History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the Member’s medical/behavioral health, including mental health, and substance abuse status;
- Unresolved problems, referrals and results from diagnostic tests;
- Plan of treatment including:
  o Medication history, current medications prescribed, including the strength, amount, directions for use and refills;
  o Therapies and other prescribed regimen; and
  o Follow-up plans including consultation and referrals and directions, including time to return; and
- Education and instructions whether verbal, written or via telephone.

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

For more information on how to request this information, members may contact Customer Service using the toll-free telephone number found on the Member’s ID card. Providers
Cultural Competency Program and Plan

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

The objectives of the Cultural Competency program are to:

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

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

The components of WellCare’s Cultural Competency program include:

- **Data Analysis**
  - Analysis of claims and encounter data to identify the health care needs of the population; and
  - Collection of Member data on race, ethnicity and language spoken.

- **Community-Based Support**
  - Outreach to community-based organizations which support minorities and the disabled to ensure that the existing resources for members are being utilized to their full potential.

- **Diversity**
  - Non-Discriminating – WellCare may not discriminate with regard to race, religion or ethnic background when hiring associates;
  - Recruiting – WellCare recruits diverse talented associates in all levels of management; and
  - Multilingual – WellCare recruits bilingual associates for areas that have direct contact with members to meet the needs identified, and encourages
providers to do the same.

- **Diversity of Provider Network**
  - Providers are inventoried for their language abilities and this information is made available in the Provider Directory so that members can choose a Provider that speaks their primary language; and
  - Providers are recruited to ensure a diverse selection of providers to care for the population served.

- **Linguistic Services**
  - Providers will identify Members 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 Customer Service Department;
  - Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency and sign language for the hearing impaired. These services will be provided by vendors with such expertise and are coordinated by WellCare’s Customer Service Department; and
  - Written materials are available for members in large print format, and certain non-English languages, prevalent in WellCare’s service areas.

- **Electronic Media**
  - Telephone system adaptations - Members have access to the TTY/TDD line for hearing impaired services. WellCare’s Customer Service department is responsible for any necessary follow-up calls to the Member. The toll-free TTY/TDD number can be found on the Member identification card.

- **Provider Education**
  - WellCare’s Cultural Competency Program provides a Cultural Competency Checklist to assess the Provider office’s Cultural Competency;
  - For more information on the Cultural Competency Program, registered Provider Portal users may access the Cultural Competency training on WellCare’s website at [https://newjersey.wellcare.com](https://newjersey.wellcare.com). A paper copy, at no charge to you, may be obtained upon request by contacting Provider Services or your Provider Relations representative; and

Providers must adhere to the Cultural Competency program as set forth above.

**Cultural Competency Survey**
The Cultural Competency Survey can be accessed on WellCare’s website at [https://newjersey.wellcare.com/provider/forms](https://newjersey.wellcare.com/provider/forms).
Section 9: Delegated Entities

Overview
WellCare may, by written contract, delegate certain functions under WellCare’s contracts with CMS and/or applicable State governmental agencies. These functions include, but are not limited to, contracts for administration and management services, marketing, utilization management, quality assurance, case management, disease management, claims processing, claims payment, credentialing, network management, Provider claim appeals, customer service, enrollment, disenrollment, billing and sales, adjudicating Medicare organization determinations, and appeals and grievances (the Delegated Services). WellCare may delegate all or a portion of these activities to another entity (a Delegated Entity).

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

Compliance
The Delegation Oversight Department is charged with the administrative oversight authority and coordination of all delegated activities. The Delegation Oversight Committee (DOC) is chaired by the Director of Delegation Oversight. Committee members include QI Directors, contract owners, subject matter experts (SME) legal and compliance associates, and representatives from each line of business. Other areas of representation include Utilization Management, Claims, Customer Service, Billing, Credentialing, Provider Relations, Corporate Compliance, Medicare Compliance, Medicaid Compliance, Regulatory Affairs, Medical Economics, Quality Management and Appeals & Grievance. In addition to the monthly scheduled meetings, the Delegation Oversight Committee may conduct weekly ad hoc online meetings as needed. The DOC is the final approval authority for delegation activity. Recommendations for vendor/entity de-delegation are submitted to the Corporate Compliance Committee for final approval.

The Delegation Oversight department participates in all internal compliance programs as directed by the organization. The department also contributes but is not limited to, external market and accreditation audits such as NCQA and EQRO (External Quality Review Organization).

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

WellCare ensures compliance through the delegation oversight process and the DOC. The DOC and its committee representatives:

- Verify eligibility of all Delegated Entities for participation in the Medicaid and Medicare programs;
- Review findings of the pre-delegation audit to evaluate the Delegated Entity’s ability to perform the delegated function;
- Review and approve entities for delegation of functions;
• Ensure written agreements with each Delegated Entity clearly define and describe the delegated activities, responsibilities, and reporting requirements of all parties;
• Conduct formal, ongoing evaluation of the Delegated Entity’s performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual on-sight audit;
• Impose sanctions if the Delegated Entity’s performance is substandard or terms of the agreement violated;
• Review and initiate recommendations such as termination of delegation, to the Corporate Compliance Committee for unresolved issues of compliance;
• Maintain central database of all pending, active and terminated delegated vendors/entities to monitor and track functions, performance, and audit schedules;
• Identify and implement an escalation process for compliance/performance issues;
• Conduct annual integrity reviews for all delegation auditors;
• Identify and implement a process for validation of audit tools;
• Implement a process for noticing contract owners of corrective action plans;
• Track and trend internal compliance with oversight standards, entity performance, and outcomes;
• Identify and implement an annual training program for internal staff regarding delegation standards, auditing, and monitoring delegated entity/vendor performance; and
• Implement a process for dissemination of regulatory changes to include Medicaid and Medicare lines of business.
Section 10: Behavioral Health

Overview
WellCare provides a behavioral health benefit for dually-eligible members. All provisions contained within the Provider Manual are applicable to medical and behavioral health Providers. Members may refer themselves for behavioral health services and do not require a referral from their PCP. Some behavioral health services may require prior authorization, including those services provided by non-participating providers.

For complete information regarding benefits, exclusions and authorization requirements, or in the event you need to contact the WellCare Provider Service Department for a referral to a behavioral health Provider, refer to the Quick Reference Guide on WellCare’s website at https://newjersey.wellcare.com/provider/resources.

Continuity and Coordination of Care between Medical and Behavioral 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. Behavioral Providers are required to use the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) multi-axial classification when assessing the Member for behavioral health services and document the DSM-V diagnosis and assessment/outcome information in the Member’s medical record.

Behavioral health Providers are encouraged to submit, with the Member’s or the Member’s legal guardian’s consent, an initial and quarterly summary report of the Member’s behavioral health status to the PCP. Communication with the PCP should occur more frequently if clinically indicated. WellCare encourages behavioral health Providers to pay particular attention to communicating with PCPs at the time of discharge from an inpatient hospitalization (WellCare recommends faxing the discharge instruction sheet or a letter summarizing the hospital stay to the PCP). Please send this communication, with the properly signed consent, to the Member’s identified PCP noting any changes in the treatment plan on the day of discharge.

We strongly encourage open communication between PCPs and behavioral health Providers. If a Member’s medical or behavioral condition changes, WellCare expects that both PCPs and behavioral health Providers will communicate those changes to each other, especially if there are any changes in medications that need to be discussed and coordinated between Providers.

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

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

**Providers are required to use the strictest access to care standards applicable to dually-eligible Members.**

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<th>Appointment Type</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Provider – Urgent</td>
<td>&lt; 48 hours</td>
</tr>
<tr>
<td>Behavioral Health Provider – Post-inpatient Discharge</td>
<td>&lt; 7 days</td>
</tr>
<tr>
<td>Behavioral Health Provider – Routine</td>
<td>&lt; 10 days</td>
</tr>
<tr>
<td>Behavioral Health Provider – Non-life threatening emergency</td>
<td>&lt; 6 hours</td>
</tr>
<tr>
<td>Behavioral Health Provider – Screening and Triage of Calls</td>
<td>&lt; 30 seconds</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid Type of Appointment</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Provider – Emergent</td>
<td>Immediately</td>
</tr>
<tr>
<td>Behavioral Health Provider – Urgent</td>
<td>&lt; 48 hours</td>
</tr>
<tr>
<td>Behavioral Health Provider – Post inpatient discharge</td>
<td>&lt; 7 days</td>
</tr>
<tr>
<td>Behavioral Health Provider – Routine</td>
<td>&lt; 10 business days</td>
</tr>
<tr>
<td>Behavioral Health Provider – Non-Life Threatening Emergency</td>
<td>&lt; 6 hours</td>
</tr>
<tr>
<td>Established Appointment – Wait-time</td>
<td>Does not exceed 45 minutes</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 the timeframes listed above.

In the event that a Member misses an appointment, the 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 a toll free behavioral crisis hotline that is staffed twenty-four (24) hours a day. The behavioral crisis phone number is printed on the Member’s card and is available on our website.

For information about WellCare’s Care Management and Disease Management programs, including how to refer a Member for these services, please see Section 4:
Utilization Management (UM), Care Management (CM) and Disease Management (DM). Additional behavioral health resources and information are available on WellCare’s website at http://newjersey.wellcare.com/provider/behavioral_health.
Section 11: Pharmacy

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

- Preferred Drug List (PDL);
- Mandatory Generic Policy;
- Step Therapy (ST);
- Quantity Limit (QL);
- Age Limit (AL):
- Coverage Determination Review Process;
- Pharmacy Lock-In Program;
- Network Improvement Program (NIP); and
- Exactus Pharmacy Solutions.

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

- Follow national standards of care guidelines for treating conditions, i.e., National Institutes of Health (NIH) Asthma guideline, Joint National Committee (JNC) VII 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 QRG available on WellCare’s Provider website.

Preferred Drug List
WellCare’s PDL is a published prescribing reference and clinical guide of prescription drug products selected by WellCare’s Pharmacy 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 drugs based on the drug’s efficacy, safety, side effects, pharmacokinetics, clinical literature and cost effectiveness profile. The medications on the PDL are organized by therapeutic class, product name, strength, form, and coverage details (quantity limit, age limitation, prior authorization, and step therapy).

You may obtain a copy of the PDL on WellCare’s website at https://newjersey.wellcare.com/provider/pharmacy. Changes to the PDL and applicable pharmaceutical management procedures are communicated to providers as the following:

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

Additions to the Preferred Drug List
You may request consideration for the 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 on WellCare’s website at https://newjersey.wellcare.com/provider/resources.

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

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

Generic drugs must be dispensed by the pharmacist when 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 the Coverage Determination Review Process below.

Step Therapy
The P&T Committee has developed step therapy 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 a safe and effective method of reducing the cost of treatment by ensuring that an adequate trial of a proven, safe and cost-effective therapy is attempted before progressing to a more costly option. First-line drugs are recognized as safe, effective, and economically sound treatments. The first-line drugs on our PDL have been evaluated through the use of clinical literature and are approved by our P&T Committee. Please refer to the PDL to view drugs requiring step therapy.

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

Age Limits
Some drugs have an age limit associated with them. WellCare utilizes age limits to help ensure proper medication utilization when necessary. Please refer to the PDL to view drugs with age limits.

**Over-the-Counter 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 / multivitamins with iron;
- Iron;
- Non-sedation antihistamines;
- Enteric coated aspirin;
- Diphenhydramine;
- Insulin & insulin syringes;
- Topical antifungals;
- Ibuprofen;
- Permethrin;
- Meclizine;
- Urine test strips; and
- H-2 receptor antagonists

For a complete listing of covered OTC medications, please refer to the PDL on our website at https://newjersey.wellcare.com/provider/pharmacy.

**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 Request Review using the Injectable Infusion Form.

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

**Coverage Limitations**
WellCare covers all drug categories currently available through the Medicaid/NJ FamilyCare fee-for-service program. The following is a list of non-covered (i.e., excluded from the Medicaid/NJ FamilyCare 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;
- Drugs for the treatment of erectile dysfunction;
- DESI drugs or drugs that may have been determined to be identical, similar or related;
- Investigational or experimental drugs; and
• Agents prescribed for any indication that is not medically accepted.

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

**Pharmacy Lock-In Program**
Members identified as over-utilizing drugs in certain therapeutic classes, receiving duplicative therapy from multiple Providers, or frequently visiting the Emergency Room seeking pain medication will 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 Provider and one (1) pharmacy to obtain their medications. Claims submitted by other Providers or other pharmacies will not be paid for the Member. Members identified will also be referred to Case Management.

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

**Coverage Determination Review Process (Requesting Exceptions to the PDL)**
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. Prior Authorization 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 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 [https://newjersey.wellcare.com/provider/forms](https://newjersey.wellcare.com/provider/forms).

To submit a request orally, refer to the contact information listed on the *Quick Reference Guide* on WellCare’s website at [https://newjersey.wellcare.com/provider/resources](https://newjersey.wellcare.com/provider/resources).

Upon receipt of the *Coverage Determination Request Form*, a decision is completed within twenty-four (24) hours. If Prior Authorization for a medication claim is required, the pharmacist will be automatically instructed to call WellCare to get a seventy-two (72) hour emergency supply of the medication for the Member.

Prior Authorization protocols are developed and reviewed at least annually by the P&T Committee. These protocols indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s),...
allergic reaction to preferred product, etc.). The criteria are available upon request when submitted to the Pharmacy department by the Member or Provider.

**Medication Appeals**
To request an Appeal of a Prior Authorization decision, contact the Pharmacy Appeals department via fax, mail, in person or phone. Refer to the *Quick Reference Guide* on WellCare’s website at https://newjersey.wellcare.com/provider/resources.

Once the Appeal of the Prior Authorization request decision has been properly submitted and obtained by WellCare, the request will follow the Appeals process described in *Section 7: Appeals and Grievances.*

**Pharmacy Management - Network Improvement Program**
The Pharmacy Network Improvement Program (NIP) is designed to provide Providers with quarterly utilization reports to identify over-utilization and under-utilization of pharmaceutical products. The reports will also identify opportunities for optimizing best practices guidelines and cost-effective therapeutic options. These reports are delivered by the State Pharmacy Director and/or Clinical Pharmacy Manager to Providers identified for the program.

**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 are experts in the special handling, storage and administration of drugs that injectables, infusibles, orals and other medications require. This team knows the insurance process and the Member’s plan benefits. This means less chance of delays in a Member receiving 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 the Exactus Pharmacy Solutions website at https://www.wellcare.com/provider/ExactusPharmacySolutions.
Section 12: Definitions

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

“Agency” means one or more of the following, when applicable: the New Jersey Department of Human Services, the New Jersey Department of Health and Senior Services; or the Division within the Department of Human Services responsible for administering the Medicaid/NJ FamilyCare Program.

“Agreement” means the Participating Provider Agreement by and between Providers and WellCare.

“Appeal” means a request for review of some action taken by or on behalf of WellCare.

“Authorization” means an approval of a prior authorization request for payment of services, and is provided only after WellCare agrees the treatment is necessary.

“Benefit Plan” means a health benefit policy or other health benefit contract or coverage document (a) issued by WellCare or (b) administered by WellCare pursuant to a government contract with a governmental authority. Benefit Plans and their designs are subject to change periodically.

“Beneficiary” means any person eligible to receive Covered Services in the Medicaid/NJ FamilyCare program.

"Care Management" means a set of Member-centered, goal-oriented, and culturally relevant steps to assure that a Member receives needed health care services.

“Care Manager” is the WellCare facilitator who provides communication and collaboration among the Interdisciplinary Care Team (ICT), a team which is comprised of individuals and Providers who have an impact on the health and well-being of a Member who is participating in WellCare’s Care Management Program. The ICT team is comprised of the Member, Care Manager, PCP, and other caregivers, specialists, and home care Providers. The role of the Care Manager is to provide communication and collaboration among the health care team for optimal coordination of care, and goal attainment. As the facilitator, the Care Manager will:

“Care Management Program” emphasizes prevention, health promotion, continuity of care and coordination of care, as necessary across Providers and settings to achieve the least restrictive and most integrated setting of care.

“Carve Out Agreement” means an agreement between WellCare and a third party Participating Provider whereby the third party assumes financial responsibility for or may provide certain management services related to particular Covered Services. Examples of possible Carve Out Agreements include agreements for behavioral health, radiology, laboratory, dental, vision, or hearing services.
“Centers for Medicare and Medicaid Services (CMS)” means that United States federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program.

“Clean Claim” means (a) the claim is for a service or supply covered by WellCare under the Medicaid/NJ FamilyCare Program; (b) the claim is submitted with all the information requested by WellCare on the claim form or in other instructions distributed to the Contracted Provider or Medicaid/NJ FamilyCare beneficiary; (c) the person to whom the service or supply was provided was covered by WellCare on the date of service; (d) WellCare does not reasonably believe that the claim has been submitted fraudulently; and (e) the claim does not require special treatment. Special treatment means that unusual claim processing is required to determine whether a service or supply is covered, such as claims involving experimental treatments or newly approved medications. The circumstances requiring special treatment should be documented in the claim file.

“Complaint” means an informal expression of dissatisfaction about any matter or a complaint that is submitted in writing, or that is orally communicated and is resolved within five (5) business days of receipt.

Comprehensive Needs Assessment ("CNA") is an assessment conducted by the Care Manager that identifies Member needs and barriers to care;

“Co-payment” means the part of the cost-sharing requirement for which a fixed monetary amount is paid for certain services/items received from WellCare’s participating providers


“Covered Services or Benefits Package” means the health care services for which WellCare has agreed to provide, arrange, and be held fiscally responsible.

“Clinical Practice Guidelines” ("CPG") are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.

"Critical Incidents" includes, but is not limited to, the following incidents when they occur in Nursing Facility/Skilled Care Nursing Facilities or home and community-based long-term care service delivery settings, including: community alternative residential settings, adult day care centers, other HCBS provider sites, and a Member’s home:

- Unexpected death of a Member;
- Missing person and/or unable to contact;
- Suspected or evidenced physical or mental abuse (including seclusion and restraints, both physical and chemical);
- Theft with law enforcement involvement;
- Law enforcement contact;
- Severe injury or fall resulting in the need for medical treatment;
- Medical or psychiatric emergency, including suicide attempt;
- Medication error;
• Inappropriate or unprofessional conduct by a Provider involving the Member;
• Sexual abuse and/or suspected sexual abuse; and
• Abuse and neglect, including self-neglect, and/or suspected abuse and neglect.

“Children with Special Health Care Needs” (“CHSCN”) are Members that are children with chronic conditions or complex health risks that impact their daily function in society due to challenges with physical, mental, or environmental challenges.

“Delegated Entity” is an entity that has been delegated certain functions under WellCare’s contracts with the Centers for Medicare & Medicaid Services and/or applicable State governmental agencies. These functions include, but are not limited to, contracts for administration and management services, marketing, utilization management, quality assurance, case management, disease management, claims processing, claims payment, credentialing, network management, Provider claim appeals, customer service, enrollment, disenrollment, billing and sales, adjudicating Medicare organization determinations, and appeals and grievances.

“Delegated Services” are certain health care plan functions under WellCare’s contracts with the Centers for Medicare & Medicaid Services and/or applicable State governmental agencies that are performed by another entity other than WellCare.

“Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity, (including severe pain) such that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in 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 to bodily functions; or serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where there is inadequate time to effect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.

“Emergency Services” means covered inpatient and outpatient services furnished by any qualified Provider that are necessary to evaluate or stabilize an emergency medical or dental condition.

“Encounter” is the basic unit of service used in accumulating utilization data and/or a face-to-face contact between a Member and a Provider resulting in a service to the Member.

“Encounter Data” means Encounter information, data and reports for Covered Services provided to a Member that meets the requirements for Clean Claims, regardless of whether a Provider is reimbursed on a capitated or fee for service basis.

“Expedited Appeal” is a request to expedite an Appeal of a determination will be considered in situations where applying the standard procedure could seriously jeopardize the Member’s life, health, or ability to regain maximum function, including
cases in which WellCare makes a less than fully favorable decision to the Member. Expedited Appeal decisions are made no later than 72 hours after the Expedited Appeal request.

“New Jersey’s Early and Periodic Screening, Diagnosis, and Treatment Program” ("EPSDT") is a comprehensive preventive health care program designed to improve the overall health of Medicaid/NJ FamilyCare eligible infants, children, and adolescents.

“Excluded services” are services that Members may obtain under the Medicaid/NJ FamilyCare plan for which WellCare is not financially responsible. Excluded Services may be paid for by the Agency on a fee-for-service basis or other basis.

“Formulary” means a list of covered drugs selected by WellCare in consultation with a team of health care providers on the Pharmacy and Therapeutics (P&T) Committee, which represents the prescription therapies believed to be a necessary part of a quality treatment program.

“Grievance” means an expression of dissatisfaction about any matter or a complaint that is submitted in writing or that is orally communicated and could not be resolved within five (5) business days of receipt.

“Home and Community-Based Services” ("HCBS") are services above state plan limits that are provided as an alternative to long-term institutional services in a nursing facility. HCBS includes personal care assistance and medical day care when they are above the limits established under New Jersey’s Title XIX State Plan. HCBS are provided to Members who meet MLTSS eligibility requirements and reside in the community or in certain community alternative residential settings.

“Healthcare Effectiveness Data and Information Set” ("HEDIS®") is a tool used by 90% of health plans to measure performance on important dimensions of care and service. The 2014 tool is comprised of eighty-one (81) measures across five (5) domains of care, including:

- Effectiveness of care;
- Access and availability of care;
- Experience of care;
- Utilization and relative resource use; and
- Health plan descriptive information.

“Individuals with Special Health Care Needs” ("ISHCN") means Members who face daily physical, mental or environmental challenges that place their health at risk and whose ability to fully function in society is limited.

“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

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WellCare Health Plans, Inc.
Medicaid/NJ FamilyCare Provider Manual

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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.

“Interdisciplinary Care Team” is the Care Management Program team is comprised of the Member, Care Manager, PCP, and other caregivers, specialists, and home care Providers.


“Medical Necessity” or “Medically Necessary” means a health care item or service that a health care provider, exercising her or his prudent clinical judgment, would provide to a Member for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance with the evaluating, diagnosing or treating of an illness, injury, disease or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Member’s illness, injury or disease; not primarily for the convenience of the Member or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Member’s illness, injury or disease.

“Member” means an enrolled participant in the WellCare’s Medicaid/NJ FamilyCare plan; also means enrollee.

“Member Expenses” means copayments, coinsurance, deductibles or other cost share amounts, if any, that a Member is required to pay for Covered Services under a Benefit Plan.

“Members with Special Health Care Needs” means members who face daily physical, mental or environmental challenges that place their health at risk and whose ability to fully function in society is limited.

“New Encounter” means an Encounter that has never been submitted to WellCare.

“Overlaid Encounter” means an Encounter that is updated or corrected within the WellCare system.

“Provider Portal Provider Identification Number” (“PIN”) is the number which Providers utilize to access the secure WellCare Provider Portal.

“Primary Care” means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, 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 (MD) or doctor of osteopathy (DO) 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, including periodic examinations, preventive health care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and initiation of referrals to specialty providers described in this contract and the Benefits Package, and for maintaining continuity of patient care. A PCP shall include general/family practitioners, pediatricians, internists, and may include specialist physicians, physician assistants, CNMs or CNPs/CNSs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with these contract provisions and licensure requirements.

“Prior Authorization or Coverage Determination Review” means an authorization granted in advance of the rendering of a service after appropriate medical/dental review.

“Provider” or “Participating Provider” means any physician, hospital, facility, or other health care professional who is licensed or otherwise authorized to provide health care services in the state or jurisdiction in which they are furnished, and who is contracted with WellCare as a Participating Provider.

“Quality Improvement Program” (“QI Program”) is the WellCare program designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral health care services, including MLTSS services. Strategies are identified and activities are implemented in response to findings. The QI Program addresses the quality of clinical care and non-clinical aspects of service with a focus on key areas.

“Qualified Individual with a Disability” means an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity (42 U.S.C. § 12131).

“Quick Reference Guide” (“QRG”) is the Quick Reference Guide available on WellCare’s website at newjersey.wellcare.com/provider/resources. QRGs contain important addresses, phone and fax numbers, and authorization requirements.

“Reopening” means a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.

“Replaced Encounter” means an Encounter that is updated or corrected within the WellCare system.
“Retrospective Review” is any review of care or services that have already been provided.

“Urgent Care” means treatment of a condition that is potentially harmful to a patient’s health and for which his or her physician determined it is medically necessary for the patient to receive medical treatment within twenty-four (24) hours to prevent deterioration.

“Utilization” means the rate patterns of service usage or types of service occurring within a specified time.

“Voided Encounter” means an encounter that WellCare deletes from the encounter file and is not submitted to the state.

“WellCare” means WellCare Health Plans of New Jersey, Inc.

“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.
Section 13: Resources

Forms and Documents
https://newjersey.wellcare.com/provider/forms

Quick Reference Guides
https://newjersey.wellcare.com/provider/resources

Clinical Practice Guidelines
https://www.wellcare.com/provider/CPGs

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

WellCare Companion Guides
https://newjersey.wellcare.com/provider/claims_updates

Provider Training
https://newjersey.wellcare.com/training/training_courses

Job Aids and Resource Guides
https://newjersey.wellcare.com/provider/job_aids
Addendum A: Managed Long Term Care (MLTSS) Overview

This Addendum contains information specifically related to the Managed Long Term Supports and Services (MLTSS) for eligible Members. The requirements listed in this section are a supplement to the WellCare Medicaid / NJ FamilyCare Managed Care plan requirements contained in Sections 1-13 in this manual.

Please refer to Section 1 for additional information on WellCare, including but not limited to Quick Reference Guide, Provider Services and Website Resources.

Benefits

Short Term Nursing Stays
Short term nursing facility stays are available for MLTSS Members receiving HCBS who require temporary placement in a nursing facility due to temporary illness, serious injury, wound care, or the absence of the primary caregiver and there is a reasonable expectation that the member will be discharged back to the community within 180 days.

The community maintenance needs allowance shall continue to apply during the provision of short-term nursing facility care in order to allow sufficient resources for the Member to maintain his or her community residence for transition back to the community.

If, prior to the end of the 180 day period (post admission date) it is determined that the Member will not be discharged from the nursing facility, the Member shall be determined as custodial. The Member is automatically converted to custodial status in the nursing facility if the Member is in the nursing facility beyond 180 days.

Provider and Member Administrative Guidelines

Provider and Administrative Guidelines
Please refer to Section 2 for additional information on WellCare’s Provider and Member Administrative Guidelines including but not limited to Prohibited Services, Responsibilities of all Providers, Members with Special Health Care Needs, Access Standards and Specialty Care Providers.

Training
Ongoing training is required for all Providers working with MLTSS patients and includes topics such as integrating and coordinating services for Members receiving MLTSS benefits, eligibility of Members, covered services and identifying abuse, neglect and exploitation.
Unable to Contact

Unable to Contact is when a MLTSS Member is absent, without notification, from any program or service offered under MLTSS where WellCare, or its contracted MLTSS Providers including staff members and care managers, are unable to identify the location of the Member using the contact information available in the Member’s record.

WellCare MLTSS Providers are required to investigate and report all unable to contact events by:

1. Immediately outreach to the Member/client using the contact information on file;
2. If no response, immediately outreach to the emergency contact(s) for the Member; and
3. If still unsuccessful, immediately notify the Member’s MLTSS care manager.

The Care Manager, after receiving notification of the unable to contact event from a MLTSS Provider, will also attempt contact with the Member including conducting a home visit on the same day of the notification to determine the safety of the Member. If attempts to contact the Member remain unsuccessful, WellCare will file a Critical Incident Report through the designated State system.

If the Member cannot be contacted after twenty-four (24) hours, local law enforcement may be notified.

All attempts to contact will be documented by WellCare including method of outreach, time and outcome.

Quality Improvement

Quality Improvement

Please refer to Section 3 for additional information on WellCare’s Quality Improvement including but not limited to Provider Participation in the Quality Improvement Program, Member Satisfaction and Web Resources.

Overview

WellCare’s Quality Improvement Program (QI Program) is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical and behavioral health care and MLTSS services. Strategies are identified and activities are implemented in response to findings. 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 health care settings/services;
- Cultural competency;
- Quality of care/service;
- Preventative health;
- Service utilization;
• Complaints/grievances;
• Network adequacy;
• Appropriate service utilization;
• Disease and Case Management;
• Member and Provider satisfaction;
• MLTSS
• Components of operational service; and
• Regulatory/federal/state/accreditation requirements.

The QI Program activities include monitoring clinical indicators or outcomes, appropriateness of care, quality studies, HEDIS® measures, and/or medical record audits. The organization’s Board of Directors has delegated authority to the Quality Improvement Committee to approve specific QI activities, (including monitoring and evaluating outcomes, overall effectiveness of the QI Program, and initiating corrective action plans when appropriate) when the results are less than desired or when areas needing improvement are identified.

**Medical Records**

Medical records should be comprehensive and reflect all aspects of care for each Member. Records are to be maintained in a secured, timely, legible, current, detailed and organized manner which conforms to good professional medical practice. Records should be maintained in a manner that permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Complete medical records include, but are not limited to: medical charts, prescription files, hospital records, Provider specialist reports, consultant and other health care professionals’ findings, appointment records, MLTSS services and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of service provided. Medical records must be signed and dated.

Confidentiality of Member information must be maintained at all times. Records are to be stored securely with access granted only to authorized personnel. 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 health care 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 records to WellCare upon request at no cost to WellCare. Information from the medical record review may be used in the re-credentialing process as well as quality activities.

For more information on medical records compliance, including but not limited to, confidentiality of Member information and release of records, refer to Section 8: Compliance in this Manual.

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

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

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

- Regular checkups;
- Immunizations; and
- Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, sexually transmitted diseases, pap smears, and mammograms.

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

**Critical Incidents**
WellCare will require its staff members and contracted MLTSS Providers to report, respond to, and document Critical Incidents as specified by WellCare in accordance with applicable requirements.

Critical Incidents will include but not be limited to the following incidents when they occur in Nursing Facility/Skilled Care Nursing Facilities or home and community-based long-term care service delivery settings, including: community alternative residential settings, adult day care centers, other HCBS provider sites, and a Member’s home:

- Unexpected death of a Member;
- Missing person and/or unable to contact;
- Suspected or evidenced physical or mental abuse (including seclusion and restraints, both physical and chemical);
- Theft with law enforcement involvement;
- Law enforcement contact;
- Severe injury or fall resulting in the need for medical treatment;
- Medical or psychiatric emergency, including suicide attempt;
- Medication error;
- Inappropriate or unprofessional conduct by a Provider involving the Member;
- Sexual abuse and/or suspected sexual abuse; and
- Abuse and neglect, including self-neglect, and/or suspected abuse
and neglect.

MLTSS Providers must report a Critical Incident to WellCare within 24 hours of becoming aware of the incident. The report may be submitted verbally, but a follow-up report must be submitted in writing within forty-eight (48) hours.

Following the occurrence of a Critical Incident, MLTSS Providers must immediately (which shall not exceed twenty-four hours) take steps to prevent further harm to any and all Members and respond to any emergency needs of Members. MLTSS Providers who become aware of a Critical Incident will conduct an internal Critical Incident investigation and submit a report on the investigation within the timeframe specified by WellCare. The timeframe for submitting the report will be as soon as possible, may be based on the severity of the incident, and, except under extenuating circumstances, will be no more than thirty (30) calendar days after the date of the incident.

WellCare shall review the Provider’s report and follow-up with the Provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes.

Additionally, in accordance with State requirements, MLTSS Providers shall:
- develop and implement a Critical Incident reporting process, including the form provided by WellCare, to be used to report Critical Incidents and reporting timeframes;
- immediately report suspected abuse, neglect, and exploitation of Members;
- cooperate, and require its staff to cooperate, with any investigation conducted by the WellCare, its designee or outside agencies, including law enforcement; and
- provide appropriate training for its staff and take corrective action as needed to ensure compliance with Critical Incident requirements.

WellCare will identify and track Critical Incidents and will review and analyze Critical Incidents to identify and address potential and actual quality of care and/or health and safety issues.

**Clinical Practice Guidelines**
WellCare adopts validated evidence-based Clinical Practice Guidelines (CPGs) and utilizes the guidelines as a clinical decision support tool. While clinical judgment by a treating Provider may supersede CPGs, the guidelines provide clinical staff and Providers with information about medical standards of care to assist in applying evidence from research in the care of both individual Members and populations, including MLTSS Members. The CPGs are based on peer-reviewed medical evidence and are relevant to the population served, including MLTSS Members. Approval of the CPGs occurs through the Quality Improvement Committee. Clinical Practice Guidelines, to include Preventative Health Guidelines, may be found on WellCare’s website at [https://www.wellcare.com/provider/CPGs](https://www.wellcare.com/provider/CPGs).
HEDIS®
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 2014 tool is comprised of eighty-one (81) measures across five (5) domains of care, including:

- Effectiveness of care;
- Access and availability of care;
- Experience of care;
- Utilization and Relative Resource Use; and
- Health Plan Descriptive Information.

HEDIS® is a mandatory process that occurs annually. It is an opportunity for WellCare and Providers to demonstrate the quality and consistency of care that is available to all members, including MLTSS Members. Medical records and claims data are reviewed to ensure the required data are captured. 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.

Utilization Management (UM), Care Management (CM), Disease Management

Utilization Management, Care Management, Disease Management
Please refer to Section 4: UM, CM, DM for additional information on WellCare’s Utilization, Care and Disease Management programs, including but not limited to Medical Necessary Services, Referrals, Prior Authorization, Transition of Care and Candidates for Disease Management.

For additional information, refer to the Quick Reference Guide on WellCare’s website at https://newjersey.wellcare.com/provider/resources.

Critical Incident Reporting for MLTSS Providers
WellCare will require full adherence to the mandatory training and reporting requirements set forth by the State of New Jersey and those applicable to Adult Protective Services, Office of Institutionalized Elderly, Department of Health, the Department of Children and Families and the Division of Disability Services.

WellCare will require that all contracted MLTSS Providers report Critical Incidents to WellCare in accordance with applicable requirements as a result of key trigger events. The trigger events follow the State’s definitions of Critical Incidents, and include but are not limited to:

- Unexpected death of a Member;
- Missing person or unable to contact;
- Suspected or evidenced physical or mental abuse (including seclusion and restraints, both physical and chemical);
• Theft with law enforcement involvement;
• Law enforcement contact;
• Severe injury or fall resulting in the need for medical treatment;
• Medical or psychiatric emergency, including suicide attempt;
• Medication error;
• Inappropriate or unprofessional conduct by a Provider involving the Member;
• Sexual abuse and/or suspected sexual abuse; and
• Abuse and neglect, including self-neglect, and/or suspected abuse and neglect.

Once the Provider has ensured that the Member is in no immediate harm, documentation of the event and Critical Incident reporting is necessary. The Provider will have access to report the Critical Incident (CI) on a 24 hour basis by calling the MLTSS Care Management toll free line. The maximum timeframe for reporting a Critical Incident to WellCare is twenty-four (24) hours. The initial report within twenty-four (24) hours may be submitted verbally, in which case the person/agency/entity making the initial report shall submit a follow-up written report within forty-eight (48) hours.

MLTSS providers with a Critical Incident occurring under their scope of service are required to conduct an internal Critical Incident investigation and submit a report on the investigation no later than forty-eight (48) hours, unless approved for extension due to extenuating circumstances. WellCare will review the Provider’s report and follow-up as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes. It is the expectation that contracted MLTSS providers will cooperate with any investigation conducted by WellCare, its designee or outside agencies, including law enforcement.

**Care Management Program**
For MLTSS Members, the Care Manager will assume primary responsibility for coordination of the Member’s physical health, behavioral health and long term care needs. To facilitate the care planning process, the Care Manager will conduct face to face visits, and determine the Member’s interest in transitioning to the community or other alternative living setting as appropriate.

**POC Development**
A MLTSS Provider may be contacted by the Care Manager for Plan of Care (POC) Development.

**Claims**

**Claims**
Please refer to *Section 5* for additional information on WellCare’s Provider claims information and process, including but not limited to timely claims submission, preauthorization number, claim processing, disputed claims and reimbursement.
**Prompt Payment**
For MLTSS Providers, WellCare will pay Clean Claims within fifteen (15) calendar days after receipt when submitted electronically, or thirty (30) calendar days after receipt when submitted by paper. Note that a Provider’s submission of a Clean Claim to WellCare’s billing agent or clearinghouse does not constitute receipt by WellCare.

If WellCare is late in paying a Clean Claim, WellCare is required to pay simple interest on that Clean Claim at twelve percent (12%) per annum, with such interest calculated from the date that the Clean Claim should have been paid. Any such interest owed will be included with the claim payment.

**Credentialing**

**Credentialing**
Please refer to Section 6 for additional information on WellCare’s Credentialing, including but not limited to Practitioner Rights, Covering Physicians, Ancillary Health Care Delivery Organizations and Delegated Entities.

**Complaints, Grievances and Appeals**

**Complaints, Grievances and Appeals**
Please refer to Section 7 for additional information on WellCare’s Complaints, Grievances and Appeals, including but not limited to actions, Provider Complaints, Member Complaints, Provider claim resolution and Appeals.

**Compliance**

**Compliance**
Please refer to Section 8 for additional information on WellCare’s Compliance Program, including but not limited to Code of Conduct and Business Ethics, Fraud, Waste, and Abuse, and confidentiality of Member information.

**Delegated Entities**

**Delegated Entities**
Please refer to Section 9 for additional information on WellCare’s Delegated Entities, including but not limited to Compliance.

**Behavioral Health**

**Behavioral Health**
Please refer to Section 10 for additional information on Behavioral Health including but not limited to responsibilities of Behavioral Health Providers.

WellCare will assist and triage MLTSS Members who may be in a behavioral health crisis including the ability to immediately access a qualified behavioral health clinician to assist the Member.

Pharmacy

Pharmacy

Please refer to Section 11 for additional information on Pharmacy, including but not limited to Preferred Drug List, Quantity and Age Limits, Coverage Limitations and Medication Appeals.