



IA Health Link and Hawki

Provider Manual

833-731-2143 | <https://provider.wellpoint.com/ia/>



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CHAPTER 1: INTRODUCTION

Introduction

Welcome

Welcome to the Wellpoint network provider family! We are pleased you have joined our Iowa network, which consists of some of the finest healthcare providers in the state. Wellpoint has been selected by the Iowa Department of Health and Human Services to provide healthcare services for Wellpoint members enrolled in the IA Health Link or Hawki programs.

IA Health Link covers all Medicaid mandatory eligibility groups, as well as various optional categorically needy and medically needy groups, including children, pregnant women, the aged and individuals with disabilities. The Healthy and Well Kids in Iowa (Hawki) program covers children 0 to 19 years of age who meet the income guidelines. Wellpoint represents a growing network of healthcare providers who make it easier for our members to receive quality care. There is strength in numbers: our health services programs, combined with those already available in our target service areas, are designed to supplement providers' treatment plans. Our programs serve to help improve our members' overall health by informing, educating, and encouraging self-care in the prevention, early detection and treatment of existing conditions and chronic disease.

We believe hospitals, physicians and other providers play a pivotal role in managed care. We can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high-quality provider network. Together, we can arrange for and provide an integrated system of coordinated, efficient and quality care for our members and your patients. All network providers are contracted with Wellpoint through a Participating Provider Agreement.

Introduction

About This Manual

This provider manual is designed for contracted Wellpoint providers, hospitals, and ancillary providers. Our goal is to create a useful reference guide for you and your office staff.

We want to help you navigate our managed healthcare plan to deliver quality healthcare to our members. Our goal is to aid you in finding the most reliable, responsible, timely and cost-effective way to deliver quality healthcare. Select any topic in the Table of Contents to view that chapter. Click on any web address to be redirected to that site. Each chapter may also contain cross-links to other chapters, to the Wellpoint website or to external websites containing additional information.

We recognize that managing our members' health can be a complex undertaking, requiring familiarity with the rules and regulations of a complex healthcare system. This system encompasses a wide array of services and responsibilities; for example, initial health assessments (IHAs), integrated case management, proper storage of medical records, and billing for emergencies. With this complexity in mind, we divided this manual into sections that reflect your questions, concerns, and responsibilities before and after an Wellpoint member walks through your doors. The sections are organized as follows:

- Legal Requirements
- Contact Information
- Before Rendering Services
- After Rendering Services
- Operational Standards, Requirements and Guidelines
- Additional Resources

Legal Requirements

The information contained in this manual is proprietary, will be updated regularly and is subject to change. This section provides specific information on the legal obligations of being part of the Wellpoint network.

Contacts

This section is your reference for important phone and fax numbers, websites, and mailing addresses.

Before Rendering Services

This section provides the information and tools you will need before providing services, including verifying member eligibility and a list of covered and noncovered services. The section also includes a chapter on the precertification process and coordination of complex care through our Integrated Case Management department.

We take pride in our proactive approach to health. The chapter on Health Services programs details how we can partner with you to make the services you provide more effective. For example, the initial health assessment (IHA) is our first step in providing preventive care. The health services programs under Condition Care (CNDC) allow us to collaborate with you to combat the most common and serious conditions and illnesses facing our members, including asthma, cardiovascular disease, and diabetes.

After Rendering Services

At Wellpoint, our goal is to make the billing process as streamlined as possible. This section provides guidelines, detailed coding charts, information on filing claims for professional and institutional services rendered. The **Member Transfer and Disenrollment** chapter outlines how a member changes primary care physician (PCP) assignment or transfers to another health plan. When questions or concerns come up about claims or adverse determination, our chapter on **Grievances and Appeals** will take you step-by-step through the process.

Operational Standards, Requirements and Guidelines

This section summarizes the requirements for provider office operations and Access Standards, thereby ensuring consistency when members need to consult with providers for IHAs, referrals, coordination of care and follow up care. Additional chapters detail provider credentialing, provider roles and responsibilities and enrollment and marketing guidelines. Chapters on clinical practice and preventive health guidelines and integrated case management outline the steps providers should take to coordinate care and help members take a proactive stance in the fight against disease. And finally, we included a chapter documenting our commitment to participate in quality assessments that help Wellpoint measure, compare and improve our standards of care.

Additional Resources

To help providers serve a diverse and ever-evolving patient population, we designed a special program, Culturally and Linguistically Appropriate Services, to improve provider and member communications by providing tools and resources to help reduce language and cultural barriers. Written translations are available in each prevalent non-English language. Interpretation services — oral interpretation in all languages and auxiliary aids such as TTY/TDD and American Sign Language — are available to each potential member and are available free of charge to each member.

All written materials for potential or current members adhere to the following standards:

- Easily understood language and format
- Font size no smaller than 12 point
- Alternative formats and auxiliary aids and services that consider the special needs of potential or current members with disabilities or limited English proficiency

- Inclusion of a large print tagline and information on how to request auxiliary aids and services, including alternative formats

In addition, Wellpoint works with nationally recognized healthcare organizations to stay current on the latest healthcare breakthroughs and discoveries. This manual provides easy links to access that information. We also provide forms and reference guides on a wide variety of subjects.

Accessing Information, Forms and Tools on Our Website

We offer the Provider Manual in hard copy upon request at no cost and post it online.

A wide array of tools, information and forms are accessible on our provider website at <https://providers.wellpoint.com/ia>. Throughout this manual, we often will refer you to items located on this resource page.

Introduction

Third-Party Websites

The Wellpoint website and this manual may contain links and references to Internet sites owned and maintained by third-party sites. Neither Wellpoint nor its related affiliated companies operate or control, in any respect, any information, products or services on third-party sites. Such information, products, services, and related materials are provided *as is* without warranties of any kind, either express or implied, to the fullest extent permitted under applicable laws. Wellpoint disclaims all warranties, express or implied, including, but not limited to, implied warranties of merchantability and fitness. Wellpoint does not warrant or make any representations regarding the use or results of the use of third-party materials in terms of correctness, accuracy, timeliness, reliability or otherwise.

If you have any questions about the content of this manual, contact Provider Services at **833-731-2143** Monday through Friday from 7:30 a.m. through 6 p.m. Central time.

CHAPTER 2: LEGAL AND ADMINISTRATIVE REQUIREMENTS

Legal and Administrative Requirements

Proprietary Information

The information contained in this manual is proprietary. By accepting this manual, providers agree:

- To use this manual solely for the purposes of referencing information regarding the provision of medical services Iowa Medicaid enrollees who have chosen Wellpoint as their healthcare plan.
- To protect and hold the manual's information as confidential.
- Not to disclose the information contained in this manual.

Legal and Administrative Requirements

Updates and Changes

The Provider Manual, as part of your Provider Agreement and related Addendums, may be updated at any time and is subject to change. In the event of an inconsistency between information contained in the manual and the Provider Agreement between you or your facility and Wellpoint, the Provider Agreement shall govern.

In the event of a material change to the Provider Manual, we will make all reasonable efforts to notify you in advance of such change through web-posted newsletters, email notifications, fax communications (such as provider bulletins), and/or other mailings. In such cases, the most recently published information should supersede all previous information and be considered the current directive.

The manual is not intended to be a complete statement of all Wellpoint policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially targeted communications, as referenced above.

This manual does not contain legal, tax or medical advice. Please consult your own advisors for such advice.

CHAPTER 3: CONTACTS

Contacts

Overview

When you need the correct phone number, fax number, website or street address, the information should be right at your fingertips. With that in mind, we have compiled the most-used contacts for you and your office staff for Wellpoint services and support.

Contacts

Wellpoint Contacts

If you have questions about. . .	Contact
Wellpoint on Call	Wellpoint on Call Phone: 866-864-2544 (English) 866-864-2545 (Spanish) TTY: 711 Hours: 24 hours a day, 7 days a week
Wellpoint Provider Services	Phone: 833-731-2143 Hours: Monday through Friday, 7:30 a.m.-6 p.m. Central time Website: https://providers.wellpoint.com/ia
Carelon Behavioral Health, Inc. National Provider Service Line	Carelon Behavioral Health, Inc. National Provider Service Line 800-397-1630 Monday through Friday, 8 a.m. to 8 p.m. ET
Behavioral Health Services	Wellpoint Medical Management Phone: 833-731-2143 (TTY 711) Hours: Monday through Friday, 7:30 a.m.-6 p.m. Central time BH Authorizations – Submit via www.availity.com
Integrated Case Management Referrals	Wellpoint Physical Health Medical Management Phone: 844-986-4991; 833-731-2143 Hours: Monday through Friday, 8 a.m.-5 p.m. Central time Fax: 844-556-6122; 800-964-3627 Email: iaicm@wellpoint.com
Claims: Electronic Submission	Availity Client Services - 800-282-4548 Submit electronic professional and institutional claims to Availity Essentials: Payer ID: WLPNT
Claims: Payment Status	Wellpoint Provider Services Phone: 833-731-2143 Hours: Monday through Friday, 7:30 a.m. to 6 p.m. Central time Fax: 800-964-3627
Claims: Payment Disputes/Correspondence	Wellpoint Provider Services Phone: 833-731-2143 (TTY 711) Hours: Monday through Friday, 7:30 a.m. to 6 p.m. Central time Fax: 800-964-3627 Mail: Wellpoint Payment Dispute Unit P.O. Box 61599 Virginia Beach, VA 23466-1599
Claims: Medical Claim Refunds	Wellpoint P.O. Box 933657 Atlanta, GA 31193-3657

If you have questions about. . .	Contact
Credentialing and Recredentialing	Phone: 855-789-7989 Email: iowamedicaid@wellpoint.com Recredentialing Email: iowarecredentialing@wellpoint.com
Condition Care Referrals	Wellpoint Condition Care Phone: 888-830-4300 (TTY 711) Hours: Monday through Friday, 8:30 a.m.-5:30 p.m. Central time Fax: 888-762-3199
Fraud and Abuse	For network providers, Wellpoint Provider Services Phone: 833-731-2143 Hours: Monday through Friday, 7:30 a.m.-6 p.m. Central time Contact the SIU directly: Mail: Special Investigations Unit 740 W Peachtree Street NW Atlanta, Georgia 30308 Attn: Iowa SIU SIU hotline: 866-847-8247
Hospital/Facility Admission Notification	Wellpoint Medical Management Phone: 833-731-2143 Hours: Monday through Friday, 7:30 a.m. to 6 p.m. Central time Fax: 800-964-3627
Interpreter Services	Wellpoint Member Services Phone: 833-731-2140 (TTY 711) Hours: Monday through Friday, 7:30 a.m.-6 p.m. Central time After hours, contact Wellpoint on Call at: 866-864-2544 (English); 866-864-2545 (Spanish); TTY: 711 ; available 24/7 Iowa Relay Service (Relay Iowa) TTY: 711/800-735-2942 (ASCII)/800-735-2943 (Voice) 800-735-4313 (VCO Direct) 800-264-7190 (Spanish) 877-735-1007 (Speech to speech) Hours: 24/7, 365 days a year
Medical Management	Wellpoint Medical Management Phone: 833-731-2143 Hours: Monday through Friday, 7:30 a.m. to 6 p.m. Central time Fax: 800-964-3627
Member Services	For Member Services, member grievances and appeals, interpreter services, and personal information changes: Phone: 833-731-2140 (TTY 711) Hours: Monday through Friday, 7:30 a.m. to 6 p.m. Central time After hours, call Wellpoint on Call at 866-864-2544 (English); 866-864-2545 (Spanish); TTY: 711 Hours: 24 hours a day, 7 days a week Written correspondence for member appeals: Fax: 844-400-3465 or mail:

If you have questions about. . .	Contact
	Central Appeals Processing Wellpoint P.O. Box 62429 Virginia Beach, VA 23466-2429
Member Eligibility	Verify eligibility through either Iowa Department of Health and Human Services (Iowa HHS) or Wellpoint: Iowa HHS eligibility information Eligibility and Verification Information System (EVS) Automated Voice Response Phone: 800-338-7752 or 515-323-9639 Hours: 24 hours a day, 7 days a week Website: https://ime-ediss5010.noridian.com/iowaxchange5010/LogonDisplay.do To verify Hawki eligibility, call 800-257-8563 . Wellpoint Provider Services Phone: 833-731-2143 Hours: Monday through Friday, 7:30 a.m. to 6 p.m. Central time Fax: 800-964-3627 Secure provider website: https://providers.wellpoint.com/ia
Pharmacy Questions and Prescriptions: Providers	Wellpoint Pharmacy Department Phone: 833-731-2143 Hours: Monday through Friday, 7 a.m. to 7 p.m. Central time Website: https://providers.wellpoint.com/ia
Pharmacy Questions and Prescriptions: Members	Wellpoint Pharmacy Phone: 833-205-6008 Hours: Monday through Friday, 7 a.m. to 7 p.m. Central time Website: https://www.wellpoint.com/ia
Precertification: Behavioral Health	Wellpoint Medical Management Phone: 833-731-2143 Hours: Monday through Friday, 7:30 a.m. to 6 p.m. Central time Inpatient: Available 24/7 All requests should be submitted using our preferred method via the web portal at: https://providers.wellpoint.com/ia
Prior Authorization: Medical	Wellpoint Medical Management Phone: 833-731-2143 (TTY 711) Hours: Monday through Friday, 7:30 a.m. to 6 p.m. Central time Fax: 800-964-3627
Prior Authorization: Medical Vascular and Radiology Modalities	Carelon Medical Benefits Management, Inc.* Phone: 800-714-0040 Hours: Monday through Friday, 7:30 a.m. to 6 p.m. Central time Website: https://www.providerportal.com
Prior Authorization: Pharmacy	Wellpoint Phone: 833-731-2143 Fax: 844-512-9004 ePrescribe: www.covermyeds.com
Provider Services Call Center	For provider advocate services, verifying eligibility and benefits, checking claims status, and EDI information: Phone: 833-731-2143 Hours: Monday through Friday, 7:30 a.m. to 6 p.m. Central time

If you have questions about. . .	Contact
<p>Transportation Services (Nonemergency medical transportation)</p>	<p>Fax: 800-964-3627</p> <p>Access2Care To contact Access2Care for transportation Services:</p> <ul style="list-style-type: none"> • Reservations (Non-Waiver Member Line): 844-544-1389 • Ride Assist (Where’s My Ride): 844-544-1390 • Hearing Impaired (TTY): 855-823-8587 • Transportation Provider Line: 888-644-3547 • Transportation Provider Fax: 877-645-7837 • Facilities Line (Waiver Member Line): 888-630-4822 <p>Hours: Monday through Friday, 7 a.m. to 6 p.m. Central time</p>
<p>Transportation Services (for HCBS Waiver participants)</p>	<p>The Elderly Waiver, Intellectual Disability Waiver, Physical Disability Waiver and Brain Injury Waiver have transportation as a covered service. To schedule transportation services, call the reservation line at 888-630-4822. To review a previously requested reservation, call the Where’s My Ride Line at 844-544-1390.</p> <p>Transportation as a Waiver service is to assist Waiver members in conducting business errands and essential shopping, to travel to and from work or day programs and to reduce social isolation. All nonemergency, nonmedical HCBS Waiver transportation services should be billed directly to Access2Care, based on the member’s Wellpoint LTSS contract and in accordance with their person-centered plan.</p> <p>Providers cannot provide nonemergent transportation under the HCBS Waiver as this is considered double billing. HCBS Waiver providers with transportation services available within their entity must contract with Access2Care to be reimbursed for nonemergency medical transportation (NEMT) services. Please see the NEMT section outlined in Chapter 5 for more details. To contract please call 888-644-3547.</p>
<p>Vision Services</p>	<p>Superior Vision Benefit Management, Inc. Provider Services phone: 866-819-4298 Member Services phone: 800-679-8901 Hours: Monday through Friday, 7:30 a.m.-6 p.m. Central time Website: https://www.superiorvision.com</p>

CHAPTER 4: COVERED AND NONCOVERED SERVICES

Covered and Noncovered Services

Covered Services

The following grids list covered and noncovered services, including notations for services requiring precertification. Because covered benefits periodically change, verify coverage before providing services. You may also refer to the state's [Benefits Comparison Grid](#) for Medicaid, Hawki, Iowa Health and Wellness Plan and Family Planning Network services.

For benefits available from out-of-network providers, please contact Provider Services to determine the requirements.

Cost sharing

A variety of methods are used to share expenses between the state and a member. These methods include monthly cost shares, copays, and premiums. For Medicaid, Iowa Health, and Wellness Plan and Hawki, copays vary based on eligibility.

Covered and Noncovered Services

Covered Services: Medicaid Services

Covered services: Medicaid Services	Coverage limits
1915(C) home- and community-based services	Covered
1915(I) habilitation services	Covered
Abortions	<p>Prior authorization may be required. May only be approved under the following situations:</p> <ul style="list-style-type: none"> • The physician certifies that the pregnant woman's life would be endangered if the fetus were carried to term. • The physician certifies that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and the physician states the medical indication for determining the fetal condition. • The pregnancy was the result of rape reported to a law enforcement agency or public or private health agency which may include a family physician within 45 days of the date of occurrence of the incident. The report shall include the name, address and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of the rape. • The pregnancy was the result of incest reported to a law enforcement agency or public or private health agency including a family physician no later than 150 days after the date of occurrence. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of incest.
Affordable Care Act (ACA) preventive services	Covered
Allergy testing and injections	Covered
Ambulance	Covered
Ambulatory surgical center	Covered, includes anesthesia
Anesthesia	Covered as medically necessary

Covered services: Medicaid Services	Coverage limits
Assertive Community Treatment (ACT)	Covered (may require prior authorization)
(b)(3) services (intensive psychiatric rehabilitation, community support services, peer support, residential substance use treatment, respite, intenerated services and supports)	Covered (may require prior authorization)
Bariatric surgery for morbid obesity	Covered as medically necessary
Behavioral health intervention services (BHIS) and assertive community treatment (ACT)	Covered (may require prior authorization)
Behavioral health services office visit	Covered (may require prior authorization)
Breast reconstruction	Covered as medically necessary, related to breast cancer and following mastectomy
Breast reduction	Covered as medically necessary (may require prior authorization)
Cardiac rehabilitation	Covered as medically necessary (may require prior authorization)
Certified nurse midwife services	Covered
Chemotherapy – inpatient and outpatient	Covered (may require prior authorization)
Childcare Medical Services	Covered
Chiropractic care (therapeutic adjustive manipulation)	Covered as medically necessary
Colorectal cancer screening	Covered
Community-based neurobehavioral rehabilitation services	Covered (may require prior authorization)
Congenital abnormalities correction	Covered as medically necessary
Contraceptive devices	Covered
Diabetes equipment and supplies	Covered
Diabetic self-management training	Covered once per member, lifetime maximum
Diagnostic genetic testing	Covered
Dialysis	Covered
Durable medical equipment (DME) and supplies (DMS)	<p>Covered; Services may require PA This does not apply to DMS. Limits (may require prior authorization):</p> <ul style="list-style-type: none"> • Up to a three-month supply of medical supplies • Supplies may require PA if benefit limits are exceeded. • Diabetic supplies are only covered under DME benefit. The pharmacy benefit does not cover these diabetics syringes, test strips or lancets. <ul style="list-style-type: none"> ○ Blood glucose test or reagent strips – six units per month (one unit = 50 strips) ○ Urine glucose test strips – three units per month (one unit = 100 strips) ○ Lancets – four units per month (one unit = 100 lancets) ○ Needles – 500 units per month (one unit = one needle) ○ Reusable insulin pens – one every six months ○ Diaper/brief – 1,080 per 90-day period ○ Liner/shield/guard/pad -- 450 per 90-day supply ○ Pull-on – 450 per 90-day period ○ Disposable under pads -- 600 per 90-day period ○ Reusable under pads – 48 per 12 months • Eyeglasses – Covered, limitations may apply

Covered services: Medicaid Services	Coverage limits
DME and DMS (continued)	<ul style="list-style-type: none"> Hearing aid batteries – up to 30 batteries per aid in a 90-day period Ostomy supplies and accessories – one unit per day of regular wear or three units per month of extended wear Note: Services are limited to members in a medical facility.
Emergency room services	Covered \$3 per visit for nonemergency medical services
Emergency medical transportation	Covered as medically necessary
Early and periodic screening, diagnosis, and treatment (EPSDT)	Covered
Private duty nursing/personal cares (EPSDT homecare benefit)	Covered
Family planning-related services and supplies	Covered
Foot care (podiatry)	Covered Note: Routine foot care is <i>not</i> covered unless it is part of a member's overall treatment related to certain healthcare conditions.
Genetic counseling	Covered as medically necessary
Gynecological exams	Covered
Health Home (Chronic Condition Health Home or Integrated Health Home)	Covered (requires member enrollment)
Hearing aids	Covered as medically necessary (may require prior authorization)
Hearing exams and services	One hearing exam per year covered
Home health services (skilled nursing, home health aide, physical therapy, occupational therapy, and speech therapy)	Limits (Electronic visit verification required and may require prior authorization): <ul style="list-style-type: none"> Skilled nursing care – five visits per week Home health aide – 28 hours per week Occupational, physical and speech therapy – limited to physician-approved visits within rules for restorative maintenance or trial therapy
Hospice Daily categories: <ul style="list-style-type: none"> Routine care (<i>If member is residing in a nursing facility, room-and-board charges covered at 95 percent</i>) Facility respite Inpatient hospital Continuous 	Limit (may require prior authorization): may only be used in five-day spans
Hospitalization	Covered as medically necessary (may require prior authorization)
ICF/ID (intermediate care facility for individuals with intellectual disabilities)	Covered, limitations apply
Imaging/diagnostics (MRI, CT, PET)	Covered as medically necessary (may require prior authorization)
Immunizations (shots)	Covered
Inhalation therapy	Covered as medically necessary (may require prior authorization)
Injections (physician's office and hospital)	Covered, limitations may apply
Inpatient hospital admissions preapproval	Required for nonemergency admissions
Inpatient hospital services room and board	Covered

Covered services: Medicaid Services	Coverage limits
Inpatient physician services	Covered, includes anesthesia
Inpatient hospital supplies	Covered
Inpatient surgical services	Covered
Intensive care unit	Covered as medically necessary
IV infusion services	Covered as medically necessary (may require prior authorization)
Laboratory tests	Covered (may require prior authorization)
Long term services support (LTSS) case management	Covered for individuals with a developmental disability and HCBS Waiver populations only
Mammography radiology services	Covered
Maternity and pregnancy services (preconception/interception prenatal postpartum)	Covered
Medical and surgical supplies	Covered as medically necessary
Mental health/behavioral health outpatient treatment	Covered as medically necessary (may require prior authorization)
Mental health/behavioral health inpatient treatment	Covered as medically necessary (may require prior authorization)
Nonemergent transportation (NEMT)	Covered
Newborn child coverage	Covered
Noncosmetic reconstructive surgery	Covered as medically necessary (may require prior authorization)
Nursing facility	Covered as medically necessary; must meet level of care
Nursing facility – special population (also known as skilled preapproval)	Requires prior authorization for out-of-state placement.
Nutritional counseling	Covered as medically necessary
Organ/bone marrow transplants	Covered, limitations apply
Orthotics	Limits (may require prior authorization): <ul style="list-style-type: none"> • Two pairs of depth shoes per member in a 12-month period • Three pairs of inserts, plus noncustomized removable inserts provided with depth shoes in a 12-month period • Two pairs of custom-molded shoes per member in a 12-month period, plus two additional pair of inserts for custom-molded shoes in a 12-month period
Outpatient hospital diagnostic lab, radiology	Covered (may require prior authorization)
Outpatient surgery	Covered as medically necessary (may require prior authorization)
Outpatient therapy (physical, occupational, speech, cardiac, respiratory pulmonary)	Covered; for physical, occupational and speech therapy, the legal Medicare Part B outpatient cap is \$1920 (may require prior authorization).
Oxygen therapy (inhalation therapy)	Covered, Prior authorization may be required
Pap smears	Covered
Pathology	Covered
Pelvic exams	Covered
Pharmacy	Limits (may require prior authorization): <ul style="list-style-type: none"> • Prior authorization is required as specified in the <i>Preferred Drug List (PDL)</i> at http://www.iowamedicaidpdl.com/. Exclusions may apply. • 72-hour emergency supply; this does not apply to medicines to help quit smoking or for hepatitis-C (Dacilzumab [Zinbryta] or PCSK9 Inhibitors [Praulent and Repatha])

Covered services: Medicaid Services	Coverage limits
	<ul style="list-style-type: none"> • Drug costs are reimbursed only for drugs marketed by manufacturers with a signed rebate agreement • Certain nonprescription over-the-counter (OTC) drugs and non-drugs are covered • Quantities covered includes: <ul style="list-style-type: none"> ○ Up to a 31-day supply at a time, except certain contraceptives, which is at 90 days ○ OTC drugs – minimum of 100 units per prescription, or currently available consumer package ○ Initial 15-day supply limit for certain drugs ○ Monthly quantity limit for certain drugs • Noncovered drug categories include: <ul style="list-style-type: none"> ○ Drugs used for anorexia, weight gain or weight loss ○ Drugs used for cosmetic purposes or hair growth ○ Outpatient drugs, if the manufacturer requires it as a condition of sale that associated tests or monitoring services be purchased only from the manufacturer or the manufacturer’s designee ○ Drugs prescribed for fertility purposes, except when prescribed for a medically accepted indication other than infertility ○ Drugs used for sexual or erectile dysfunction ○ Drugs for symptomatic relief of cough and colds, except listed OTC drugs ○ Vaccines are not covered under pharmacy benefit [Vaccines are covered under medical benefit for members over 18 years of age—some restrictions may apply. Vaccines for members 18 years of age and younger are covered under the VFC (Vaccines For Children program)]
Physician services (office visits, physician emergency room visits, inpatient hospital visits and consultations)	Covered
Physical therapy	Covered
Prescription drug generic copay	Covered
Prescription drug nonpreferred brand name copay	Covered
Prescription drug preferred brand name copay	Covered
Prescription drug coverage - quantity	31-day supply for all prescriptions, except contraceptives which is a 90-day supply.
Preventive care	Covered
Private duty nursing services	Covered up to age 21 under EPSDT
Psychiatric medical institutions for children (PMIC)	Covered (may require prior authorization)
Primary care physician services	Covered
Prostate cancer screening	Covered as medically necessary
Prosthetics	Covered as medically necessary (may require prior authorization)
Pulmonary rehabilitation	Covered, Prior authorization may be required
Radiation therapy	Covered as medically necessary (may require prior authorization)

Covered services: Medicaid Services	Coverage limits
Reconstructive surgery (noncosmetic)	Covered as medically necessary
Routine check-ups	Covered
Sexually transmitted infection (STI) and sexually transmitted disease (STD) testing	Covered
Screening Pap test	Covered as medically necessary
Screening mammography	Covered as medically necessary
Second surgical option	Covered
Skilled nursing facility	Covered, limitations apply
Sleep apnea treatment	Covered (may require prior authorization)
Sleep study testing	Covered (may require prior authorization)
Prescription and nonprescription drugs for smoking cessation	Covered
Prescription oral contraceptives	Covered
Specialist office visit	Covered; PCP referral may be required
Special physician services	Covered as medically necessary
Special population skilled nursing facility out of state (skilled preapproval)	Covered, limitations apply
Substance use disorder inpatient/outpatient treatment	Must meet American Society of Addiction Medicine (ASAM) criteria as the utilization management guidelines for substance use disorder services (may require prior authorization). Note: Additional substance use disorder services may be covered through the Iowa Department of Public Health (IDPH) for members who qualify.
Temporomandibular joints (TMJ) treatment	Covered as medically necessary (may require prior authorization)
Tobacco cessation	Covered
Tobacco cessation for pregnant women	Covered
Transplant – organ and tissue	<p>May require prior authorization. Limited to the following specified medical conditions and diagnoses:</p> <ul style="list-style-type: none"> • Certain bone marrow/stem cell transfers from a living donor (in other words, allogeneic stem cell transplants), or from the patient him/herself (in other words, autologous stem cell transplants) • Heart • Heart/lung • Ventricular assist devices for “bridge” therapy • Kidney • Liver • Lung • Pancreas • Simultaneous pancreas/kidney • Small bowel • Corneal transplants • Donor expenses incurred directly in connection with a covered transplant are payable, but only as part of the payment for the transplant itself. • Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery.

Covered services: Medicaid Services	Coverage limits
	Noncovered services include: <ul style="list-style-type: none"> • Transport of living donor • Transplantation of islet cells or partial pancreatic tissue • Ventricular assist devices, (related to heart transplants) for “destination” therapy • Expenses of searching for a donor
Urgent care centers/facilities and emergency clinics (nonhospital based)	Covered
Vision services	Limits: one per 12-month period
Vision frames and lenses	Frame services and single vision and multifocal lens services are covered: <ul style="list-style-type: none"> • Up to three times for children up to age 1 • Up to four times per year for children ages 1-3 • One frame every 12 months for children ages 4-7; safety frames are covered for children through age 7 • One frame every 24 months for members age 8 and older Gas permeable contact lenses are covered: <ul style="list-style-type: none"> • Up to 16 lenses for children up to age 1 • Up to eight lenses every 12 months for children ages 1-3 • Up to six lenses every 12 months for children ages 4-7 • Two lenses every 24 months for members age 8 and older Replacement of lost or damaged glasses beyond repair are covered: <ul style="list-style-type: none"> • For adults age 21 and older, once every 12 months • For children younger than age 21
Walk-in center services	Covered as medically necessary
X-ray procedures such as MRIs, CAT scans and PET scans require prior authorization	Covered as medically necessary (may require prior authorization)

The list provided does not show all benefits. For more information, please contact Provider Services at 833-731-2143.

Covered and Noncovered Services

Noncovered Services: Medicaid Services

Noncovered Services: Medicaid Services	Details
Acupuncture	Not covered
Clinical trials	Not covered
Infertility diagnosis and treatment	Not covered
Pharmacy	Noncovered drug categories include: <ul style="list-style-type: none"> • Drugs used for anorexia, weight gain or weight loss • Drugs used for cosmetic purposes or hair growth • Outpatient drugs if the manufacturer requires as a condition of sale that associated tests or monitoring services be purchased only from the manufacturer or the manufacturer’s designee • Drugs prescribed for fertility purposes, except when prescribed for a medically accepted indication other than infertility • Drugs used for sexual or erectile dysfunction

	<ul style="list-style-type: none"> • Drugs for symptomatic relief of cough and colds, except listed OTC drugs • Drugs prescribed for a use other than the drug’s medically accepted use • Drugs classified as less than effective by the Centers for Medicare and Medicaid Services • Drugs marketed by manufacturers that have not signed a Medicaid rebate agreement • Vaccines are not covered under pharmacy benefit [Vaccines are covered under medical benefit for members over 18 years of age—some restrictions may apply. Vaccines for members 18 years of age and younger are covered under the VFC (Vaccines For Children program)]
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The list provided does not show all benefits. For more information, please contact Provider Services at **833-731-2143**.

Covered and Noncovered Services

Covered Services: Hawki

Deductible: none

Maximum out-of-pocket expense (calendar year): none

Lifetime maximum: none

Covered Services: Hawki	Details
Abortions	<p>Prior authorization may be required. Approved if federal and state requirements are met. May only be approved if:</p> <ul style="list-style-type: none"> • The physician certifies that the pregnant woman’s life would be endangered if the fetus were carried to term. • The physician certifies that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and the physician states the medical indication for determining the fetal condition. • The pregnancy was the result of rape reported to a law enforcement agency or public or private health agency which may include a family physician within 45 days of the date of occurrence of the incident. The report shall include the name, address and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of the rape. • The pregnancy was the result of incest reported to a law enforcement agency or public or private health agency including a family physician no later than 150 days after the date of occurrence. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of incest.
Affordable Care Act (ACA) preventive services	Covered
Allergy testing and injections	Covered
Ambulance	Covered
Ambulatory surgical center	Covered, includes anesthesia
Bariatric surgery for morbid obesity	Covered, limitations may apply (may require prior authorization)
Behavioral health services office visit	Covered (may require prior authorization)

Covered Services: Hawki	Details
Blood and blood administration	Covered if medically necessary
Breast reconstruction, following breast cancer and mastectomy	Covered, limitations may apply
Cardiac rehabilitation outpatient therapy services	Covered, (may require prior authorization)
Certified nurse midwife services	Covered
Chemotherapy	Covered (may require prior authorization)
Chiropractic care	Covered (limitations apply)
Colorectal cancer screening	Covered
Contraceptives	Covered
Dental services	Outpatient hospital charges and anesthesia if criteria are met. Covered for accidental injury.
Diabetes equipment and supplies	Covered (under DME. Not covered under pharmacy benefit)
Diabetic self-management training	Covered
Diagnostic genetic testing	Covered
Dialysis	Covered (may require prior authorization)
Durable medical equipment (DME) and durable medical supplies (DMS)	Covered; May Require PA. This does not apply to DMS (other limitations may apply; contact Provider Services).
Emergency medical transportation	Covered as medically necessary
Emergency room services	Covered; emergency services for nonemergency conditions are subject to a \$25 copay if the family pays a premium for the Hawki program
Family planning-related services and supplies	Covered
Genetic counseling	Covered (requires prior authorization)
Gynecological exam	Covered
Hearing evaluation, test, and hearing aids	Covered (may require prior authorization)
Home health services	Limited to those situations that require skilled services as defined for Medicare (Electronic visit verification required and may require prior authorization)
Hospice	Covered
Hospital inpatient services	Covered services include: <ul style="list-style-type: none"> • Room and board (semi-private) Services that are covered as medically necessary include: <ul style="list-style-type: none"> • Supplies • Outpatient facility or surgi-center • Anesthesia • Surgery

Covered Services: Hawki	Details
Immunizations (shots)/Vaccines	Covered; limitations may apply Note: Wellpoint will cover the cost of the vaccine and the administration of vaccines to Hawki members; providers shouldn't use the Vaccines for Children program as it is for Medicaid children only.
Injections: physician's office	Covered, limitations may apply
Injections: hospital (inpatient or outpatient)	Covered, limitations may apply
Inpatient hospital admissions preapproval	Required for nonemergency admissions
Laboratory tests	Covered (may require prior authorization)
Mammography radiology services	Covered
Maternity and pregnancy services	Covered services include: <ul style="list-style-type: none"> • Physician medical services • Hospital inpatient service for maternity • Room and board • Miscellaneous
Mental/behavioral health and substance abuse services (inpatient, outpatient, and office)	Covered (may require prior authorization)
Morbid obesity treatment	Covered as medically necessary (if criteria are met)
Newborn child coverage	Covered
Nursing facility	Covered (may require prior authorization)
Physician surgical services	Covered services include: <ul style="list-style-type: none"> • Office • Inpatient • Outpatient
Primary care physician services	Covered
Organ/bone marrow transplants	Covered, with limitations (may require prior authorization)
Orthotics	Covered, limitations may apply, and prior authorization required
Outpatient hospital diagnostic lab, radiology	Covered (may require prior authorization)
Outpatient physician services	Covered services include: <ul style="list-style-type: none"> • Home visits or nursing facility visits • Allergy testing • Allergy injections Immunizations (cannot use Vaccines for Children [VFC])

Covered Services: Hawki	Details
Outpatient rehabilitative therapy (physical, occupational, speech, cardiac, respiratory, and pulmonary)	Covered (limitations may apply); (may require prior authorization)
Outpatient surgery	Covered (may require prior authorization)
Oxygen therapy	Covered
Pap smears	Covered
Pathology	Covered
Pelvic exams	Covered
Pharmacy	Covered as medically necessary; follow the Iowa Preferred Drug List (PDL)
Physician services	Covered services include: <ul style="list-style-type: none"> • Office visits • Physician emergency room visits • Inpatient hospital visits and consultations
Podiatry	Covered
Prescription drug generic copay	Covered, \$0 copay
Prescription drug nonpreferred brand name copay	Covered, \$0 copay
Prescription drug preferred brand name copay	Covered, \$0 copay
Prescription drug coverage - quantity	31-day supply for all prescriptions, except contraceptives which is a 90-day supply.
Preventive care	Covered services include routine preventive physical exams, including well-childcare and gynecological exams
Prosthetics	Covered (may require prior authorization)
Radiation therapy	Covered (may require prior authorization)
Reconstructive surgery (noncosmetic)	To restore function lost or impaired as the result of illness, injury, or birth defect, even if there is an incidental improvement in physical appearance. (May require prior authorization)
Routine check-ups	Covered
Routine eye exam	Covered, one routine hearing exam per calendar year.
Routine hearing exam	Covered, one routine hearing exam per calendar year.
Routine laboratory screening and diagnostic services	Covered
Routine radiology screening and diagnostic services	Covered
Second surgical option	Covered
Sexually transmitted infection (STI) and sexually transmitted disease (STD) testing	Covered
Skilled nursing facility	Covered (may require prior authorization)
Sleep study testing	Covered (may require prior authorization)
Sleep apnea treatment	Covered (may require prior authorization)
Specialist office visit	Covered
Substance use disorder inpatient treatment	Covered (may require prior authorization)
Substance use disorder outpatient treatment	Covered (may require prior authorization)
Temporomandibular joints (TMJ) treatment	Services that are medically necessary; osteotomy not covered.

Covered Services: Hawki	Details
Urgent care centers/facilities and emergency clinics (nonhospital based)	Covered
Vision frames and lenses	One visit per year is covered (other limitations may apply; contact Provider Services for more information).
X-ray procedures such as MRIs, CAT scans and PET scans require prior authorization	Covered services include: <ul style="list-style-type: none"> • Hospital (inpatient or outpatient) • Office As medically necessary: <ul style="list-style-type: none"> • Radiation therapy and chemotherapy

The list provided does not show all benefits. For more information, please contact Provider Services at 833-731-2143.

Covered and Noncovered Services

Noncovered Services: Hawki

Noncovered Services: Hawki	Details
1915(C) home- and community-based services	Not covered
1915(I) habilitation services	Not covered
Acupuncture	Not covered
Assertive Community Treatment (ACT)	Not covered
(b)(3) services (intensive psychiatric rehabilitation, community support services, peer support, residential substance use treatment)	Not covered
Behavioral health intervention services (including applied behavior analysis)	Not covered
Breast reconstruction	Not covered
Cardiac rehabilitation	Not covered
Childcare medical services	Not covered
Chronic Condition Health Homes	Not covered
Colorectal cancer screening	Not covered
Cosmetic procedures	Not covered
Counseling and education services	Not covered
Custodial care	Not covered
Outpatient rehabilitative therapy (physical, occupational, speech, cardiac and pulmonary)	As medically necessary for physical and speech. Not covered for cardiac or pulmonary.
Early and periodic screening, diagnostic and treatment (EPSDT) services	Not covered
Exception for certain clinical trials for treatment studies on cancer, approved by the National Cancer Institute or the National Institutes Of Health	Must meet criteria
Foot care	Not covered
Hospice	Not covered
ICF/ID (intermediate care facility for individuals with intellectual disabilities)	Not covered
Integrated Health Homes	Not covered
Long term services support (LTSS) case management	Not covered
Oxygen therapy (inhalation therapy)	Not covered

Noncovered Services: Hawki	Details
Nonemergency medical transportation	Not covered
Nursing facility	Not covered
Private duty nursing/personal cares per EPSDT authority	Not covered
Psychiatric medical institutions for children (PMIC)	Not covered
Prostate cancer screening	Not covered
Tobacco cessation	Not covered

The list provided does not show all benefits. For more information, please contact Provider Services at **833-731-2143**.

Covered and Noncovered Services

Covered Services: Iowa Health and Wellness Plan

Covered services: Iowa Health and Wellness Plan	Coverage limits
Abortions	Certain circumstances must apply; contact Provider Services for more information.
Affordable Care Act (ACA) preventive services	Covered
AIDS/HIV parity	Covered
Ambulance	Covered
Ambulatory surgical center	Covered, includes anesthesia
Allergy testing and injections	Covered as medically necessary
Anesthesia	Covered as medically necessary
Behavioral health intervention services (including applied behavior analysis)	Covered; residential treatment is not covered (may require prior authorization)
Behavioral health services office visit	Covered (may require prior authorization)
Breast reconstruction, following breast cancer and mastectomy	Covered
Breast reduction	Covered as medically necessary (may require prior authorization)
Cardiac rehabilitation	Covered
Cardiac therapy (outpatient)	Limit: 60 visits per year
Certified nurse midwife services	Covered
Chemotherapy – inpatient and outpatient	Covered (may require prior authorization)
Chiropractic care (therapeutic adjustive manipulation)	Covered, limitations may apply
Clinical trials	Not covered
Colorectal cancer screening	Covered
Congenital abnormalities correction	Covered as medically necessary
Contraceptive devices	Covered
Counseling and education services	Limits – noncovered services include: <ul style="list-style-type: none"> • Bereavement, family, or marriage counseling • Education, other than for diabetes
Diabetes equipment and supplies	Medically necessary equipment and supplies and education services are covered; diabetic supplies are only covered under the DME benefit..

Covered services: Iowa Health and Wellness Plan	Coverage limits
Diabetic self-management training	Covered: 10 hours of outpatient self-management training within a 12-month period, plus follow-up training of up to two hours annually
Diagnostic genetic testing	Covered; prior authorization is needed
Dialysis	Covered (may require prior authorization)
Durable medical equipment (DME) and durable medical supplies (DMS)	Covered; a DME purchase less than \$500 does not require prior authorization. This does not apply to DMS. Limits – noncovered services include: <ul style="list-style-type: none"> • Elastic stockings and bandages • Trusses • Lumbar braces • Garter belts • Similar items that can be purchased without a prescription
Emergency room services	Covered; nonemergency medical services are subject to a copay.
Emergency medical transportation	Covered as medically necessary
Early and periodic screening, diagnosis, and treatment (EPSDT)	Covered for members up to age 21 Limits: Oral and vision services are covered for children ages 19-20
Eyeglasses	Covered for ages 19 to 20, limitations may apply Note: For members that qualify as medically exempt, eyeglasses are covered.
Private duty nursing/personal cares (EPSDT homecare benefit)	Covered
Family planning-related services and supplies	Covered
Foot care (podiatry)	Covered Routine foot care is not covered unless it is part of a member's overall treatment related to certain healthcare conditions.
Genetic counseling	Covered with prior authorization
Gynecological exams	Limit: one exam per year
Health Home (Chronic Condition Health Home or Integrated Health Home)	Covered if member has been determined to be medically exempt (requires member enrollment)
Hearing aids	Covered for ages 19-20; limitations may apply
Hearing exams	Limit: one exam per year
Home health services (home health aide, PT, OT, and ST)	Covered (Electronic visit verification required and may require prior authorization)
Hospice Daily categories: <ul style="list-style-type: none"> • Routine care (<i>If member is residing in a nursing facility, room-and-board charges covered at 95 percent</i>) • Facility respite • Inpatient hospital Continuous	<ul style="list-style-type: none"> • For respite care (may require prior authorization): may only be used in five-day spans
Hospitalization	Covered as medically necessary (may require prior authorization)
Imaging/diagnostics (MRI, CT, PET)	Covered as medically necessary (may require prior authorization)
Immunizations	Covered. Limit: Immunizations for travel are not covered.

Covered services: Iowa Health and Wellness Plan	Coverage limits
Injections (physician’s office and hospital)	Covered, limitations may apply
Inhalation therapy	Limit (may require prior authorization): 60 visits in a 12-month period
Inpatient hospital admissions preapproval	Required for nonemergency admissions
Inpatient hospital services room and board	Covered
Inpatient physician services	Covered, includes anesthesia
Inpatient surgical services	Covered as medically necessary (may require prior authorization)
Intensive care unit	Covered as medically necessary
IV infusion services	Covered as medically necessary (may require prior authorization)
Laboratory tests	Covered (may require prior authorization)
Mammography Radiology Services	Covered (may require prior authorization)
Maternity and pregnancy services (preconception/interception prenatal postpartum)	Covered; member is required to report pregnancy and eligibility for consideration of benefits under the Medicaid state plan.
Medical and surgical supplies	Covered (may require prior authorization) Limits – noncovered services include: <ul style="list-style-type: none"> • Elastic stockings and bandages • Trusses • Lumbar braces • Garter belts • Similar items that can be purchased without a prescription
Mental health/behavioral health outpatient treatment	Covered (may require prior authorization)
Mental health/behavioral health inpatient treatment	Covered (may require prior authorization) Limit: residential treatment is not covered with the exception of members identified as medically exempt.
Newborn child coverage	Covered
Noncosmetic reconstructive surgery	Covered as medically necessary (may require prior authorization)
Nutritional counseling	Covered as medically necessary
Occupational therapy (OT) - outpatient	Limit (may require prior authorization): 60 visits per year Noncovered: <ul style="list-style-type: none"> • Occupational therapy supplies • Inpatient occupational therapy in the absence of a separate medical condition requiring hospitalization
Orthotics	Covered as medically necessary (may require prior authorization)
Outpatient hospital diagnostic lab, radiology	Covered (may require prior authorization)
Outpatient surgery	Covered as medically necessary (may require prior authorization)
Oxygen therapy	Limit: 60 visits in a 12-month period
Pap smears	Covered
Pathology	Covered
Pelvic exams	Covered
Pharmacy	Covered (may require prior authorization)

Covered services: Iowa Health and Wellness Plan	Coverage limits
	<p>Limits:</p> <ul style="list-style-type: none"> • Prior authorization is required as specified in the Preferred Drug List (PDL) at www.iowamedicaidpdl.com. Exclusions may apply. • 72-hour emergency supply; this does not apply to medicines to help quit smoking or for hepatitis-C (Dacilzumab [Zinbryta] or PCSK9 Inhibitors [Pralent and Repatha]). • Drug costs are reimbursed only for drugs marketed by manufacturers with a signed rebate agreement. • Certain nonprescription over-the-counter (OTC) drugs and nondrugs are covered. • Quantities covered includes: <ul style="list-style-type: none"> ○ Up to a 31-day supply at a time, except certain contraceptives, which is at 90 days ○ OTC drugs – minimum of 100 units per prescription, or currently available consumer package ○ Initial 15-day supply limit for certain drugs ○ Monthly quantity limit for certain drugs • Noncovered drug categories include: <ul style="list-style-type: none"> ○ Drugs used to cause anorexia, weight gain or weight loss. ○ Drugs used for cosmetic purposes or hair growth. ○ Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed in section B ○ Drugs used for anorexia, weight gain or weight loss ○ Drugs used for cosmetic purposes or hair growth • Outpatient drugs, if the manufacturer requires as a condition of sale that associated tests or monitoring services be purchased only from the manufacturer or the manufacturer’s designee • Vaccines are not covered under pharmacy benefit [Vaccines are covered under medical benefit for members over 18 years of age—some restrictions may apply. Vaccines for members 18 years of age and younger are covered under the VFC (Vaccines For Children program)]
Physical therapy - outpatient	<p>Covered (may require prior authorization) Limit: 60 visits per year Noncovered: Inpatient physical therapy in the absence of a separate medical condition requiring hospitalization</p>
Physician services (office visits, physician emergency room visits, inpatient hospital visits and consultations)	Covered
Preventive care	Covered
Prescription drug coverage - quantity	31-day supply for all prescriptions except contraceptives, which is a 90-day supply
Prescription drug generic copay	Covered, \$0 copay

Covered services: Iowa Health and Wellness Plan	Coverage limits
Prescription drug nonpreferred brand name copay	Covered, \$0 copay
Prescription drug preferred brand name copay	Covered, \$0 copay
Prescription oral contraceptives	Covered
Primary care illness/injury physician services	Covered
Private duty nursing/personal cares per EPSDT authority	Covered up to age 21 under EPSDT
Psychiatric Medical Institutions for Children (PMIC)	Covered for 19- to 20-year-olds. Limitations may apply. (may require prior authorization)
Prostate cancer screening	Limit: one per year for men ages 50-64
Prosthetics	As medically necessary (may require prior authorization)
Pulmonary therapy – outpatient	Limit: 60 visits per year
Pulmonary rehabilitation	Covered as medically necessary (may require prior authorization)
Radiation therapy	Covered as medically necessary (may require prior authorization)
Reconstructive surgery (noncosmetic)	Covered (may require prior authorization)
Respiratory therapy	Covered, limited to 60 visits per year
Routine check-ups	Covered, limitations may apply
Routine eye exam	Covered, one routine vision exam per calendar year
Routine hearing exam	Covered, one routine hearing exam per calendar year
Routine laboratory screening and diagnostic services Laboratory	Covered
Routine radiology screening and diagnostic services Radiology Services	Covered
Screening Pap test	Covered as medically necessary
Screening mammography	Covered, limit: one screening per year
Second surgical option	Covered
Sexually transmitted infection (STI) and sexually transmitted disease (STD) testing	Covered
Skilled nursing facility	Covered (may require prior authorization) Limits: up to 120 days annually
Sleep apnea treatment	Covered; sleep apnea diagnostic services only (may require prior authorization)
Sleep study testing	Limits (may require prior authorization): <ul style="list-style-type: none"> • Services must be for a diagnosis of sleep apnea • Treatment for snoring (without a diagnosis of sleep apnea) is not covered
Specialty physician services	Covered as medically necessary
Speech therapy - outpatient	Covered, limit: 60 visits per year
Specialist office visit	Covered
Substance use disorder inpatient/outpatient treatment	Covered; must meet American Society of Addiction Medicine (ASAM) criteria as the utilization management guidelines for substance use disorder services. Additional substance use disorder services may be covered through the Iowa Department of Public Health (IDHP) for members who qualify. (may require prior authorization) Residential treatment is not covered.
Tobacco cessation	Covered

Covered services: Iowa Health and Wellness Plan	Coverage limits
Tobacco cessation for pregnant women	Covered; member is required to report pregnancy eligibility for consideration of benefits under the Medicaid state plan.
Transplant – organ and tissue	Covered, requires prior authorization Limited to the following specified medical conditions and diagnoses: <ul style="list-style-type: none"> • Certain bone marrow/stem cell transfers from a living donor (in other words, allogeneic stem cell transplants), or from the patient him/herself (in other words, autologous stem cell transplants) • Heart • Heart/lung • Ventricular assist devices for “bridge” therapy • Kidney • Liver • Lung • Pancreas • Simultaneous pancreas/kidney • Small bowel • Corneal transplants • Donor expenses incurred directly in connection with a covered transplant are payable, but only as part of the payment for the transplant itself. • Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Noncovered services include: <ul style="list-style-type: none"> • Transport of living donor • Transplantation of islet cells or partial pancreatic tissue • Ventricular assist devices, (related to heart transplants) for “destination” therapy • Expenses of searching for a donor
Urgent care centers/facilities Emergency clinics (nonhospital based)	Covered
Vision care exams	Limit: one general ophthalmology service per year for adults, not including medical exams
Vision frames and lenses	Frames and lenses are covered for individuals between the ages of 19 and 20.
Walk-in center services	Covered as medically necessary
X-ray procedures such as MRIs, CAT scans and PET scans require prior authorization	Covered as medically necessary (may require prior authorization)

The list provided does not show all benefits. For more information, please contact Provider Services at 833-731-2143.

Covered and Noncovered Services
Noncovered Services: Iowa Health and Wellness Plan

Noncovered services: Iowa Health and Wellness Plan	Details
1915(C) home- and community-based services	Not covered
1915(I) habilitation services	Not covered
(b)(3) services (intensive psychiatric rehabilitation, community support services, peer support and residential substance use treatment)	Not covered
Assertive Community Treatment (ACT)	Not covered
Bariatric surgery for morbid obesity	Not covered
Childcare medical services	Not covered
Infertility diagnosis and treatment	Not covered
Intermediate care facility for individuals with intellectual disabilities (ICF/ID)	Not covered
Long term services support (LTSS) case management	Not covered
Nonemergent transportation	Not covered
Nursing facility	Not covered
Nursing services	Not covered
Orthotics	Not covered
Pharmacy	<p>Noncovered drug categories include:</p> <ul style="list-style-type: none"> • Drugs used for anorexia, weight gain or weight loss • Drugs used for cosmetic purposes or hair growth • Outpatient drugs if the manufacturer requires as a condition of sale that associated tests or monitoring services be purchased only from the manufacturer or the manufacturer’s designee • Drugs prescribed for fertility purposes, except when prescribed for a medically accepted indication other than infertility • Drugs used for sexual or erectile dysfunction • Drugs for symptomatic relief of cough and colds, except pseudoephedrine • Drugs prescribed for a use other than the drug’s medically accepted use • Drugs classified as less than effective by the Centers for Medicare and Medicaid Services • Drugs marketed by manufacturers that have not signed a Medicaid rebate agreement • Vaccines are not covered under pharmacy benefit [Vaccines are covered under medical benefit for members over 18 years of age—some restrictions may apply. Vaccines for members 18 years of age and younger are covered under the VFC (Vaccines For Children program)]
Psychiatric medical institutions for children (PMIC)	Not covered
Temporomandibular joints (TMJ) treatment	Not covered
Vision frames and lenses	Not covered

The list provided does not show all benefits. For more information, please contact Provider Services at 833-731-2143.

Covered and Noncovered Services

Covered Services: Substance Use Disorder Services

Covered services	Coverage limits
Outpatient treatment	Covered as medically necessary
Intensive outpatient treatment	Covered as medically necessary
Partial hospitalization (day treatment)	Covered as medically necessary
Clinically managed low intensity residential treatment	Covered as medically necessary
Clinically managed medium intensity residential treatment	Covered as medically necessary
Clinically managed high intensity residential treatment	Covered as medically necessary
Medically monitored intensive inpatient treatment	Covered as medically necessary
Intake assessment and diagnosis services	Covered services include: <ul style="list-style-type: none"> • Appropriate physical exam • Urine screening • All needed medical testing to: <ul style="list-style-type: none"> ○ Decide a substance abuse disorder diagnosis ○ Identification of a medical or health problems ○ Screen for contagious diseases
Evaluation, treatment planning and service coordination	Covered as medically necessary
Substance abuse treatment services	Services vary based on the level of service and may include but are not limited to: <ul style="list-style-type: none"> • Physician, physician assistant, psychologist, nurse, certified addictions counselor, social worker, and trained staff services • Rehabilitation therapy and counseling • Family counseling and intervention for the primary recipient of services, including codependent/collateral counseling with primary recipient of services • Diagnostic X-ray, specific to substance abuse treatment • Diagnostic urine testing, specific to substance abuse treatment • Psychiatric, psychological, and medical lab testing, specific to substance use disorder treatment • Equipment and supplies • Cost of prescription drugs
Substance abuse counseling services through approved opioid treatment programs licensed under Iowa Code Chapter 125	Covered
Substance abuse treatment for Iowa Department of Public Health (IDPH) participants whose driving licenses or nonresident operating privileges are revoked under chapter 321J, provided treatment services meet the criteria for service necessity and sliding fee scale	Covered as medically necessary
Court-ordered evaluation for substance abuse	Covered as medically necessary

The list provided does not show all benefits. For more information, please contact Provider Services at **833-731-2143**.

Covered and Noncovered Services

Covered Services: Home and Community Based Services (HCBS)

Covered service: HCBS	Coverage limits
1915 (c) services (AIDS/HIV, Brain Injury, Children’s Mental Health, Elderly, Health and Disability, Intellectual Disability, Physical Disability)	Must meet Home and Community-Based Services waiver eligibility level of care criteria. Providers may reference the IME’s HCBS Provider Manual at https://dhs.iowa.gov/sites/default/files/HCBS.pdf for required covered services and minimum coverage limits.
1915 (i) Habilitation services	Must meet Habilitation needs-based eligibility criteria. Providers may reference the IME’s Habilitation Provider Manual at http://dhs.iowa.gov/sites/default/files/Habilitation.pdf for required covered services and minimum coverage limits.

The list provided does not show all benefits. For more information, please contact Provider Services at **833-731-2143**.

Covered and Noncovered Services

Chiropractic Services

For chiropractic services, Wellpoint will comply with the Iowa Department of Health and Human Services provider manual located at <http://dhs.iowa.gov/sites/default/files/Chiropr.pdf>. This includes that benefit limits are based off of a rolling vs calendar year.

Covered and Noncovered Services

Covered Services: Value-Added Services

Wellpoint believes by offering expanded programs and services, we provide opportunities to help care for the whole person and better address the specific needs for each segment of the population. To help care for the whole person and address the specific needs for each population segment, Wellpoint has developed benefits that will enhance care, promote healthier outcomes, and increase member satisfaction. For a description of the value-added services, please see **Appendix A**.

Member Choice:

- Fresh Food Connect
- Baby essentials
- Asthma relief toolkit
- Personal care and hygiene supplies
- Assistive devices and wheelchair accessories

Access:

- Transportation essentials
- Digital mental health toolkit
- Smartphone Member Connect
- Digital library membership and E-reader

Safety:

- Carpet cleaning services
- Home delivered meals

- Healthy lifestyle aids
- Dental hygiene kits

Independence:

- Employment support package
- Home essentials
- Nursing support package
- Sensory products

Responsibility:

- Tutorial services
- Summer reading benefit
- Healthy Kids Healthy Choices
- Healthy Adults Healthy Results
- Community Resource Link

Covered and Noncovered Services

Covered Services: Tobacco Cessation

Provider Help Desk: **855-712-0104**
 Prior Authorization of Benefits Center: **800-601-4829**
 Member Services: **833-731-2140**

Wellpoint members have two great benefits to assist with smoking cessation. 1) *Wellpoint smoking cessation program* and 2) *Iowa Medicaid Pharmacy Benefit*.

1. Wellpoint Smoking Cessation Program

The Wellpoint Smoking Cessation Program is a great place to start. A member can enroll with Wellpoint’s smoking cessation program which offers Nicotine Replacement Therapy (NRT) and counseling. If a member is participating with Wellpoint’s smoking cessation program administered by National Jewish Health (NJH), no Prior Authorization (PA) is required.

To help a member enroll with the Wellpoint Smoking Cessation Program:

The member can self-refer by calling Member Services at **833-731-2140**. The provider can also refer the member by calling Provider Services at **833-731-2143**.

What happens when a member is referred to the Wellpoint Smoking Cessation Program?

- a) Wellpoint confirms member enrollment and the member’s information is passed along to Wellpoint’s vendor, National Jewish Health (NJH). NJH contacts the member within one business day of receiving the referral. Three attempts are made to reach the member. If the member is reached, counseling begins. After completion of the first call, the member is eligible for NRT product.
- b) If the member wants NRT, NJH conducts a medical screen for contraindications. If contraindication is indicated, NJH sends provider consent form to provider. The provider completes the form and returns it to NJH as indicated on consent form (via fax to (888) 827-7057 or mail Real Solutions Tobacco Cessation Program by Wellpoint c/o National Jewish Health 1400 Jackson St., S117A Denver, CO 80206).
- c) If the provider approved use of NRT or the member does not have any contraindications, NJH ships a 28-day supply of NRT directly to member’s home. Under this program the member is allowed up to a two months’ supply of patches, lozenges, or gum.

2. **Iowa Medicaid pharmacy benefit (oral and NRT products) provided at a retail pharmacy:** Nicotine Replacement Therapy (NRT) and Oral Smoking Cessation Therapy products are covered under the pharmacy benefit. These smoking cessation products may have a preferred or non-preferred status on the [Preferred Drug List \(PDL\)](#)¹. Non-preferred products will be subject to Non-Preferred Drug PA criteria. Pharmacists that are enrolled with Fee for Service and have a State Medicaid ID may prescribe NRT and Oral Smoking Cessation Therapy.

Smoking Cessation Products will be available with the following Prospective Drug Utilization Review (ProDUR) edits:

1. Therapy Duration
 - i. NRT – 24 weeks combined therapy within a twelve-month period.
 - b. Oral Smoking Cessation Therapy – 24 weeks therapy within a twelve-month period.
2. Quantity Limits
 - a. NRT (4-week supply)
 - i. Nicotine Patches – one unit per day
 - ii. Nicotine Gum – 330 pieces
 - iii. Nicotine Lozenge – 288 lozenges
 - iv. Nicotine Inhaler – 336 inhalers
 - v. Nicotine Nasal Spray – 80 mls
 - b. Oral Smoking Cessation Therapy
 - i. Bupropion (for smoking cessation) – 2 tablets per day
 - ii. Chantix – 2 tablets per day
 - iii. Chantix Starter Pak – 53 tablets per 28 days
3. Age Edit – Payable for members 18 years of age and older

In addition to the smoking cessation products, providers should encourage members to seek additional assistance for this behavior change through individual, group, and telephone (Quitline) counseling.

- a. Under the retail pharmacy program the member may receive NRT or smoking cessation oral products as defined by the State's [Preferred Drug List](#)¹. The smoking cessation non-preferred products require a PA in which a provider may call Wellpoint at **833-731-2143**. Submit a new prior authorization at www.covermyeds.com or by fax to **844-512-9004**. Wellpoint's Pharmacy PA forms are located at <https://providers.wellpoint.com/QuickTools/Pages/Iowa-PriorAuth.aspx>. This process allows the member to pick up the prescription at a retail pharmacy if the non-preferred PA is approved.

Covered and Noncovered Services

Covered Services: Healthy Rewards Program

The Wellpoint Healthy Rewards program rewards members for doing things that are good for their health. Members can earn \$10-\$30, which is loaded to a Healthy Rewards card and can be used to purchase approved items at specific retailers near them.

Members must enroll in the program by calling **877-868-2004** or visiting <https://www.wellpoint.com/ia/medicaid/benefits/healthy-rewards.html>. The website lists the current rewards and includes details about the rules for each reward. Incentives and retailers are subject to change.

¹ http://www.iowamedicaidpdl.com/preferred_drug_lists

To help you in your practice, most of our Healthy Rewards activities are tied to HEDIS® scores and health initiatives. We offer incentives for screenings, diabetic management, behavioral health medication management, smoking cessation, maternal/child exams, wellness visits and vaccines. For a current list of all incentives, please log on to the secure provider website or contact your Wellpoint representative.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Covered and Noncovered Services

State-Covered Services

Some services are covered by the state instead of Wellpoint. These services are labelled as *carved-out services*. Although Wellpoint does not cover these services, providers and specialists must provide all required referrals and assist in setting up these services. These include the following:

- Services included in the PACE program
- Dental services provided outside of a hospital setting
- Money Follows the Person (MFP) grant services
- Services provided in an Iowa veteran's home
- School-based services provided by the area's education agencies or local education agencies
- Services for members over the age of 21 and under the age of 65 in a state mental institution.

For details on how and where to access these services, members can call the Iowa Medicaid Enterprise Member Services Unit toll free at 1-800-338-8366, Monday-Friday from 8 a.m.-5 p.m. Central time.

Covered and Noncovered Services

Noncovered Services

Wellpoint does not cover the following services:

- Care provided outside the United States, Canada, and Mexico, including emergency services
 - Wellpoint reimburses for emergency services provided to members in Canada or Mexico; however, payment for such services must be made to a financial institution or entity located within the United States. Nonemergency services in Canada or Mexico may be covered by Wellpoint per precertification policies, provided the financial institution receiving payment is located within the United States.
- Cosmetic surgery, including tattoo removal and ear lobe repair
- Experimental or investigational procedures
- Services that are not medically necessary
- Sex change surgery or treatments
- Surgery or drugs to enhance fertility

Noncovered services also include any instance when the precertification for a service was not granted, or the service was provided before precertification was given.

Covered and Noncovered Services

Pharmacy

Pharmaceutical management procedures are a crucial part of the pharmacy program. These procedures promote and ensure the utilization of clinically appropriate drugs to improve the health and well-being of our members.

Violating the Pain Management Contract. A Pain Management Contract is a written agreement between a provider and member that the member will not misrepresent his or her need for medication. If the contract is violated, the provider has the right to drop the member from his or her practice.

Covered and Noncovered Services

Services Requiring Precertification

Services requiring precertification include, but are not limited to the following:

- Air ambulance
- Behavioral health (All inpatient, some outpatient services, in-home therapy services and psychological testing require precertification; for specialist referrals and precertification, call **833-731-2143**.)
- Circumcision (Wellpoint covers routine circumcision without authorization up to 12 months of age. After 12 months of age, medical necessity review is required)
- Durable medical equipment (DME) and durable medical supplies (DMS)
- Genetic testing (except routine amniocentesis and prenatal testing)
- Home healthcare services (Electronic visit verification required)
- Hyperbaric oxygen therapy (no coverage for use of equipment)
- Infusion/injection therapy
- Inpatient hospital services
- Inpatient surgeries and procedures
- Outpatient surgeries and procedures
- Pharmacy
- Physician services (Referrals to out-of-network specialists require precertification.)
- Radiology services
- Spinal surgeries (lumbar fusion, disc excision and decompression surgery)
- Therapy services, including physical, occupational and speech therapies
- Transplant services
- Vision (Most routine vision services do not require precertification. If you have questions or need clarification, call Superior Vision Provider Services at **866-819-4298**).
- Nursing facility – special population (in other words, skilled preapproval) for out-of-state placement

For information concerning precertification, select the **Precertification** tab on the left side of our **Providers** page at <https://providers.wellpoint.com/ia>.

Covered and Noncovered Services

Dental Services

Wellpoint covers all medically necessary charges related to dental procedures provided in a hospital setting. Dental service providers outside of a hospital setting are covered by Delta Dental of Iowa and MCNA Dental. Professional services provided both inside and outside of a hospital setting are the responsibility of Delta Dental of Iowa or MCNA Dental.

Delta Dental of Iowa:

800-544-0718 (toll-free)

515-261-5500 (local)

888-287-7312 (TDD)

MCNA Dental:

855-247-6262 (toll-free)

800-735-2942 (TTY)

Wellpoint may provide coverage for services related to anesthesia and hospitalization for dental procedures for members for the below procedures (including, but not limited to):

- Genioplasty
- Augmentation, mandibular body, or angle; prosthetic material
- Augmentation, mandibular body, or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
- Reconstruction midface, LeFort I (includes codes 21141, 21142, 21143, 21145, 21146, 21147)
- Reconstruction midface, LeFort II
- Reconstruction midface, LeFort III
- Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)
- Reconstruction of mandibular rami (includes codes 21193, 21194, 21195, 21196)
- Osteotomy, mandible, segmental
- Osteotomy, mandible, segmental; with genioglossus advancement
- Osteotomy, maxilla, segmental (for example, Wassmund or Schuchard)
- Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
- Osteoplasty, facial bones; reduction
- Graft, bone; nasal, maxillary, or malar areas (includes obtaining graft)
- Graft, bone; mandible (includes obtaining graft)
- Reconstruction of mandible, extraoral, with transosteal bone plate (for example, mandibular staple bone plate)
- Reconstruction of mandible or maxilla, subperiosteal implant
- Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (for example, for hemifacial microsomia)
- Reconstruction of mandible or maxilla, endosteal implant (for example, blade, cylinder)
- Osteoplasty, for orthognathic deformities
- Osteotomy; mandibular rami
- Osteotomy; mandibular rami with bone graft; includes obtaining the graft
- Osteotomy; segmented or subapical
- Osteotomy; body of mandible
- LeFort I (maxilla, total/segmented)
- LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion); without/with bone graft
- Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla, autogenous or nonautogenous, by report
- Synthetic graft, mandible, or facial bones, by report
- Implant, mandible for augmentation purposes (excluding alveolar ridge), by report
- Reconstruction of mandibular rami, horizontal, vertical, C or L osteotomy; without bone graft
- Reconstruction of mandibular rami, horizontal, vertical, C or L osteotomy; with bone graft
- Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
- Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
- Osteotomy, mandible segmental
- Osteotomy, mandible, segmental; with genioglossus advancement
- Osteotomy, maxilla, segmental (for example, Wassmund or Schuchardt)
- Hyoid myotomy and suspension
- Palatopharyngoplasty (for example, uvulopalatopharyngoplasty, uvulopharyngoplasty)
- Osteoplasty, for orthognathic deformities
- Osteotomy, mandibular rami
- Osteotomy, mandibular rami with bone graft; includes obtaining the graft
- Osteotomy, segmented or subapical
- Osteotomy, body of mandible

- LeFort I (maxilla total, segmented)
- Arthrocentesis, aspiration and/or injection, intermediate joint, or bursa (for example, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance
- Arthrocentesis, aspiration and/or injection, intermediate joint, or bursa (for example, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting
- Arthrotomy, temporomandibular joint
- Condylectomy, temporomandibular joint (separate procedure)
- Meniscectomy, partial or complete, temporomandibular joint (separate procedure)
- Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (in other words, general or monitored anesthesia care)
- Application of interdental fixation device for conditions other than fracture or dislocation, includes removal
- Injection procedure for temporomandibular joint arthrography
- Graft, bone; nasal, maxillary, or malar areas (includes obtaining graft)
- Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)
- Arthroplasty, temporomandibular joint, with allograft
- Arthroplasty, temporomandibular joint, with prosthetic joint replacement
- Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)
- Arthroscopy, temporomandibular joint, surgical
- Open reduction of dislocation
- Closed reduction of dislocation
- Manipulation under anesthesia
- Condylectomy
- Surgical discectomy, with/without implant
- Disc repair
- Synovectomy
- Myotomy
- Joint reconstruction
- Arthrotomy
- Arthroplasty
- Arthrocentesis
- Nonarthroscopic lysis and lavage
- Arthroscopy- surgical: lavage and lysis of adhesions
- Arthroscopy- surgical: disc repositioning and stabilization
- Arthroscopy- surgical: synovectomy
- Arthroscopy- surgical: discectomy
- Arthroscopy- surgical: debridement
- Occlusal orthotic appliance
- Unspecified TMD therapy, by report
- Occlusal guards, by report
- Occlusion analysis- mounted case
- Occlusal adjustment- limited
- Occlusal adjustment- complete

Covered and Noncovered Services

Vision Services

Wellpoint contracts with Superior Vision Benefit Management, Inc. to provide covered routine and emergency vision services. Wellpoint covers the following services when performed by a Superior Vision Care-contracted provider or with precertification from Superior Vision Care by an out-of-network provider:

- Emergency vision services (immediately if trauma or eye conditions have turned to life-threatening conditions)
- Routine vision services

To arrange for vision services, call Superior Vision Care at **866-819-4298** for Provider Services and **800-679-8901** for Member Services.

Covered and Noncovered Services

Nonemergent Transportation Services

Nonemergent transportation is a benefit managed by Access2Care for Wellpoint members enrolled in Iowa Medicaid. These services include the following:

- Bus and taxi rides for members needing help getting to medical appointments
- Special vehicle transportation for Wellpoint members in wheelchairs
- Reimbursement for the following items during periods of transportation and medical treatment:
 - Costs of members' meals
 - Lodging expenses
 - Car rental costs
 - Medically necessary escort's travel expenses (when an escort is required because of the member's needs)

Members should schedule nonemergent transportation a minimum of two days in advance.

To arrange nonemergent transportation services through Access2Care, call **844-544-1389** for reservations or **844-544-1390** for Ride Assist.

HCBS Waiver Transportation Services

The Elderly Waiver, Intellectual Disability Waiver, Physical Disability Waiver and Brain Injury Waiver have transportation as a covered service. To schedule transportation services for waiver members that have transportation authorized in their service plan.

- Facilities Line (Waiver Member Line): **888-630-4822**

The EDI form must be completed by the facility.

Note: Transportation as a waiver service is to assist waiver members in conducting business errands and essential shopping, to travel to and from work or day programs and to reduce social isolation. Providers cannot provide nonemergent transportation under a HCBS waiver as this is considered double billing.

To schedule transportation services, members can call the reservation line at **844-544-1389** or, to review a previously requested reservation, they can call Ride Assist at **844-544-1390**.

CHAPTER 5: LONG-TERM SERVICES AND SUPPORTS

Long-term Services and Supports

Overview

Our fundamental approach to long-term services and supports (LTSS) is founded on person-centered principles and practices to facilitate member and family driven services and supports that are responsive

and meaningful to evolving preferences, support needs and personal goals. We are dedicated to assisting all members in exploring service and support options to maximize community integration in alignment with their personal goals and the Olmstead Decision. Through this commitment, not only do we support members to succeed in communities of their choice, but we also partner with providers, stakeholders, and associations.

Iowa has seven HCBS waiver programs. The waiver programs are as follows:

- AIDS/HIV waiver
- Brain Injury waiver
- Children’s Mental Health waiver
- Elderly waiver
- Health and Disability waiver
- Intellectual Disability waiver
- Physical Disability waiver

The Habilitation Services program, administered by our Behavioral Health department, is also available under CMS waiver authority 1915(i); applicants must meet the needs-based eligibility criteria.

Below is more information on each program.

Long-term Services and Supports

Home and Community Based Service Descriptions

AIDS/HIV Waiver

The AIDS/HIV waiver offers services for those who have been diagnosed with AIDS or HIV. Services include:

- Adult day care
- Consumer Choice Option (CCO)
- Consumer-directed attendant care (CDAC)
- Counseling services
- Home-delivered meals
- Home health aide
- Homemaker
- Nursing
- Respite

Brain Injury Waiver

The Brain Injury waiver offers services for those that have been diagnosed with a brain injury. Members must be aged at least one month; there is no age maximum for this waiver. Services include:

- Adult day care
- Behavioral programming
- CCO
- CDAC
- Family counseling and training
- Home and vehicle modification
- Interim medical monitoring and treatment
- Personal emergency response
- Prevocational services
- Respite
- Specialized medical equipment
- Supported community living
- Supported employment
- Transportation

Children’s Mental Health Waiver (administered by our Behavioral Health department)

The Children’s Mental Health waiver offers services for children who have been diagnosed with serious emotional disturbance. Services include:

- Environmental modifications and adaptive devices
- Family and community support services
- In-home family therapy
- Respite

Elderly Waiver

The Elderly waiver provides services for elderly persons. Individuals must be at least 65 years of age for this waiver. Some of the services that members may receive if there is a need include:

- Adult day care
- Assistive devices
- Assisted living
- CCO
- Chore Assistance
- CDAC
- Home and vehicle modification
- Home-delivered meals
- Home health aide
- Homemaker
- Mental health outreach
- Nursing
- Nutritional counseling
- Personal emergency response
- Respite
- Senior companion
- Transportation

Health and Disability Waiver

The Health and Disability waiver provides services for persons who are blind or disabled. The services that a member may receive if there is a need include:

- Adult day care
- CCO
- CDAC
- Counseling
- Home-delivered meals
- Home health aide
- Homemaker services
- IMMT
- Home and vehicle modification
- Nursing
- Nutritional counseling
- Personal emergency response
- Respite

Intellectual Disability Waiver

The Intellectual Disability waiver provides services for persons who have been diagnosed with intellectual disability. The services that a member may receive if there is a need include:

- Adult day care
- Personal emergency response
- CCO
- Consumer-directed attendant care (CDAC)
- Prevocational services
- Day habilitation
- Respite services
- Home and vehicle modification
- Supported community living
- Home health aide
- Supported community living-residential based
- Interim medical monitoring and treatment
- Supported employment
- Nursing
- Transportation

Physical Disability Waiver

The Physical Disability waiver provides services for persons who have a physically disability determination. An applicant must be at least 18 years of age, but less than 65 years of age. The services that a member may receive if there is a need include:

- CCO
- Consumer-directed attendant care (CDAC)
- Home and vehicle modification
- Personal emergency response
- Specialized medical equipment
- Transportation

Habilitation Services Program (administered by our Behavioral Health department)

The Habilitation Services program is designed to assist participants in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. The services that a member may receive if there is a need include:

- Home-based habilitation
- Day habilitation
- Prevocational services
- Supported employment

Long-term Services and Supports

Facility Information

Nursing Facilities and Skilled Nursing Facilities

Nursing facilities provide 24-hour care for individuals who need nursing or skilled nursing care and meet nursing facility/intermediate care facility level of care. The facility will provide or assist a member with access to:

- Physician services
- Nursing services
- Dietary services
- Pharmacy services
- Social services and activities
- Specialized rehabilitation services (including but not limited to physical therapy, speech language pathology and occupational therapy)
- Laboratory services
- Radiology and other diagnostic services
- Durable medical equipment (DME) as ordered by a physician
 - Note: DME provided in a NF/SNF is the responsibility of the facility and not payable separately. However, payment will be made for the following exceptions:
 - Catheter (indwelling Foley)
 - Colostomy and ileostomy appliances
 - Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape
 - Diabetic supplies (disposable or retractable needles and syringes, test-tape, clinitest tablets and clinistix)
 - Disposable catheterization trays or sets (sterile)
 - Disposable bladder irrigation trays or sets (sterile)
 - Disposable saline enemas (for example, sodium phosphate type)
 - Hearing aid batteries
 - Orthotic and prosthetic services, including augmentative communication devices
 - Orthopedic shoes
 - Repair of member-owned equipment
 - Oxygen services
 - Therapeutic shoes for diabetics
 - Wheelchairs, when the wheelchair is a customized wheelchair (Note: A customized wheelchair is one that is designed, assembled, modified, or constructed for the specific member in whole or in part, based on the member's condition, measurements, and needs. The member's condition must necessitate the regular use of a wheelchair on a long-term basis to enable independent mobility within the facility - prior authorization is required.)

Hospice is a covered benefit in a nursing facility, as the nursing facility can be considered the member's residence. When the person does reside in a nursing facility, if all of the following conditions are met:

- The resident is terminally ill
- The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.
- The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care, and the facility agrees to provide room and board to the resident.

It's not a requirement that the care provided is under the immediate direction of either the facility or the resident's personal physician.

Intermediate Care Facilities for Persons with Intellectual Disabilities

Intermediate care facilities for persons with intellectual disabilities (ICF/ID) provide 24-hour active treatment and services for persons with intellectual disabilities and other related conditions. The facility will provide or assist a member with access to the following:

- Dietetic services
- Nursing services
- Laboratory services
- Pharmacy services
- Behavior management services
- Specialized rehabilitation services (including but not limited to physical therapy, speech language pathology and occupational therapy)
- Laboratory services
- Radiology and other diagnostic services
- Durable medical equipment (DME) as ordered by a physician
 - Note: DME provided in an ICF/ID is the responsibility of the facility and not payable separately. However, payment will be made for the following exceptions:
 - Catheter (indwelling Foley)
 - Colostomy and ileostomy appliances
 - Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape
 - Diabetic supplies (disposable or retractable needles and syringes, test-tape, clinitest tablets and clinistix)
 - Disposable catheterization trays or sets (sterile)
 - Disposable bladder irrigation trays or sets (sterile)
 - Disposable saline enemas (for example, sodium phosphate type)
 - Hearing aid batteries
 - Orthotic and prosthetic services, including augmentative communication devices
 - Orthopedic shoes
 - Repair of member-owned equipment
 - Oxygen services
 - Therapeutic shoes for diabetics
 - Wheelchairs

Hospice is a covered benefit for ICF/IDs.

Long-term Services and Supports

Precertification Requirements

Precertification, sometimes referred to as prior authorization (PA), is required for skilled nursing facility (SNF) and LTSS services for which Medicaid is the primary payer, medical and nonmedical absences, and reserve days (leaves of absence).

Providers must submit precertification requests with all supporting documentation immediately upon identifying a SNF admission or at least 72 hours prior to the scheduled admission. Failure to comply with notification rules will result in an administrative denial.

Administrative Denial

An administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admission, lack of precertification or failure by the provider to submit clinical information when requested.

Disputes for administrative denials must address the reason for the denial (in other words, why precertification was not obtained or why clinical information was not submitted). If Wellpoint overturns its administrative decision, the case will be reviewed for medical necessity. If approved, either the claim will be reprocessed, or the requestor will be notified of the action that needs to be taken.

So, we can ensure appropriate discharge planning, you must provide notice to Wellpoint via our precertification process when the following events occur:

- Admission to an acute care or behavioral healthcare facility
- Admission to hospice

For members that enter the facility as “Medicaid Pending,” please request precertification as soon as the state approves the Medicaid eligibility and the member’s eligibility is reflected on the Wellpoint website. The Wellpoint website and your Provider Manual list those services that require precertification and notification. Our provider website also houses evidence-based criteria we use to complete precertification and concurrent reviews.

The precertification request can be submitted by:

- Faxing the request to **844-556-6121**
- Calling Care Management at **833-731-2143**

Providers can obtain the status of a precertification request by visiting our provider website at <https://providers.wellpoint.com/ia>.

Routine precertification requests will be approved or denied within 14 days of the request. Urgent precertification requests as determined by the treating provider will be approved or denied within 72 hours of the request.

If a provider asks for prior approval of a service and a decision is made that the service is not medically needed, the provider will be able to discuss this decision with Wellpoint. If the decision remains the same, the member, member’s approved representative or the provider (on the member’s behalf and with their written consent) can appeal the decision. See the section on [Appeals](#).

Dates of Service –April 1, 2017, and forward

After the first year, if services were approved before the member’s coverage started with Wellpoint, those services will remain approved for the first 30 days the member is enrolled in Wellpoint, whether an in-network or out-of-network provider asked for the approval.

After the first 30 days the member is enrolled in Wellpoint: If the member wishes to keep receiving services from an out-of-network provider, or if the services require prior approval, the provider must ask Wellpoint to approve them before the member can receive these services.

Long-term Services and Supports

Person-Centered Case Management Model

Our approach utilizes regional case management teams with multifunctional expertise to assist community-based case managers, members, families, representatives, and members’ interdisciplinary teams in the development of person-centered service plans. This model serves as an ongoing resource to

meet the varying needs of members to support health, well-being, independence, and community living in the most integrated setting such as employment and participation in community activities. Our case management model involves a continuous process of communicating, coordinating, delivering, monitoring, and assessing services and supports and progress toward achieving member goals to optimize person-centered service delivery.

The core components of the case management model will include:

- Matching our members to the right community-based case manager by carefully considering member diagnoses, complexity of medical and/or behavioral health conditions and intensity of service and support needs and identifying a community-based case manager on our team with appropriate experience, knowledge, and skills.
- Person-centered planning through partnership and collaboration with members, their natural supports and member-identified interdisciplinary teams who will consider members holistically using discovery and assessment results to make sure that medical, behavioral, social, and educational needs are addressed to maximize health, well-being, and independence in the development of a comprehensive, person-centered service plan.
- Coordination and collaboration across member systems of care to align resources based on need, integrate services, reduce duplication of efforts, improve continuity of care and services, and increase cost efficiencies.
- The continuous process of delivering, monitoring, and assessing interventions designed to meet the members' goals defined in person-centered service plans, as well as other care/treatment plans as part of their system of care to maximize individual health, well-being, and quality of life.
- Technology and innovations to improve member and natural support experiences expand the tools to enable collaboration among multiple stakeholders, enhance our members' ability to self-direct services and supports, provide real-time member information, and improve provider and system performance.
- Ongoing stakeholder engagement at the member and system levels to build consensus, innovative solutions related to issues and concerns, and facilitate continuous program improvements to better serve members.

Supporting Member Education and Informed Choices

A core responsibility within our model is embracing person-centered service planning. We communicate an array of options available to our members, supporting and promoting their informed decision-making and their well-being. Our approach promotes member engagement in all aspects of care and services, including interdisciplinary team development, use of supports, and choice of specific providers. From our experience, we know fully informed members make effective decisions that promote health and safety and are suited to their preferences. This is a cornerstone to improving member experience, adherence to the service plans and overall outcomes.

Long-Term Services and Supports

Initial Discovery, Assessments, and Informed Consent

Once a member has enrolled in our LTSS program, our Community-Based Case Management team contacts the member and begins the educational process regarding our role, program services, benefits, resources, and options available to promote integrated coordination. During this conversation, the member receives an overview of the core service planning and case management processes including all applicable assessments. This comprehensive orientation allows us to align with the member on his or her preferences and confirm the member's interest in LTSS.

During face-to-face assessments, we engage members, their interdisciplinary team, member-selected participants, and natural supports, including family, in a highly individualized conversation to identify needs and preferences for building out their service plan. While outlining the benefits included in the LTSS

program, we remind members of their right to choose their interdisciplinary team members, case managers and services including the option to self-direct their services through the CCO. If members choose the CCO, we provide training and administrative support to bolster member confidence in self-directing while preventing gaps in services. Wellpoint helps ensure all processes, such as selecting providers and developing a service plan, reflect and honor the member's strengths, goals, and preferences.

Long-term Services and Supports

Person-centered Service Planning

Our community-based case managers work collaboratively with members to develop a service plan that emphasizes and supports member choice and individual goals. During service plan development, we continuously engage members and their family or representatives about needs and preferences. Our community-based case managers work with members, their family or representatives and their providers to identify all available services and supports, including but not limited to the following:

- Covered benefits
- Community and state agency resources
- Value-added services
- Health insurance coverage options (such as Medicare and natural supports)

Our case managers reside in the same communities as our members and therefore have detailed knowledge about the community, local provider network, other community resources available, and Medicare, Medicaid, and LTSS benefits. We train our case managers in cultural competency to help assure that members have every opportunity to comfortably express preferences and communicate with their case manager.

Long-term Services and Supports

Incorporating Member Choice in Funding Decisions

As members request adjustments to their service plans based on changing circumstances or new information, our community-based case managers honor their preferences, unless a requested service is unavailable. If a service could potentially pose a health or safety issue or is not a covered benefit, the community-based case manager will work to educate the member and revise the service plan to address all concerns and preferences.

Our community-based case managers ensure all approved services are consistent with the member's level of care and waiver designation as applicable. Throughout this process, we will put our members' needs and preferences first and will not hesitate to deploy creative strategies to help support our members.

Long-term Services and Supports

Identification

Wellpoint has developed operational protocols, policies, and procedures to promote early identification of member service and support gaps that may signal emerging needs that are better addressed through LTSS programs to enhance member health, well-being, and independence. All community-based case managers are trained to recognize indicators that suggest a member may benefit from and meet LTSS program enrollment criteria. Wellpoint will train all community-based case managers on LTSS eligibility criteria established by Iowa Medicaid Enterprise (IME) so timely action is taken in coordination with HHS.

Our community-based case managers engage and inform members regarding all available LTSS options. After conducting initial assessments for interested members using a state-approved tool, Wellpoint will refer all potentially eligible members to the state or its designee for level of care determination. Through

this process, we are better able to align services and supports with member strengths, needs and preferences to accommodate the periods of transition that all people and families experience.

Long-term Services and Supports

Processing Referrals to LTSS Services

Our “no wrong door” approach provides a single point of entry for LTSS program referrals from end to end. All member-facing staff accepts self-referrals from members or referrals from their families, support networks, service providers or health professionals. Training includes respect for the member’s own advocacy and self-direction, active listening skills, how to gather situational facts, accurate documentation of essential information for follow-up, and proper routing of requests to the LTSS case specialist or the assigned case manager or care coordinator. In each instance, staff will work in consultation with the case management team manager to link the member with a community-based case manager. The member’s case manager or care coordinator will work in tandem with the newly assigned community-based case manager to facilitate continuity and integration of all service and support needs in the process described below.

In the event that a member has not been linked to a specific case manager or care coordinator, the newly assigned case manager will consult and engage team members with relevant expertise throughout the process detailed below:

- Regardless of the referral source, the assigned case manager will contact the member and, as appropriate, their family or representative to learn more about the member’s needs and concerns. The case manager will discuss the request and the required steps prior to LTSS program referral to the state or its designee. If the member has an established relationship with another case manager or care coordinator, he or she will facilitate the introductory call. The case manager will describe LTSS options and discuss interest in receiving LTSS. During the initial call, the case manager will also perform a brief telephonic screening to determine the level of urgency to prioritize both access to services and the face-to-face assessment.
- If it is determined that the member has an urgent need compromising health and safety as a result of a recent change in daily living circumstances or health-related conditions, the case manager will authorize medically necessary interim services and schedule and complete a face-to-face screening assessment no later than seven days from the date of referral.
- If the results of the telephonic screening indicate the need for LTSS is not urgent, the case manager will work with the member and as appropriate the family or representative to schedule and complete the face-to-face assessment no later than 30 days from the date of referral. Referrals received after-hours will be routed through our 24/7 member call center. The call center representative will have access to our core operating system and will enter a detailed message that tasks the member’s community-based case manager for follow up with the member the next business day. When indicated, the call center representative will also be able to connect the member to an on-call community-based case manager after hours. If members need immediate assistance, their call will be referred to Wellpoint on Call (our 24/7 on-call nurse service) or 911 (if necessary).
- For members in crisis, a referral will be made immediately to emergency services. In the event of a medical emergency, our members are encouraged to call 911; our call center representatives will assist as requested to facilitate the call.

Ongoing Identification of Members Who May Be Eligible for LTSS

In addition to processing all inbound referrals, our person-centered approach uses an array of ongoing discovery and assessment strategies to facilitate proactive identification of members who currently need additional resources available through LTSS programs. Additionally, we are able to identify risks factors that signal signs of instability in life circumstances such as physical and/or behavioral health conditions that may result in a change that leads to LTSS eligibility. Our comprehensive approach emphasizes an integrated

model that utilizes our collective expertise of our health plan employees and the interdisciplinary team to develop a holistic view of each member's evolving life experiences and service and support needs across physical, behavioral health and social service delivery systems.

Through internal and external collaboration and coordination we are able to maximize available state, regional and community resources to eliminate service and support gaps promoting member health, wellbeing, and independence. For example, our physical health, behavioral health and LTSS leadership and teams are co-located to facilitate an internal referral process to address unmet needs. As behavioral health case managers become aware of changing needs with a member, they can consult and refer the member to their LTSS colleagues to provide all needed supports. Additionally, the teams conduct a variety of internal collaborative case rounds to build immediate and long-range solutions for our members with the most complex needs, including integrated rounds for members with co-occurring conditions, complex case rounds for LTSS members with medically fragile conditions and nursing facility reintegration rounds for members we are assisting in repatriating to the community. Our case managers navigate delivery systems and coordinate with our state and regional partners, contracted providers, and community resources to link members to needed services and supports that are brainstormed through our collaborative processes.

Long-term Services and Supports

Transition and Discharge Planning

When LTSS is necessary, Wellpoint works with the provider and member (or their designated representative) to plan the transition or discharge to an appropriate setting for extended services. These services can be delivered in a nonhospital facility such as:

- Nursing facilities and skilled nursing facilities (NF/SNF).
- Respite care – in home or out of home.
- Home and Community Based Services (HCBS).
- Home healthcare program (in other words, home I.V. antibiotics).

When the member and family, together with the provider, identify medically necessary and appropriate services, Wellpoint will assist in providing a timely and effective plan that meets our member's needs and goals.

Discharge Planning

Wellpoint assists with discharge planning, either to the community or through a transfer to another facility, if the member or responsible party so requests. If the member or responsible party requests a discharge to the community, the care or service coordinator will:

- Collaborate with the skilled nursing facility (SNF) social worker to convene a planning conference with the SNF staff to identify all potential needs in the community.
- Facilitate a home visit to the residence where the member intends to move to assess environment, durable medical equipment (DME) and other needs upon discharge.
- Convene a discharge planning meeting with the member and family, using the data compiled through discussion with the SNF staff as well as a home visit, to identify member preferences and goals.
- Involve and collaborate with community organizations such as Mental Health and Disability Service Regions, Centers for Independent Living (CILs) or Area Agencies on Aging (AAAs) in this process to assist members as they transition to the community.
- Finalize and initiate execution of the transition plan.

Although our person-centered approach is driven by the member, the transition implementation is a joint effort between the SNF social worker and the Wellpoint community-based case manager.

Long-term Services and Supports

Responsibilities of the LTSS Provider

- All home- and community-based services will be provided in integrated settings. All facility-based providers and home health agencies must notify an Wellpoint case manager within 24 hours when a member dies, leaves the facility, or moves to a new residence or moves outside the service area or state.
- Participation in the member's interdisciplinary care team (ICT), dependent on the member's need and preference.
- Follow all federal rules and regulations as applicable.
- Provide regular updates related to the care of service delivered
- Participate in discharge planning

Long-term Services and Supports

Self-Direction (Consumer Choices Option and Consumer-Directed Attendant Care)

Consumer Choices Option (CCO) and Consumer-Directed Attendant Care (CDAC) are Home- and Community-Based (HCBS) options that allow individuals enrolled in most HCBS waivers more flexibility, choice, and control over how their services and supports are provided.

The programs give the member control over their Medicaid waiver dollars so they can develop a plan to meet their needs by directly hiring their own employees and/or purchasing other goods and services. An independent support broker (ISB) will help the CCO member develop a budget based on the monthly funds approved by their case manager. CDAC members receive support from individual or agency-based CDAC providers.

Member participation in consumer self-direction of HCBS is voluntary. Members may elect to participate in or withdraw from consumer direction of HCBS at any time without affecting their enrollment. To participate in the CCO program, members must live in the state of Iowa, be eligible for the HCBS waiver and complete the *Consumer-Directed Self-Assessment* form with their support broker and Wellpoint community-based case manager. Member responsibilities in CCO include:

- Choosing which services they want to be self-directed.
- Choosing whether to use an independent CCO provider or one affiliated with an agency.
- Developing a plan of care with the interdisciplinary team.
- Using the budget authorized in the service plan, establish service hours and employee payment rate.

Wellpoint will partner with Veridian Fiscal Solutions as the financial management service provider for the CCO program. Veridian will work with members to assist with providing information on their budget and coordination of payment to workers on the member's behalf.

To participate in the CDAC program, members must live in the state of Iowa, be eligible for the HCBS waiver and complete the CDAC agreement with their Wellpoint community-based case manager. Member responsibilities in CDAC include:

- Choosing whether to use an independent CDAC provider or one affiliated with an agency.
- Developing a plan of care with the interdisciplinary team.
- Completing the CDAC agreement, establishing service hours and payment rates, including signing it along with the provider and giving a copy to the community-based case manager.

CDAC can be for skilled and unskilled services. Unskilled services include help with normal daily life activities such as the following:

- Getting dressed and undressed

- Cleaning up after meals
- Getting into and out of bed
- Scheduling appointments
- Communicating with others
- Going to the doctor
- Fixing meals
- Handling money
- Taking a bath
- Shopping

Like the CCO program, the member may be in charge of hiring their own employees. The employee:

- Must be at least 18 years old.
- Can be a family member, friend, or neighbor.
- Cannot be the member's wife or husband.
- Cannot be the member's parent, stepparent, or guardian if the member is under 18 years old.

To learn more about the CCO program, visit the Iowa Medicaid web site at <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/consumer-choices-option>.

To learn more about the CDAC program, visit <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/cdac>.

For more information on Veridian Fiscal Solutions, visit their website at <https://www.veridianfiscalsolutions.org/cco>.

Long-term Services and Supports

Electronic Visit Verification

Electronic visit verification (EVV) is a telephone and computer-based system that electronically verifies when service visits occur and documents the precise time service begins and ends. The purpose of EVV is to verify individuals are receiving the services authorized for their support and for which the state or managed care plan is being billed.

Iowa is using a Managed Care implementation model for EVV. All MCOs are using the same vendor, CareBridge.

To Learn more about the EVV requirement, visit the Iowa Medicaid web site at <https://hhs.iowa.gov/programs/welcome-iowa-medicaid/current-projects/evv>.

Long-term Services and Supports

Client Participation

Wellpoint recognizes the unique challenges faced by HCBS and facility providers. Wellpoint works with providers to address when a member/family that is noncompliant in paying the client participation, including facilitating a transfer if the issue cannot be resolved. You may refer to the [Client Participation/Member Liability](#) section for more information on client participation.

The paragraphs below outline our plan for working with the provider and the member/family to resolve such issues.

1. The HCBS provider, facility administrator or office manager contacts the Wellpoint community-based case manager with details regarding the lack of payment of the client participation including:
 - The date the last payment was made.

- Discussions held with the member/family to date.
 - Correspondence between the member/family to date.
 - History of late and/or missed payments, if applicable.
 - Any knowledge of family dynamics, concerns regarding the responsible party, or other considerations.
2. An Wellpoint community-based case manager and the provider or nursing home social worker, if applicable, discuss the issue with the member, determine the barrier to payment and elicit cooperation:
 - The Wellpoint community-based case manager guides the discussion, including review of the obligation, potential impact to ongoing eligibility, and potential threat to continued services or residence at the current facility.
 - The Wellpoint community-based case manager screens for any potential misappropriation of funds by family or representative payee.
 3. The Wellpoint community-based case manager discusses the issue with the identified responsible party if the member is unable to engage in a discussion regarding payment of the client participation due to cognitive impairment or other disabilities.
 4. The Wellpoint community-based case manager, provider, or facility social worker will take action if concerns related to misappropriation of funds are raised or suspected, and may:
 - Refer the member to Adult Protective Services and/or law enforcement.
 - Submit a request to the Social Security Administration to change the representative payee status to the person of the member's choosing.
 - Engage additional family members.
 - Engage the Guardianship program to establish a conservator or guardian.
 5. The Wellpoint community-based case manager requests copies of the cancelled check or other bank document, and/or requests a copy of a receipt issued by the provider or facility for payment of liability if the member or responsible party asserts that the required liability has been paid. The community-based case manager will present evidence of payment to the provider or facility's business office and request confirmation that the issue is resolved. The Wellpoint community-based case manager will also engage the assigned Wellpoint LTSS Provider Relations consultant to work with the provider or SNF to improve its processes.
 6. Wellpoint will send correspondence that outlines the obligation to pay the client participation, potential impact to ongoing eligibility and potential threat to continued services or residence at the current facility if the responsible party is unresponsive and/or living out of the area.
 - The correspondence will be submitted to the state for review and approval as required.
 - The correspondence will provide the responsible party with an opportunity to dispute the allegation and provide evidence of payment.
 7. Wellpoint will take the following actions in conjunction with the provider or facility social worker if client participation remains unsatisfied after the first rounds of discussion or correspondence, and:
 - Convene a formal meeting with the provider or facility leadership, member and/or responsible party, Adult Protective Services representative, other representative of the state as applicable and other parties key to the discussion.
 - Review the patient liability obligation and potential consequences of continued nonpayment.
 - Attempt to resolve the payment gap with a mutually agreed-upon plan.
 - Explain options if the member or responsible party wishes to pursue transfer to another provider or facility or discharge to the community.
 8. Wellpoint, together with the provider or facility, will engage in any of the following as may be applicable if the client participation continues to go unsatisfied:
 - Update and escalate intervention by Adult Protective Services or law enforcement.
 - Refer to the state Medicaid Fraud Control Unit or other eligibility of fraud management staff that the state may designate.
 - Escalate engagement to facilitate a change to representative payee, power of attorney or guardian.

- Escalate appointment of a volunteer guardian or conservator.
- Initiate discharge planning.

Long-term Services and Supports

Nursing Facility Preadmission Screening and Resident Review

Prior to admission to a nursing facility and any time there is a significant change in status, members will receive a preadmission screening and resident review (PASRR) by the state or its designee. Wellpoint will work with the state or its designee responsible for implementation and oversight of the PASRR process. The PASRR process must be completed prior to a facility admission. Members entering a nursing facility must have a completed Level I PASRR Screening Tool. If positive, Wellpoint will ensure the Level II evaluation is completed by the state mental health and/or developmental authority.

If the Level II evaluation determines the member requires specialized services, the Wellpoint community-based case manager will ensure the nursing facility complies with federal PASRR requirements to provide, or arrange to provide, specialized services and all applicable Iowa law governing admission, transfer, and discharge policies. A copy of all PASRR documentation (Level I Screening tool and Level II Evaluation, if required) will be maintained in our clinical management system in the member's electronic medical record.

The Wellpoint community-based case manager will monitor members in accordance with contract visits and inform members of their right to return to the community. The Wellpoint community-based case manager will also ensure that members have the option to receive HCBS in more than one residential setting appropriate to their needs and will educate members on the available settings.

Long-term Services and Supports (LTSS)

LTSS Continuity of Care

LTSS-Specific Services

Upon enrollment with Wellpoint:

- LTSS services will be authorized until a new comprehensive needs assessment is completed or up to 90 calendar days in the absence of a completed assessment.
- Active LTSS members will continue to receive services in accordance with their h approved service plan, including any nonparticipating providers, until an assessment and service plan is completed and either agreed upon by the member or resolved through the appeals or fair hearing process and implemented.
- LTSS services will not be reduced, modified, or terminated in the absence of a new/up-to-date assessment of needs that would support any service reduction, modification, or termination.
- Wellpoint will extend the authorization of LTSS from a noncontracted provider as necessary to ensure continuity of care, pending the provider's contracting with Wellpoint, or the member's transition to a contracted provider.
- Wellpoint will facilitate a seamless transition to new services and/or providers, as applicable, in the plan of care/service plan developed by Wellpoint without any disruption in services.

Wellpoint will make every effort to engage the provider in the contracting process so the member may be able to continue with that same provider if the member so desires. The provider would be requested to meet the same qualifications as other providers in the network.

Wellpoint members using a residential provider at the time of enrollment will have continued access to that residential for up to one year, even on a non-network basis. Members cannot be made to move to another residential provider unless the following conditions are met:

- The member or his/her representative specifically requests to transition.

- The member or his/her representative provides written consent to the move, based on quality or other concerns raised by Wellpoint.

Any Wellpoint issues regarding the current residential provider's rate of reimbursement or contracted vs. noncontracted status will not be grounds for moving a member to another residential provider. If the residential provider is a noncontracted provider, Wellpoint may:

- Authorize continuation of the services pending contracting with the provider.
- Authorize continuation of the services for at least 30 days pending facilitation of the member's transition to a contracted provider, subject to the member's agreement with such transition.
- Continue to reimburse services from the noncontracted providers.

If a member is transitioned to a contracted residential provider, Wellpoint shall extend the authorization of services with the noncontracted provider beyond the minimum 30-day requirement as necessary to ensure continuity of care and the member's seamless transition to a new provider.

Wellpoint will permit a member with a dual diagnosis of a behavioral health condition and developmental disorder to remain with their residential provider for at least one year or with their inpatient psychiatric provider, regardless of network status, as long as the services continue to be medically necessary.

When a provider is not in-network, Wellpoint shall permit members with a dual diagnosis of a developmental disorder and a behavioral health condition to remain with their providers of all outpatient behavioral health services for a minimum of three months as long as the services continue to be medically necessary. Wellpoint would shorten this transition time frame only if/when that service provider is no longer available to serve the member or when a change in providers is requested in writing by the member or the member's representative.

Non-LTSS Specific Services

Upon enrollment with Wellpoint:

- Wellpoint will honor existing authorizations for covered benefits for a minimum of 90 calendar days, without regard to whether such services are being provided by contracted or noncontracted provider, when a member transitions to Wellpoint from another source of coverage.
- Existing authorizations will be honored for a minimum of 30 calendar days when a member transitions to Wellpoint from another source of coverage, without regard to whether services are being provided by contracted or noncontracted providers.
- Wellpoint will utilize processes to identify existing prior authorization of services at the time of the member's enrollment
- Wellpoint will allow a member who is receiving covered benefits from a non-network provider to continue accessing that provider. Wellpoint will make commercially reasonable attempts to contract with providers from whom an enrolled member is receiving ongoing care.

Long-term Services and Supports (LTSS)

Critical Incident Reporting and Management

We have a critical incident reporting and management system for incidents that occur in a home- and community-based long-term care services and supports delivery setting. As a participating Wellpoint provider, you'll be required to participate in critical incident reporting. Immediate action will be taken to assure the member is protected from further harm. Critical incidents will be tracked and presented to our Quality Improvement committee for review.

A critical incident, also known as a major incident, means an occurrence that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital.

2. Results in the death of any person.
3. Requires emergency mental health treatment for the member.
4. Requires the intervention of law enforcement.
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3.
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in 1, 2, or 3.
7. Involves a member's location being unknown by provider staff who are assigned protective oversight.

Providers must report critical incidents to Wellpoint in accordance with applicable requirements and as outlined in Article 3.7 of the Wellpoint Provider Agreement. The maximum time frame for reporting an incident to Wellpoint is 24 hours. The initial report of an incident within 24 hours may be submitted verbally, in which case the person, agency or entity making the initial report will submit a follow-up written report within 48 hours. A report must also be filed with the HHS through their Incident Management Provider Access system..

Effective July 1st, 2023, providers must report critical incidents in IMPA (Iowa Medicaid Portal Access).

Provider access and incident report completion instructions can be found at [IMPA - Iowa Medicaid Portal Access](#)

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Suspected abuse, neglect and exploitation of members who are adults must be immediately reported. Suspected brutality, abuse or neglect of members who are children must also be immediately reported. The HHS form cannot be used to report suspected child abuse and dependent adult abuse. Reports of suspected child abuse and dependent abuse must be made by calling the HHS Abuse Hotline at **800-362-2178**.

Providers must immediately (in other words, within 24 hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members. Providers with a critical incident must conduct an internal critical incident investigation and submit a report on the investigation by the end of the next business day. Wellpoint will 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 time frames. Providers must cooperate with any investigation conducted by Wellpoint or outside agencies (for example, the HHS, Adult Protective Services, Child Protective Services, and law enforcement).

Long-term Services and Supports (LTSS)

Nonemergency Medical Transportation (NEMT)

The following procedures are required for billing NEMT services:

Transportation Companies only Performing NEMT

Transportation companies that only perform NEMT services are required to contract with Access2Care to bill Access2Care and receive payment for services provided. Providers may contact Access2Care **888-644-3547**, for contract information.

Home- and Community-Based Services (HCBS) Waiver Service Providers that do not Provide Transportation Services

HCBS Waiver service providers that do not provide transportation services within their entity may use an entity contracted with Access2Care. Providers must use a service provider that is contracted with Access2Care, or the transportation services will not be reimbursed.

If an HCBS Waiver service provider, staff member, case worker or other eligible employee is transporting the member for nonmedical HCBS Waiver service errands, they may bill directly to Wellpoint based on their LTSS contract. The services must also be considered part of the member's person-centered plan.

HCBS Waiver Service Providers Providing Transportation Services

HCBS Waiver service providers with transportation services available within their entity must contract with Access2Care in order to be reimbursed for NEMT services. Providers may contact Access2Care at **888-644-3547**, for contract information.

All nonmedical HCBS Waiver services transportation provided should be billed directly to Access2Care based on their LTSS contract. The services must also be considered part of the member's person-centered plan. If the transport is for NEMT provided by staff, case workers or other eligible employees, they can be reimbursed on a per-mile basis. Providers would need to contact Access2Care at least one hour before transport and indicate the trip should be for mileage reimbursement.

Scheduling Ride Assistance for a Member

Providers assisting members in scheduling trips should contact Access2Care with at least two business days' notice for any single-day NEMT trip requests. Trips may be scheduled up to 30 days in advance. Same-day rides may be scheduled in certain situations. Urgent appointments may be scheduled on the same day through Access2Care. HCBS Waiver providers may contact Access2Care for same-day service for NEMT needs when those trips are in accordance with the member's person-centered plan.

Reservations can be made by calling Access2Care **844-544-1389** Monday through Friday, 7:30 a.m.-6 p.m. Central time. Please have member ID information and pickup and drop-off address locations ready when you call.

Providers assisting members with rides already scheduled can call Access2Care's Where's My Ride line at **844-544-1390**.

CHAPTER 6: BEHAVIORAL HEALTH SERVICES

Behavioral Health Services

Overview of Behavioral Health at Wellpoint

The mission of Wellpoint is to coordinate the physical and behavioral healthcare of members, offering a continuum of targeted interventions, education, and enhanced access to care to ensure improved outcomes and quality of life for Wellpoint members. Wellpoint works collaboratively with healthcare providers (in other words, Community Mental Health Centers (CMHCs), Iowa Department of Public Health (IDPH) Substance Use Disorder providers, waiver service providers and a variety of community agencies and resources) to meet the needs of members with mental health (MH) and substance use disorders (SUDs), including those participating in waiver programs.

Behavioral Health Services

Goals

The goals of the Wellpoint Behavioral Health program are to:

- Ensure adequacy of service availability and accessibility to eligible members.
- Assist members and providers to utilize the most appropriate, least restrictive medical and behavioral healthcare in the right place at the right time.
- Promote integration of the management and delivery of physical and behavioral health services to members.
- Achieve the Wellpoint quality initiatives, including those related to HEDIS NCQA and Iowa Department of Health and Human Services (Iowa HHS) performance requirements.
- Work with members, providers and community supports to provide tools and an environment that supports members towards their recovery and resiliency goals.

Behavioral Health Services

Values

The following values are incorporated into our policies and practices:

- Hope and respect for members and families, based on the knowledge that personally-valued recovery is possible
- A belief in member dignity and self-determination
- The encouragement to strengthen empowering relationships
- The elimination of stigma and discrimination

Behavioral Health Services

Principles

Wellpoint adheres to the following principles related to the delivery of behavioral health services:

- Members are allowed to choose their behavioral health professional(s) to the fullest extent possible and appropriate.
- We support the involvement of the member, and those significant in the member's life as appropriate, in decisions about services provided to meet the member's health needs.
- We establish and promote strategies to engage members who may have histories of inconsistent involvement in treatment.
- For adult members who have a serious mental illness and child members with a severe emotional disturbance (SED), services focus on helping the member maintain their home environment, education, and employment, and on promoting their recovery and resiliency.
- Mental health services for children are most appropriately directed toward helping a child and the child's family to develop resiliency and maintain a stable and safe family environment for the child.

- We are committed to exploring the use of emerging technology (for example, telehealth) as a way to expand access to services and extend the reach of mental health and substance use disorder service professionals, particularly into rural areas of the state.
- We facilitate the coordination of services to eliminate both gaps in service and duplication of services.
- We promote quality improvement initiatives as well as monitoring and tracking outcomes such as member satisfaction, health status and clinical improvement and service utilization.

Behavioral Health Services

Objectives

The objectives of the Wellpoint Behavioral Health program are to:

- Work with care providers to ensure the provision of medically necessary and appropriate care and services to our members at the least restrictive level of care, including inpatient care, alternative care settings, and outpatient care, both in-and out-of-network.
- Provide high quality case management and care coordination services designed to identify member needs and address them in a person-centered, holistic manner.
- Promote continuity and coordination of care among physical and behavioral healthcare practitioners.
- Maintain compliance with local, state, and federal requirements, as well as accreditation standards.
- Utilize evidence-based guidelines and clinical criteria and promote the use of same in the provider community.
- Enhance member satisfaction by working with members-in-need of services to implement an individually-tailored and holistic support and care plan that allows the member to succeed at achieving his/her recovery and resiliency goals.
- Enhance provider satisfaction and provider success by working to develop collaborative and supportive provider relationships built on mutually agreed upon goals, outcomes, and incentives.
- Promote all healthcare partners to work together to achieve quality and recovery goals through education, technological supports, and the promotion of recovery ideals.
- Initiate quality improvement activities: plan, do, study, act (PDSA).
- Establish systems to monitor and track outcomes annually.

Wellpoint-contracted providers deliver behavioral health and IDPH substance use disorder (SUD) services in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by Iowa HHS and IME. This includes, but may not be limited to, mental health services such as psychiatric inpatient hospital services, 24-hour psychiatric medical institutions for children (PMICs), outpatient mental health services, case management, psychiatric rehabilitation services and behavioral health crisis services. Also included are SUD treatments such as inpatient, residential and outpatient services.

Behavioral Health Services

Recovery and Resiliency

“[Recovery is] a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence.” — Townsend, W., S. Boyd, G. Griffin, and P. L. Hicks. 2000. *Emerging best practices in mental health recovery*. Columbus: Ohio Department of Mental Health.

“Recovery involves living as well as possible.” —Slade, M. (2009) *Personal Recovery and Mental Illness; A Guide for Mental Health Professionals*. New York: Cambridge University Press.

“A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”— Substance Abuse and Mental Health Services Administration (SAMHSA, 2011)

Wellpoint believes physical and behavioral health services should be rendered in a manner that supports the recovery of persons experiencing mental illness and enhances the development of resiliency of those who are impacted by mental illness, serious emotional disturbance and/or substance use disorder issues. Recovery is a consumer-driven process in which consumers find their paths to work, learn, and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life despite the continued presence of a disability.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has released a consensus statement on mental health recovery. The components listed in this consensus statement are reflective of our desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency. The ten fundamental components of recovery as elucidated by SAMHSA include the following:

1. **Self-direction:** Consumers lead, control and exercise choice over and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
2. **Individualized and person-centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliency, as well as his or her needs, preferences, experiences (including past trauma) and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result, as well as an overall paradigm for achieving wellness and optimal mental health.
3. **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions — including the allocation of resources — that will affect their lives and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
4. **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services (for example, recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
5. **Nonlinear:** Recovery is not a step-by-step process, but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
6. **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (for example, partner, caregiver, friend, student, and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
7. **Peer support:** Mutual support — including the sharing of experiential knowledge and skills and social learning — plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
8. **Respect:** Community, systems and societal acceptance and appreciation of consumers — including protecting their rights and eliminating discrimination and stigma — are crucial in achieving recovery.

Self-acceptance and regaining belief in oneself are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

9. **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
10. **Hope:** Recovery provides the essential and motivating message of a better future — that people can and do overcome the barriers and obstacles that confront them. Hope is internalized but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

Resiliency is a dynamic developmental process especially for children and youth (and their families) that encompasses positive adaptation and is manifested by traits of self-efficacy, high self-esteem, maintenance of hope and optimism within the context of significant adversity.

Services that are provided to children and youth with serious emotional disturbances and their families are best delivered based on the System of Care Values and Principles that are endorsed by the SAMHSA and the Center for Mental Health Services (CMHS). Services should be:

- Child-centered and family focused with the needs of the child and family dictating the types and mix of services provided.
- Community-based with the focus of services as well as management and decision-making responsibility resting at the community level.
- Culturally competent with agencies, programs and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.
- Led by the guiding principles of a system of care, which include:
 - Children should have access to a comprehensive array of services that address the child’s physical, emotional, social, educational, and cultural needs.
 - Children should receive individualized services in accordance with their unique needs and potential, which is guided by an individualized service plan.
 - Children should receive services within the least restrictive, most normative environment that is clinically appropriate.
 - Children should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
 - Children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the child and family.
 - Children should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics.

Behavioral Health Services

General Provider Information

How to Become a Behavioral Health Provider in the Wellpoint Network

Please see our credentialing information in this Provider Manual. If you have questions about the Wellpoint credentialing process before joining our network, call our Network Development team at **855-789-7989**. If you are being recredentialled, you will receive a packet of instructions and contact information for questions or concerns.

Wellpoint believes the success of providers is necessary to achieve our goals. We are committed to supporting and working with qualified providers to ensure we jointly meet quality and recovery goals. Such commitment also includes:

- Improving communication of the clinical aspects of behavioral healthcare to improve outcomes and recovery.
- Supporting providers in delivering integrated, coordinated physical and behavioral health services to meet the needs of the whole person.
- Precertification rules, referrals, claims and payment processes to help providers reduce administrative time and focus on the needs of members.
- Using reasonable precertification requirements that minimize administrative burden.

Behavioral Health Services

Health Home Services

Overview

Iowa has two CMS-approved Health Home State Plan Amendments, Chronic Condition Health Home, and Integrated Health Home, for Medicaid members with chronic medical and behavioral health conditions.

An Integrated Health Home is a team of Healthcare Professionals, and the Chronic Condition Health Home is a Designated Provider that deliver personalized, coordinated care for individuals who meet program eligibility criteria. Services utilize a whole-person treatment approach coordinated between multiple delivery systems. Health Information Technology (HIT) assists in linking services, providing feedback, and facilitating communication among providers.

A Health Home facilitates access to a range of health and community services, simplifying the process for the member. Core Health Home services include the following:

- Comprehensive care management
- Care coordination
- Transitions in care
- Support to individual and family members
- The facilitation of referrals to community services and supports
- Health promotion and self-care

Eligibility Criteria

Chronic Condition Health Home eligibility criteria require members to have two chronic conditions, or one chronic condition and the risk of developing another from the following list:

- Mental health condition
- Substance use disorder
- Asthma
- Diabetes
- Heart disease
- BMI over 25
- Chronic Pain
- COPD
- Hypertension
- Child BMI > 85th percentile

An Integrated Health Home (IHH) is a team of professionals working together to provide person-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional

disturbance (SED). Eligibility for IHH services includes either a diagnosis of Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) with severe functional impairment.

Eligibility criteria for either a Chronic Condition Health Home or Integrated Health Home include:

- Members who get full Medicaid benefits
- Members who get full Medicaid benefits and who also have Medicare
- Members enrolled in the Iowa Health and Wellness Plan and determined to be medically exempt

Wellpoint will identify eligible members, or a Health Home may refer a member to Wellpoint for eligibility determination. Members in the following programs are not eligible for the Health Home program:

- Iowa Health and Wellness Plan (unless determined to be medically exempt)
- Qualified Medicare Beneficiary
- Special Low-Income Medicare Beneficiary
- Program of All-Inclusive Care for the Elderly (PACE)
- Health Maintenance Organization members
- Presumptive Eligible*

**Temporary Medicaid coverage for women who are pregnant, or who need treatment for breast and cervical cancer, and children under the age of 19 who need temporary medical coverage.*

Case management activities for enrollees in the 1915(c) Children's Mental Health Waiver and 1915(i) Habilitation program will be provided through the Integrated Health Home. For more information, refer to the Health Homes Supplemental Provider Manual located at <https://providers.wellpoint.com/ia>.

Behavioral Health Services

Services Requiring Precertification

Please visit <https://providers.wellpoint.com/ia> to access a full list of covered services, codes and authorization rules.

If a provider asks for prior approval of a service and a decision is made that the service is not medically needed, the provider will be able to discuss this decision with Wellpoint. If the decision remains the same, the member, member's approved representative or the provider (on the member's behalf and with their written consent) can appeal the decision. See the section on **Appeals**.

Dates of Service

If services were approved before the member's coverage started with Wellpoint, those services will remain approved for the first 30 days the member is enrolled in Wellpoint, whether an in-network or out-of-network provider asked for the approval.

After the first 30 days the member is enrolled in Wellpoint: If the member wishes to keep receiving services from an out-of-network provider, or if the services require prior approval, the provider must ask Wellpoint to approve them before the member can receive these services.

Behavioral Health Services

Member Records and Treatment Planning

Member records must meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews:

- Information related to the provision of appropriate services to a member must be included in his or her record to include documentation in a prominent place, and whether there is an executed declaration for mental health treatment.

- For members in the population, a comprehensive assessment that provides a description of the consumer's physical and mental health status at the time of admission to services. This comprehensive assessment covers:
 - **A psychiatric assessment that includes:**
 - Description of the presenting problem
 - Psychiatric history and history of the member's response to crisis situations
 - Psychiatric symptoms
 - A diagnosis using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM) and current ICD coding
 - Mental status exam
 - History of alcohol and drug abuse
 - **A medical assessment that includes:**
 - Screening for medical problems
 - Medical history
 - Present medications
 - Medication history
 - **A substance use assessment that includes:**
 - Frequently used over-the-counter medications
 - Alcohol and other drugs and history of prior alcohol and drug treatment episodes
 - History reflecting the impact of substance use in the domains of the community functioning assessment.
 - **A community functioning assessment or an assessment of the member's functioning in the following domains:**
 - Living arrangements, daily activities (vocational/educational)
 - Social support
 - Financial
 - Leisure/recreational
 - Physical health
 - Emotional/behavioral health
 - An assessment of the member's strengths, current life status, personal goals, and needs.
- A patient-centered, wellness-oriented care plan, which is based on the psychiatric, medical, substance use, and community functioning assessments listed above, must be completed for any member who receives behavioral health services.
- The patient-centered care plan must be completed within the first 14 days of admission to behavioral health services and updated every 90 days, or more frequently as necessary based on the member's progress towards goals or a significant change in psychiatric symptoms, medical condition and/or community functioning.
- **There must be documentation in every case that the member and, as appropriate, his or her family members, caregivers, or legal guardian, participated in the development and subsequent reviews of the treatment plan.**
- For providers of multiple services, one comprehensive treatment/care/support plan is acceptable as long as at least one goal is written, and updated as appropriate, for each of the different services that are being provided to the member.
- The treatment/support/care plan must contain the following elements:
 - Identified problem(s) for which the member is seeking treatment
 - Member goals related to problem(s) identified, written in member-friendly language
 - Measurable objectives to address the goals identified
 - Target dates for completion of objectives
 - Responsible parties for each objective

- Specific measurable action steps to accomplish each objective
- Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent, de-escalate or defuse crisis situations; names and phone numbers of contacts that can assist the member in resolving crisis; and the member's preferred treatment options, to include psychopharmacology, in the event of a mental health crisis
- Signatures of the member as well as family members, caregivers, or legal guardian as appropriate.
- Clinical progress notes are written to document status related to goals and objectives indicated on the treatment plans.
 - Correspondence concerning the member's treatment and signed and dated notations of telephone calls concerning the member's treatment.
 - A brief discharge summary must be completed within 15 calendar days following discharge from services or death.
 - Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the member is receiving behavioral health services should also be included.
- Wellpoint will monitor provider compliance with treatment plan requirements through medical record reviews or other measures. Providers who do not meet the goal of 100-percent compliance with treatment plan requirements may be subject to corrective action and may be asked to submit a plan for meeting the 100-percent requirement.

Behavioral Health Services

Adverse Incident Reporting (including PMIC, CMH Waiver and Habilitation Program Services)

Adverse occurrence (for example, sentinel events, major critical events) reports must be made by each participating provider to all appropriate agencies as required by licensure and state and federal laws within the specified time frames required immediately following the event. See the section on **Critical Incident Reporting and Management** for more information. Examples of adverse occurrences include, but are not limited to:

- Treatment complications (including medication errors and adverse medication reactions)
- Accidents or injuries to a member
- Morbidity
- Suicide attempts
- Death of a member
- Allegations of physical abuse, sexual abuse, neglect, and mistreatment, and/or verbal abuse
- Use of isolation, mechanical restraint, or physical holding restraint
- Any clear and serious breach of accepted professional standards of care that could endanger the safety or health of a member or members

Behavioral Health Services

Psychotropic Medication

Iowa law permits the state of Iowa to restrict access to prescription drugs through the use of a Preferred Drug List (PDL) through PA 441 Iowa Administrative Code § 78.2(4)a. Wellpoint will follow and enforce the PDL under the Medicaid Fee-for-Service (FFS) pharmacy benefit for psychotropic medications, which may include prior authorization criteria, quantity limits and days-supply limitations. The PDL is located at <http://www.iowamedicaidpdl.com>.

Providers must inform all members being considered for prescription of psychotropic medications of the benefits, risks, and side effects of the medication, alternate medications, and other forms of treatment. The medical record is expected to reflect such conversations as having occurred.

Members on psychotropic medications may be at increased risk for various disorders. As such, it is expected that providers are knowledgeable about side-effects and risks of medications and regularly inquire about and seek for any side-effects from medications. This especially includes:

- Follow-up to inquire about suicidality or self-harm in children placed on anti-depressant medications as per FDA and APA guidelines.
- Regular and frequent weight checks and measurement of abdominal girth especially for those on antipsychotics or mood stabilizers.
- Glucose tolerance test or hemoglobin A-1C tests especially for those members on antipsychotics or mood stabilizers.
- Triglyceride and cholesterol checks especially for those members on antipsychotics and mood stabilizers.
- ECG checks for members placed on medications with risk for significant QT-prolongation.
- Ongoing checks for movement disorders related to antipsychotic use and psychotic disorders.

Guidelines for such testing and follow-up are provided by the American Psychiatric Association, amongst others. Summary guidelines are referenced in our *Clinical Practice Guidelines* (CPGs), which can be found at <https://providers.wellpoint.com/ia>. While the prescriber is not expected to personally conduct all of these tests, the prescriber is expected to ensure that these tests occur where indicated and to initiate appropriate interventions to address any adverse results. These tests and the interventions are expected to be documented in, at minimum, the medical record for the member.

Behavioral Health Services

Utilization Management Process

Utilization Management Decision Making

Individuals involved in utilization management (UM) decisions are governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Wellpoint does not specifically reward practitioners or other individuals for issuing denial of coverage care. Decisions about hiring, promoting, or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support denial of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

Our Behavioral Health Customer Service Staff

Provider calls to our Provider Services line during regular business hours are taken by our experienced team of Utilization Management representatives (UMRs). UMRs assist providers with routine inquiries about member eligibility, benefits, and claims or with referrals to network providers for your patients. If you are calling about precertification for a service that requires precertification and clinical review, these requests are referred to a member of our clinical staff to initiate a review of the request.

Provider calls after business hours are taken by our Wellpoint on Call staff, who will issue you a reference number for precertification requests for urgent/emergent care. Requests for routine/outpatient care are taken during normal business hours. All requests for precertification will be reviewed by appropriate Behavioral Health staff within decision and notification timeliness standards (see the “Timeliness of Decisions on Requests for Precertification” grid below).

Behavioral Health Services

Behavioral Health Authorization Time Standards

Wellpoint will make authorization determinations within time frames that facilitate timely access to care per the standards outlined in Chapter 16. For this to occur, it is critical Wellpoint receives all necessary clinical information in a timely manner.

Our Clinical Staff

Wellpoint has assembled a highly trained and experienced team of clinical care managers, case managers and support staff to provide high-quality care management and care coordination services to Wellpoint members and to work collaboratively with you, our providers. All clinical staff is licensed and meet experience requirements, which generally include at least four years of prior clinical experience.

Behavioral Health Services

The quickest, most efficient way to request prior authorization is through Availity Essentials secure provider website at <https://www.availity.com>. Through the secure provider website, you can access the Interactive Care Reviewer (ICR), which offers a streamlined and efficient experience for providers requesting inpatient and outpatient behavioral health services for CCHA members. Providers can also use this tool to inquire about previously submitted requests regardless of how they were submitted (phone, fax, ICR or other online tool).

- **Initiate preauthorization requests online**, eliminating the need to fax. ICR allows detailed text, photo images and attachments to be submitted along with your request.
- **Review** requests previously submitted via phone, fax, ICR or other online tool.
- **Instant accessibility** from almost anywhere, including after business hours.
- **Utilize the dashboard** to provide a complete view of all utilization management requests with real-time status updates.
- **Real-time results** for some common procedures.
- **Access the ICR** under Patient Registration > *Authorizations and Referrals* via Availity Essentials.

For an optimal experience with the ICR, use a browser that supports 128-bit encryption. This includes Chrome, Firefox, or Safari.

You may also request authorization for inpatient mental health services by calling **833-731-2143**, 24/7, 365 days a year. Please be prepared to provide clinical information in support of the request at the time of the call.

Notification or Request Preauthorization

The quickest, most efficient way to request precertification is using our preferred method through Availity Essentials via the Interactive Care Reviewer, at www.availity.com.

You may also request authorization for inpatient mental health services by calling **833-731-2143**, 24/7, 365 days a year. We do not accept outpatient preauthorization requests via phone. Please refer to the ICR information above for outpatient preauthorization. Please be prepared to provide clinical information in support of the request at the time of the call.

You may also request preauthorization via fax. Wellpoint-approved fax forms can be obtained on our provider website at <https://providers.wellpoint.com/ia>.

Note: All requests for precertification for psychological and neuropsychological testing beyond the three-hour initial limit should be submitted using our preferred electronic method via www.availity.com

Behavioral Health Services

Clinical Criteria

Wellpoint Clinical Criteria

- In addition to utilizing the “Iowa Definition of Medical Necessity” (see below), Wellpoint utilizes clinical criteria to evaluate the medical necessity of requests for care and services as follows:
 - Mental health: Wellpoint Medical Policies and Clinical Utilization Management Guidelines
 - Substance use disorder: American Society of Addiction Medicine (ASAM) Principles of Addiction Medicine
- Additional level of care criteria will be used for services not included in Wellpoint or ASAM criteria sets. For more information about additional criteria in use by Wellpoint, please visit <https://providers.wellpoint.com/ia>.
- All criteria used by Wellpoint are approved by the Wellpoint Medical Advisory Committee and the Wellpoint Medical Policy and Technology Assessment Committee.
- For information about how to access the Wellpoint medical necessity criteria, please call the Wellpoint Provider Services line at **833-731-2143**.

“Medical necessity” is defined by Iowa as those covered services that are determined through Utilization Management to be:

- Appropriate and necessary for the symptoms, diagnosis, or treatment of the condition of the member.
- Provided for the diagnosis or direct care and treatment of the condition of member enabling the member to make reasonable progress in treatment.
- Within standards of professional practice and given at the appropriate time and in the appropriate setting.
- Not primarily for the convenience of the member, the member's physician, or other provider.
- The most appropriate level of covered services, which can safely be provided.

Behavioral Health Services

Behavioral Health Medical Necessity Determination and Peer Review

When a provider requests initial or continued precertification for a covered behavioral health service, Wellpoint utilization managers obtain necessary clinical information and review it to determine if the request appears to meet applicable medical necessity criteria.

If the information submitted does not appear to meet such criteria, the utilization manager submits the information for review by an Wellpoint behavioral health medical director, or other appropriate practitioner, as part of the peer review process.

The Wellpoint reviewer, or the requesting provider, may initiate a peer-to-peer conversation to discuss the relevant clinical information with the clinician working with the member. If an adverse decision is made by the Wellpoint reviewer without a peer-to-peer conversation taking place (as may occur when the provider is unavailable for review), the provider may request such a conversation within two business days of the issuance of the adverse decision. In this case, we will make a behavioral health medical director or other appropriate practitioner available to discuss the case with the requesting provider. This conversation may result in the decision being upheld or changed.

Members, requesting providers and applicable facilities are notified of any adverse decision by Wellpoint within notification time frames that are based on the type of care requested, and in conformance with regulatory and accreditation requirements.

Behavioral Health Services

Nonmedical Necessity Adverse Decisions

Nonmedical Necessity Adverse Decisions (Administrative Adverse Decision)

A request for precertification may result in an adverse decision for reasons other than a lack of medical necessity. Reasons for such an adverse decision may include:

- The notification of admission was late; providers must notify Wellpoint of admission (including preliminary clinical information) within 24 hours or the next business day of any inpatient admission of an Wellpoint member.
- The provider failed to request precertification of a service that requires it.
- The member was ineligible on the date of service.
- The requested service/benefit was a noncovered service/benefit.
- The limit on the benefit has been reached.

Behavioral Health Services

Appeals, Grievance and Payment Disputes

If precertification was not received or you disagree with the decision, refer to the **Appeals, Grievance and Payment Disputes** chapter.

Behavioral Health Services

Avoiding an Adverse Decision

Most administrative adverse decisions result from nonadherence to or a misunderstanding of utilization management policies. Familiarizing yourself and your staff with notification and precertification policies and acting to meet those policies can eliminate the majority of these decisions. Other administrative adverse decisions result from misinformation about the member's status or the member's benefits. Such information is readily available from Wellpoint by calling Provider Services at **833-731-2143**.

Adverse decisions of a medical nature are rare. Such adverse decisions usually involve a failure of the clinical information to meet evidenced-based, national guidelines. Wellpoint is committed to working with all providers to ensure that such guidelines are understood and to identify gaps for providers around meeting such guidelines. Peer-to-peer conversations (between a Wellpoint medical director and the provider clinicians) are one way that Wellpoint is able to ensure the completeness and accuracy of the clinical information and provide a one-on-one communication about the guidelines, as necessary. Medical record reviews are another way to ensure that clinical information is complete and accurate. Providers who are able to appropriately respond in a timely fashion to peer-to-peer and medical record requests are less likely to encounter dissatisfaction with the utilization management process. Wellpoint is committed to ensuring a process that is quick and easy; working with participating providers to ensure a mutually satisfying process whenever possible.

Reducing Risk to Members With Behavioral Health or SUD Healthcare Needs Through the Wellpoint Case Management/Care Coordination Process

- When a member is identified as having mental health and/or SUD needs requiring some type of intervention to reduce risk, Wellpoint utilizes the following strategies:
 - Inpatient management: moderate to high-risk hospitalized members
 - When at-risk members are identified as part of the census management process, the UM staff works with provider discharge planners, our transitional care coaches, the member's Health

Home team and/or Wellpoint case managers to develop a discharge plan that maximizes the likelihood of the member making a successful transition back into the community. Key elements of the discharge plan include, but are not limited to:

- Understanding the characteristics of each particular member (job, family, education, social activities, family background, prior service utilization, etc.)
- In the case of rapid readmissions – an admission that occurs within 30 days of discharge from the same level of care:
 - What has worked in the past in helping this member to stay out of the hospital (for example, medications, treatment interventions, services, and supports)?
 - What elements of the previous discharge plan did not work and need to be changed?
- How do medical issues or complications impact the member?
- What is the involvement of the family in the treatment process and how do the family and other social supports factor into the discharge plan?
- Are follow-up appointments scheduled within seven days of discharge?
- The behavioral health medical director conducts rounds and participates in complex case rounds to assist in facilitating the member's successful transition back into the community
- Transitional care: moderate to high-risk hospitalized members
 - A transitional care coach or Health Home care coordinator collaborates with the UM staff to work with members, their family caregivers, their Health Home team and, when appropriate, the hospital's discharge planning staff to develop a discharge plan. The plan may include:
 - Pretransition contacts
 - Assisting the member with planning for follow-up care and ensuring that appointments are scheduled, transportation arranged, etc.
 - Post-discharge contacts
 - Medication reconciliation
 - "Red-flag" education for the member and family/caregiver, as appropriate, about potential problems or relapse triggers
 - Disease-specific interventions
 - Transitional care is a short-term intervention strategy with the goals of reducing the member's risk of readmission and increasing the likelihood that he or she will make a successful transition back into the community.
- Complex case management
 - Once a member is identified as having complex case management needs through identification methods outlined above, the case manager attempts to engage the member to conduct an assessment to determine the member's care management needs.
 - The case manager works with the member, as well as the member's family/caregiver, as appropriate, to identify goals that are expressed in member-friendly language.
 - The care plan includes interventions that are agreed upon to achieve the member's goals.
 - The case manager also obtains input from the member's PCP and other specialty providers in developing the care plan.
 - For members with mental health and/or SUD needs, the case manager ensures that all needed behavioral health and medical care needs are integrated in a holistic manner, by facilitating communication among treating providers and scheduling regular case conferences as required. The case manager may also utilize complex case rounds to obtain input on especially difficult integration issues.
 - The case manager then monitors the member's progress, at regular intervals depending on the member's acuity, in meeting care plan goals. The case manager coordinates care and services with all treating providers and assists the member with community resource referrals. Contacts

- with the member may be done telephonically, or through face-to-face contact, depending on the member's level of acuity.
- Case Management continues until the care plan goals have been substantially met or there is agreement with the member/family/caregiver, as appropriate, that further care management is not indicated.
- Wellpoint Condition Care (CNDC)
 - The needs of members with lower acuity, mental health or substance use disorder needs may be met by CNDC through some combination of:
 - Lower acuity telephonic care management
 - Condition Care programs (schizophrenia, major depression, bipolar disorder, or substance use disorder)
 - Referrals to preventive services
 - Providing them with health promotion materials

Behavioral Health Services

Behavioral Health Drug Utilization Review Program

Our Psychotropic Drug Utilization Review Program processes medical and pharmacy claims data to identify and outreach to prescribers who are not following recommended evidence-based psychotropic treatment guidelines. Our goal is not to infringe on the prescriber's decision-making practice, but to provide education and training on best practices for prescribing psychotropic medications to support prescriber self-regulation.

We design educational information to help the prescriber make care decisions based on the latest medical evidence. We monitor claims data to determine whether the provider makes changes after intervention. DUR programs have been shown to be effective at improving healthcare quality while reducing medical and/or pharmacy costs.

Behavioral Health Services

Post-Discharge Outreach, Diversion Plans and Crisis Assessments

Post-Discharge Outreach

Wellpoint inpatient providers are required to conduct outreach to all members being discharged from inpatient care to encourage the member's attendance at follow-up appointments to be scheduled with a behavioral health specialty provider within seven calendar days of discharge.

Wellpoint will require providers to maintain records of the results of such outreach efforts and will require reporting of this information to Wellpoint on a regular basis. Wellpoint will also conduct on-site audits of member records on at least a quarterly basis.

Providers are also encouraged to use these outreach opportunities to ensure discharged members/caregivers have been able to fill necessary prescriptions and have access to transportation for follow-up appointments. If members/caregivers need assistance with filling prescriptions, with transportation to their appointments, or with appointment scheduling, they should be encouraged to contact Wellpoint Member Services at **833-731-2140** (TTY 711) for assistance.

Diversion Plans

When clinically indicated, Wellpoint encourages providers conducting crisis assessments for members at risk for admission to higher levels of care (for example, acute inpatient, PMIC) to carefully consider the opportunity for developing diversion plans, with appropriate member and family/caregiver involvement, to assist the member in safely achieving stabilization at a lower level of care.

The provider should contact the member/family/caregiver, as appropriate, as soon as possible following the diversion to offer needed outpatient services.

Crisis Assessments

Providers delivering crisis assessments/screenings to members must initiate a follow-up contact within one business day to any member seen for or provided with any emergency service and not detained for inpatient care and treatment, to determine the need for any further services or referral to any services.

Behavioral Health Services

Clinical Practice Guidelines

All providers have ready access to evidence-based *Clinical Practice Guidelines* for a variety of behavioral health disorders commonly seen in primary care, including ADHD, bipolar disorder for adults and adolescents, major depressive disorder, schizophrenia, and SUDs as well as evidence-based information on the use of psychotropic medications. Please see the provider website at <https://providers.wellpoint.com/ia>.

Coordination of Behavioral Health and Physical Health Treatment

- Wellpoint emphasizes the coordination and integration of physical and behavioral health services, wherever possible. Key elements of the Wellpoint model of coordinated care include:
 - Ongoing communication and coordination between PCPs and specialty providers, including behavioral health (mental health and substance use) providers
 - The expectation that providers screen for co-occurring disorders, including:
 - Behavioral health screening by PCPs
 - Medical screening by behavioral health providers
 - Screening of mental health patients for co-occurring SUDs
 - Screening of consumers in substance use disorder treatment for co-occurring mental health and/or medical disorders
 - Screening tools for PCPs and behavioral health providers can be located at <https://providers.wellpoint.com/ia>
 - Referrals to PCPs or specialty providers, including behavioral health providers, for assessment and/or treatment for consumers with co-occurring disorders
 - Involving members, as well as caregivers and family members, as appropriate, in the development of patient-centered treatment plans. Case management and condition care programs to support the coordination and integration of care between providers
- As a Wellpoint network provider, you're required to notify a member's PCP when a member first enters behavioral healthcare and anytime there is a significant change in care, treatment or need for medical services, provided that you have secured the necessary release of information. The minimum elements to be included in such correspondence are:
 - Patient demographics
 - Date of initial or most recent behavioral health evaluation
 - Recommendation to see a PCP, if medical condition identified or need for evaluation by a medical practitioner has been determined for the member (for example, EPSDT screen, complaint of physical ailments)
 - Diagnosis and/or presenting behavioral health problem(s)
 - Prescribed medication(s)
 - Vital signs
 - Allergy/drug sensitivity
 - Pregnancy status
 - Behavioral health clinician's name and contact information

Behavioral Health Services

Provider Training

Wellpoint must monitor and ensure all participating providers that deliver behavioral health services provide relevant staff with training in accordance with Iowa HHS requirements. As a contracted provider of Wellpoint, your organization is required to provide training to your staff as appropriate. Your organization is also responsible for complying with any updates in training requirements. Additionally, Wellpoint will implement measures to monitor compliance with training requirements.

Additional Training

Wellpoint will present training programs for PCPs and behavioral health providers on topics related to the coordination of behavioral health and physical healthcare. Some of these training events will include the opportunity for providers to obtain CME/CEU credit for participation. Please consult the Wellpoint provider website at <https://providers.wellpoint.com/ia> for a schedule of these training events.

Behavioral Health Consultations for Primary Care Providers

Wellpoint will provide all contracted PCPs with the ability to consult with a behavioral health specialist. For more information about this and other behavioral health consultation resources, please call the Wellpoint Provider Services line at **833-731-2143**.

Behavioral Health Services

Critical Incident Reporting and Management

We have a critical incident reporting and management system for incidents that occur in a home- and community-based long-term care services and supports delivery setting. As a participating Wellpoint provider, you will be required to participate in critical incident reporting. Immediate action will be taken to assure the member is protected from further harm. Critical incidents will be tracked and presented to our Quality Improvement committee for review.

A critical incident, also known as a major incident, means an occurrence that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital.
2. Results in the death of any person.
3. Requires emergency mental health treatment for the member.
4. Requires the intervention of law enforcement.
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3.
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in 1, 2 or 3.
7. Involves a member's location being unknown by provider staff who are assigned protective oversight.

Providers must report critical incidents to Wellpoint in accordance with applicable requirements and as outlined in Article 3.7 of the Wellpoint Provider Agreement. The maximum time frame for reporting an incident to Wellpoint is 24 hours. The initial report of an incident within 24 hours may be submitted verbally, in which case the person, agency or entity making the initial report will submit a follow-up written report within 48 hours. A report must also be filed with HHS through their Incident Management Provider Access system. Instructions can be found at:

http://dhs.iowa.gov/sites/default/files/PCIR_CriticalIncidentReportUserGuideForm470_4698.pdf.

The HHS form can be found at <https://dhs.iowa.gov/sites/default/files/470-4698.pdf>.

The form utilized for reporting incidents is the same for all managed care organizations; please send only Wellpoint member reports to us. The *Critical Incident Report* form can be downloaded at the provider portal at <https://providers.wellpoint.com/ia> under Provider Resources & Documents > Forms. Once complete, please fax it to **844-400-3465** or email it to IAincidents@wellpoint.com.

Suspected abuse, neglect and exploitation of members who are adults must be immediately reported. Suspected brutality, abuse or neglect of members who are children must also be immediately reported. The HHS form cannot be used to report suspected child abuse and dependent adult abuse. Report of suspected child abuse and dependent abuse must be made by calling the HHS Abuse Hotline at **800-362-2178**. Providers must immediately (in other words, within 24 hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members.

Providers with a critical incident must conduct an internal critical incident investigation and submit a report on the investigation by the end of the next business day.

Wellpoint will 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 time frames.

Providers must cooperate with any investigation conducted by Wellpoint or outside agencies (for example, the HHS, Adult Protective Services, Child Protective Services, and law enforcement).

Behavioral Health Services

Psychiatric Medical Institutions for Children (PMIC)

PMICs provide 24-hour care for individuals under the age of 21 years old. To qualify, an independent team evaluates and determines that ambulatory care resources available in the community do not meet the individual's treatment needs. Proper treatment of the individual's psychiatric condition requires:

- Inpatient services under the direction of a physician.
- Services reasonably expected to improve his or her condition or prevent further regression, so the services will no longer be needed.

PMICs will provide or assist a member with access to:

- **Active treatment;** active treatment is the implementation of a professionally developed and supervised individual plan of care. The plan of care is designed to achieve the member's discharge from inpatient status at the earliest possible time and must be developed and implemented by an interdisciplinary team no later than 14 days after admission.
- **An individual plan of care;** an individual plan of care is a written plan developed for each member to improve his or her condition to the extent inpatient care is no longer necessary. The team will review the plan every 30 days to determine whether services being provided are or were required on an inpatient basis and recommend changes in the plan based on the member's overall adjustment as an inpatient. The plan of care shall:
 - Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the member's situation and reflects the need for inpatient psychiatric care.
 - Be developed by an interdisciplinary team (as specified below) in consultation, if possible, with the member and member's parents, legal guardians, or others who the member will be released to for care after discharge.
 - State the treatment objectives.
 - Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives.

- Include, at an appropriate time, post-discharge plans and coordination of inpatient services, with partial discharge plans and related community services, to ensure continuity of care with the member's family, school, and community upon discharge.
- **An interdisciplinary team;** the individual plan of care shall be developed by an interdisciplinary team of physicians and other personnel who are employed by the facility or who provide services to patients in the facility. Membership includes those physicians and other professionals who are involved in the direct provision of treatment services, involved in the organization of the plan of care or involved in consulting with or supervising those professionals involved in the direct provision of care. The team shall:
 - Be based on education and experience, preferably including competence in child psychiatry.
 - Be capable of assessing the member's immediate and long-range therapeutic needs, developmental priorities and personal strengths and liabilities; this includes assessing the potential resources of the member's family, setting treatment objectives, and prescribing therapeutic modalities to achieve the plan's objectives.
 - Include, as a minimum, either:
 - A board-eligible or board-certified psychiatrist, a clinical psychologist who has a doctoral degree and a physician licensed to practice in medicine or osteopathy, or
 - A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology and has been licensed by the state.
 - Also include one of the following:
 - A social worker with a master's degree in social work with specialized training or one year's experience in treating persons with mental illness.
 - A registered nurse with specialized training or one year's experience in treating persons with mental illness.
 - An occupational therapist who is licensed and who has specialized training or one year of experience in treating persons with mental illness.
 - A psychologist who has a master's degree in clinical psychology or who has been licensed by the state.

Behavioral Health Services

Behavioral Health Waivers

1915(c) Children's Mental Health (CMH) Services Waiver

Wellpoint delivers the state's 1915(c) CMH Waiver services to all members meeting the eligibility criteria and authorized to be served by these programs. Children enrolled in the CMH Waiver program will also be enrolled in an Integrated Health Home. Wellpoint is responsible for the following:

- Assessment of needs-based eligibility
- Service plan review and authorization
- Claims payment
- Provider recruitment
- Provider agreement execution
- Rate setting
- Providing training and technical assistance to providers

Behavioral Health Services

1915(i) Habilitation Services Program

Wellpoint delivers the state's 1915(i) Habilitation Services to all members meeting the eligibility criteria and authorized to be served by these programs. Services available include the following:

- Home-based habilitation
- Day habilitation
- Prevocational services
- Supported employment

Members enrolled in the Habilitation Services waiver will also be enrolled in an Integrated Health Home.

Wellpoint is responsible for the following:

- Assessment of needs-based eligibility
- Service plan review and authorization
- Claims payment
- Provider recruitment
- Provider agreement execution
- Rate setting
- Training and technical assistance for providers

Case management activities for enrollees in the 1915(c) Children's Mental Health Waiver and 1915(i) Habilitation program is provided through the Integrated Health Home. For more information, refer to the Health Homes Supplemental Provider Manual located at <https://providers.wellpoint.com/ia>.

CHAPTER 7: MEMBER ELIGIBILITY

Member Eligibility

Overview

Given the increasing complexities of healthcare administration, widespread potential for fraud and abuse, and constant fluctuations in program membership, providers need to be vigilant about member eligibility. This may mean taking extra steps to verify that any patient treated by network providers is, in fact, a currently enrolled Wellpoint member.

Wellpoint members enrolled in IA Health Link or Hawki are required to carry and present their IA Health Link or Hawki identification (ID) card when seeking services. The IA Health Link and Hawki ID cards are issued by Wellpoint. To prevent fraud and abuse, providers should confirm the identity of the person presenting the ID card. Providers also must verify a member's eligibility before services are delivered. Because eligibility can change, verify eligibility at each visit. Remember, claims submitted for services rendered to noneligible members are not eligible for payment.

Member Eligibility

How to Verify Member Eligibility

To verify member eligibility, log on to Availity at <https://www.availity.com>. From Availity's homepage, select **Patient Registration > Eligibility & Benefits**.

Providers can ALSO verify member eligibility as follows:

- Real-time member enrollment and eligibility verification for IA Health Link is available 24 hours a day, 7 days a week, by calling the hotline or using the website to determine the member's specific benefit plan and coverage:
 - Automated voice response: **800-338-7752** (24 hours a day, 7 days a week)
 - Website: <https://dhs.iowa.gov/ime/providers>
- Contact Provider Services to verify enrollment and benefits for our members:
 - Phone: **833-731-2143**, Monday through Friday, 7:30 a.m.-6 p.m. Central time
 - The secure Wellpoint provider website: <https://providers.wellpoint.com/ia>. Select **Login** or **Register** to access the secure site.

Please refer to information on the primary medical group (PMG) member assignment lock-in program regarding additional requirements for verification of member eligibility.

Paper panels are also available if specifically requested by calling Provider Services at **833-731-2143**.

To verify Hawki eligibility, call Hawki customer service at **800-257-8563**.

Member Eligibility

Identification Cards

The IA Health Link and Hawki member ID cards include the member's name and member ID number (10 digits, no prefix). Members will receive an Wellpoint ID number as well as an ID card.

The front includes the Wellpoint ID, the IA Health Link or Hawki ID assigned by the state and the name and phone number of the primary medical group (PMG) where the member is assigned. The back important phone numbers and the general correspondence and appeal mailing address.

The following are two examples:

IA Health Link

 	Effective Date: Date of Birth: Wellpoint #: 123456789 www.yourlifeiowa.org
wellpoint.com/ia/medicaid Wellpoint Iowa, Inc.	
Member Name: JOHN Q SAMPLE	
Medicaid Number:	
Primary Care Provider (PCP):	
PCP Telephone #:	
Vision: 1-800-879-6901	
Copays: No Copays	
988 Suicide & Crisis Lifeline: Call or text 988	
Schedule Transportation (Non-Waiver Member Line): 1-844-544-1389	
Schedule Transportation (Waiver Member Line): 1-888-630-4822	
Member Services/Behavioral Health: 1-833-731-2140 (TTY 711)	
24/7 Wellpoint On Call/Nurse HelpLine: 1-866-864-2544 (TTY 711)	
Pharmacy Member Services: 1-833-205-6008	

MEMBERS: Please carry this card at all times. Show this card before you get medical care. You do not need to show this card before you get emergency care. If you have an emergency, call 911 or go to the nearest emergency room. Always call your Wellpoint PCP for nonemergency care. If you have questions, call Member Services at 1-833-731-2140. If you are deaf or hard of hearing, call 711.

MIEMBROS: Lleve esta tarjeta de identificación con usted siempre. Muéstrela antes de recibir cuidado médico. No tiene que mostrar esta tarjeta antes de recibir cuidado de emergencia. Si tiene una emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Llame siempre a su PCP de Wellpoint para cuidado que no sea de emergencia. Si tiene preguntas, llame a Servicios al Miembro al 1-833-731-2140. Si es sordo o tiene problemas auditivos, llame al 711.

HOSPITALS: Preadmission certification is required for all nonemergency admissions, including outpatient surgery. For emergency admissions, notify Wellpoint within 24 hours after treatment at 1-833-731-2143.

PROVIDERS: Certain services must be preauthorized. Care that is not preauthorized may not be covered. For preauthorization/billing information, call 1-833-731-2143. For preauthorization of medications, call 1-833-731-2143.

PHARMACIES: Submit claims using RxBIN: 020107; RxPCN: FM; RxGRP: WKYA
For technical help, call 1-833-236-5925.

SUBMIT MEDICAL CLAIMS TO:
WELLPOINT • P.O. BOX 61010 • VIRGINIA BEACH, VA 23466-1010
USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD.

IA01 01/24

Hawki

 	Effective Date: Date of Birth: Wellpoint #: 123456789 www.yourlifeiowa.org
wellpoint.com/ia/medicaid Wellpoint Iowa, Inc.	
Member Name: JOHN Q SAMPLE	
Hawki Number:	
Primary Care Provider (PCP):	
PCP Telephone #:	
Vision: 1-800-879-6901	
Copays: Nonemergency ER Visits: \$25 No Other Copays	
988 Suicide & Crisis Lifeline: Call or text 988	
Member Services/Behavioral Health: 1-833-731-2140 (TTY 711)	
24/7 Wellpoint On Call/Nurse HelpLine: 1-866-864-2544 (TTY 711)	
Pharmacy Member Services: 1-833-205-6008	

MEMBERS: Please carry this card at all times. Show this card before you get medical care. You do not need to show this card before you get emergency care. If you have an emergency, call 911 or go to the nearest emergency room. Always call your Wellpoint PCP for nonemergency care. If you have questions, call Member Services at 1-833-731-2140. If you are deaf or hard of hearing, call 711.

MIEMBROS: Lleve esta tarjeta de identificación con usted siempre. Muéstrela antes de recibir cuidado médico. No tiene que mostrar esta tarjeta antes de recibir cuidado de emergencia. Si tiene una emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Llame siempre a su PCP de Wellpoint para cuidado que no sea de emergencia. Si tiene preguntas, llame a Servicios al Miembro al 1-833-731-2140. Si es sordo o tiene problemas auditivos, llame al 711.

HOSPITALS: Preadmission certification is required for all nonemergency admissions, including outpatient surgery. For emergency admissions, notify Wellpoint within 24 hours after treatment at 1-833-731-2143.

PROVIDERS: Certain services must be preauthorized. Care that is not preauthorized may not be covered. For preauthorization/billing information, call 1-833-731-2143. For preauthorization of medications, call 1-833-731-2143.

PHARMACIES: Submit claims using RxBIN: 020107; RxPCN: FM; RxGRP: WKYA
For technical help, call 1-833-236-5925.

SUBMIT MEDICAL CLAIMS TO:
WELLPOINT • P.O. BOX 61010 • VIRGINIA BEACH, VA 23466-1010
USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD.

IA01 01/24

CHAPTER 8: MEDICAL MANAGEMENT

Medical Management

Overview

The Wellpoint Medical Management program is a cooperative effort with providers to promote, provide and document the appropriate use of healthcare resources. Our goal is to provide the right care, to the right member, at the right time, in the appropriate setting.

The decision-making criteria used by the Medical Management department are evidence-based and consensus-driven. We update criteria periodically as standards of practice and technology change. We involve practicing physicians in these updates and then notify providers of changes through fax communications (such as provider bulletins) and other mailings. Based on sound clinical evidence, the Medical Management department provides the following service reviews:

- Precertification
- Concurrent/continued stay reviews.
- Post-service reviews

Decisions affecting coverage or payment for services are made in a fair, consistent, and timely manner. The decision-making process incorporates nationally recognized standards of care and practice from sources including the following:

- Iowa Medicaid coverage criteria
- MCG Care Guidelines
- Anthem approved criteria
- Professional societies such as:
 - American College of Cardiology
 - American College of Obstetricians and Gynecologists
 - American Academy of Pediatrics
 - American Academy of Orthopedic Surgeons
 - Cumulative professional expertise and experience

After a case has been reviewed, decisions and notification time frames will be given for service:

- Approval
- Modification
- Denial

Please note: UM decision-making is based only on appropriateness of care and service and existence of coverage. Wellpoint does not specifically reward practitioners or other individuals for issuing denial of coverage care. Decisions about hiring, promoting, or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denial of benefits. There are no financial incentives for UM decision-makers that encourage decisions resulting in under-utilization, or that create barriers to care and service.

Treating physicians may wish to speak with the Wellpoint reviewing physician. This peer-to-peer discussion may be initiated by calling the peer-to-peer number at **844-227-8345**.

Medical necessity is defined by Iowa as those covered services that are determined through Utilization Management to be:

- Appropriate and necessary for the symptoms, diagnosis, or treatment of the condition of the member.
- Provided for the diagnosis or direct care and treatment of the condition of member enabling the member to make reasonable progress in treatment.

- Within standards of professional practice and given at the appropriate time and in the appropriate setting.
- Not primarily for the convenience of the member, the member's physician, or other provider.
- The most appropriate level of covered services which can safely be provided.

Medical Management

Availability of UM Criteria

If a Wellpoint medical director denies your service request, both you and the member will receive a notice of action letter that including the reason for denial, note the criteria/guidelines used for the decision, and explain the appeal process and your rights. If you'd like to speak with a medical director about the service request denial, call Provider Services at **833-731-2143** or the health plan at **515-327-7012**. To request a copy of the specific criteria/guidelines used for the decision, call **833-731-2143** or write to:

Medical Management
Wellpoint
4800 Westown Parkway, Suite 200
West Des Moines, IA 50266

Medical Management

Access to UM Staff

We are staffed with clinical professionals who coordinate our members' care and are available 24 hours a day, 7 days a week to accept precertification requests. You can submit precertification requests by:

- Calling us at **833-731-2143**.
- Faxing them to **800-964-3627**.
- Logging in to <https://providers.wellpoint.com/ia> and using the Precertification Lookup Tool.

Have questions about utilization decisions or the utilization management process in general? Call our clinical team at **833-731-2143**, Monday-Friday from 8 a.m.-5 p.m. Central time.

Medical Management

Precertification

If a provider asks for prior approval of a service and a decision is made that the service is not medically needed, the provider will be able to discuss this decision with Wellpoint. If the decision remains the same, the member, member's approved representative or the provider (on the member's behalf and with their written consent) can appeal the decision. See the section on [Appeals](#).

Dates of Service

If services were approved before the member's coverage started with Wellpoint, those services will remain approved for the first 30 days the member is enrolled in Wellpoint, whether an in-network or out-of-network provider asked for the approval.

After the first 30 days the member is enrolled in Wellpoint: If the member wishes to keep receiving services from an out-of-network provider, or if the services require prior approval, the provider must ask Wellpoint to approve them before the member can receive these services.

Medical Management

Services Requiring Precertification

Some common services requiring precertification include the following (This is not an all-inclusive list and is meant to be a guide only):

- Air ambulance

- Selected behavioral health services
- Biofeedback
- Circumcision (Wellpoint covers routine circumcision without precertification for up to 12 months of age; after 12 months of age, medical necessity review is required)
- Selected durable medical equipment and disposable supplies
- Genetic testing (except routine amniocentesis and prenatal testing)
- Home healthcare services (Electronic visit verification required)
- Hyperbaric oxygen therapy (no coverage for use of equipment)
- Infusion/injection therapy
- Inpatient hospital services
- Inpatient surgeries and procedures
- Outpatient surgeries and procedures
- Pharmacy (follows Iowa Medicaid *Preferred Drug List (PDL)* and Prior Authorization (PA) criteria.
 - Prescribing providers must review the patient’s use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website prior to prescribing controlled substances to determine if use of the controlled substance is appropriate for this member based on review of PMP and the patient’s risk for opioid addiction, abuse, and misuse of the controlled substance.

Prescription Monitoring Program | Iowa Board of Pharmacy
- Physician services (referrals to out-of-network specialists require precertification)
 - NOTE: In-network physician evaluation and management services do NOT require precertification.
- Selected radiology services
- Spinal surgeries (lumbar fusion, disc excision and decompression surgery)
- Therapy services (physical, occupational and speech therapies)
- Transplant services
- Vision (Most routine vision services do not require precertification. If you have questions, call Superior Vision Care at **866-819-4298**.)
- Nursing Facility – special population (in other words, skilled preapproval) for out of state placement

To determine prior authorization requirements, use the lookup tool on the precertification page of our website at <https://providers.wellpoint.com/ia> > Provider Resources & Documents > Quick Tools.

Please note: This tool is only applicable to outpatient services at the CPT or HCPCS level. All inpatient services require prior authorization.

If the network is unable to provide a necessary service covered under its member contract, Wellpoint must provide adequate and timely coverage of these services out-of-network for members.

Please note: Emergency hospital admissions do not require precertification; however, notification is required within 24 hours or the next business day.

For members who enter a long-term care facility as *Medicaid pending*, please request precertification as soon as the state approves the Medicaid facility eligibility and the member’s updated eligibility is reflected on the Wellpoint website.

Please note: Per Iowa Administrative Code (IAC), the Iowa Medicaid Enterprise must approve facility level of care prior to a facility being eligible for payment for long-term care services provided in a facility.

Medical Management

Services Not Requiring Precertification

The following services do not require precertification when the provider is within the Wellpoint network:

- Dialysis
- Emergency services (notify Wellpoint of hospital admissions within 24 hours or the next business day)
- Selected behavioral health services
- Family planning or well-woman check-up; members may self-refer to any IA Health Link provider for the following services:
 - Birth control
 - Federal Drug Administration (FDA)-approved family planning devices and supplies (for example, intra-uterine devices)
 - Genetic counseling (Note: Genetic *testing* does require precertification, with the exception of routine amniocentesis and prenatal testing.)
 - Screening for human immunodeficiency Virus (HIV) or Sexually Transmitted Infections (STIs)
 - Lab work
 - Pelvic and breast examinations
- Laboratory services (in-network laboratories)
- Obstetrical care -please notify us of the following:
 - Pregnancies: We encourage notification of pregnancy at the first prenatal visit and notification of delivery following birth. You may choose to complete the notification of pregnancy and delivery in Availity or fax the forms to Wellpoint at **800-964-3627**.
 - The form can be found at **provider.wellpoint.com/ia** > Resources > Forms > Notification of Pregnancy.
 - Members may self-refer to a network OB-GYN.
 - Note: We only require notification; precertification is not required for labor and delivery or OB services, including OB visits, diagnostic tests, laboratory services, prenatal/postpartum office visits or ultrasounds when performed by a participating provider.
 - You should also complete the Maternity Form through Availity Essentials.
 - **Perform an Eligibility and Benefits (E&B) request on the desired member.**
 - **Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.**
 - **Before the benefit results screen, you will be asked if the member is pregnant. Choose “Yes,” if applicable. If you indicate “Yes,” provide the estimated due date, if it is known, or leave it blank if the due date is unknown. You may update the estimated due date as soon as it is known.**
 - **After submitting your answer, the E&B will display. If the member was identified as pregnant, a Maternity form will be generated. Once generated, you may access the form in the Maternity work queue.**
 - The first prenatal visit: within three days
 - Within 24 hours of delivery: Please include newborn information using the Newborn Notification of Delivery Form (baby’s date of birth, mode of delivery, gender, weight in grams, gestational age in weeks and disposition at birth).
 - The mother’s pediatrician selection for continuity of care.
- Nonemergent transportation services; call Access2Care 1-844-544-1389 for reservations
- Physician referrals (in-network for consultations or a nonsurgical course of treatment)
- Standard X-rays or ultrasound

Medical Management

Starting the Process

Contact us with questions or precertification requests regarding healthcare services, including:

- Routine, nonurgent care reviews
- Urgent or expedited preservice reviews.
- Urgent concurrent or continued stay reviews.

Precertification requests with all supporting documentation must be submitted at least 72 hours prior to the scheduled admission. Failure to comply with notification rules will result in an administrative denial.

Administrative Denial

An administrative denial is a denial of services based on reasons other than medical necessity.

Administrative denials are made when a contractual requirement is not met, such as late notification of admission, lack of precertification or failure by the provider to submit clinical information when requested.

Appeals for administrative denials must address the reason for the denial (in other words, why precertification was not obtained or why clinical information was not submitted). If Wellpoint overturns its administrative decision, the case will be reviewed for medical necessity. If approved, either the claim will be reprocessed, or the requestor will be notified of the action that needs to be taken.

Requests for precertification may be submitted by phone, fax or online:

Phone: **833-731-2143**

Fax: **800-964-3627**

Online: <https://providers.wellpoint.com/ia>

The Medical Management department will return calls:

- Same day when received during normal business hours
- Next business day when received after normal business hours

Faxes are accepted during and after normal business hours. Faxes received after hours will be processed the next business day.

Medical Management

Information Needed for Medical Necessity Determination

Medical necessity determinations are made:

- Online through Interactive Care reviewer which is accessed through Availity Essentials at www.availity.com, by following the prompts to provide all requested information.
- Via fax, by completing the Prior Authorization Request Form found at <https://providers.wellpoint.com/ia> > Provider Resources & Documents > Forms.
- By phone, by having the following information available as appropriate to the service request:
 - Member name and IA Health Link ID number
 - Diagnosis with the International Classification of Diseases (ICD-10) code
 - Procedure with the Current Procedural Terminology (CPT) code
 - Date of injury or hospital admission and third-party liability information, if applicable
 - Facility name, if applicable
 - Primary care physician (PCP)
 - Specialist or attending physician name
 - Clinical justification for the request
 - Level of care
 - Lab, radiology, and pathology test results

- Medications
- Treatment plan, including time frames
- Prognosis
- Psycho-social status
- Exceptional or special needs issues
- Ability to perform activities of daily living
- Discharge plans

All providers, including physicians, hospitals, and ancillary providers, are required to provide information to the Medical Management department. You must obtain a separate precertification for each service requiring approval. Precertification is necessary whether an in-network or out-of-network provider performs the service. For the latest information about which services require precertification, go to <https://providers.wellpoint.com/ia>.

Generally speaking, the provider is responsible for contacting us to request preservice review for both professional and institutional services. However, hospital or ancillary providers should also contact Wellpoint to verify preservice review status for all nonurgent care before rendering services.

Medical Management

Requests with Insufficient Clinical Information

When the Medical Management department receives requests with insufficient clinical information, we will contact the provider with a request for the information reasonably necessary to determine medical necessity. We will make at least one attempt to contact the requesting provider to obtain this additional information. If we do not receive a response, the request will be reviewed with the information originally submitted and denied. A denial letter will be sent to both the member and the provider.

Medical Management

Urgent Requests

Based on the member's condition, you may request an urgent determination. The Medical Management department will complete an urgent preservice determination once clinical information is received from the provider. If additional information is needed to authorize the admission, the Medical Management team will submit a request within 24 hours. The provider will then have 48 hours to provide the additional clinical information.

Medical Management

Routine Requests

For nonurgent requests, the Medical Management department will make a determination as quickly as possible, but always within 14 calendar days of a routine request.

Medical Management

Emergency Medical Services

Wellpoint does not require precertification for treatment of emergency medical conditions. In the event of an emergency, members may access emergency services 24 hours a day, 7 days a week. If the emergency room visit results in the member's admission to the hospital, providers must contact Wellpoint within 24 hours or the next business day.

Medical Management

Emergency Stabilization and Post-Stabilization

The emergency department's treating provider determines the services needed to stabilize the member's emergency medical condition. After the member is stabilized, the emergency department's provider must contact Wellpoint for authorization of further services. If we do not respond within one hour, we consider the necessary services authorized.

The emergency department should send a copy of the emergency room record to the PCP's office within 24 hours. The PCP should:

- Review and file the chart in the member's permanent medical record
- Contact the member
- Schedule a follow-up office visit or a specialist referral, if appropriate

Medical Management

Concurrent Review: Hospital Admissions

Hospitals must notify us of an admission within 24 hours of admission or by the next business day. Notify us by providing preliminary clinical information about the following admissions:

- Behavioral health
- Medical care
 - Inpatient admissions
 - Observation admissions (notification only required) – This can be removed. Observation no longer requires an authorization.
- Substance abuse

After notification of an inpatient admission is received, we will send a request for clinical information supporting the admission's medical necessity. Evidence-based criteria are used to determine medical necessity and the appropriate level of care.

Medical Management

Concurrent Review: Clinical Information for Continued-Stay Review

When a member's hospital stay is expected to exceed the number of days authorized during preservice review, or when the inpatient stay did not have preservice review, the hospital must contact us for continued stay review. We require clinical reviews on all members admitted as inpatients to:

- Acute care hospitals
- Intermediate facilities
- Skilled nursing facilities
- Custodial nursing facilities
- Inpatient rehabilitation, psychiatric and substance abuse treatment facilities

We perform these reviews to assess medical necessity and determine whether the facility and level of care are appropriate. Wellpoint identifies members admitted as inpatients by:

- Facilities reporting admissions
- Providers reporting admissions
- Members or their representatives reporting admissions
- Claims submitted for services rendered without authorization
- Preservice authorization requests for inpatient care

The Medical Management department will complete a continued-stay inpatient review within 24 hours of receipt of clinical information or sooner, consistent with the member's medical condition. Medical

Management nurses will request clinical information from the hospital on the same day as notification regarding the member's admission and/or continued stay. Providers should notify the health plan of an inpatient admission within 24 hours of the admission.

If the information meets medical necessity review criteria, we will approve the request within 24 hours of receipt of the information. We will send requests that do not meet medical policy guidelines to the physician adviser or medical director for further review. In addition to notifying providers of the decision within 24 hours, we will send written notification of denial or modification of the request to the member and the requesting provider.

Readmission

Wellpoint follows the state of Iowa's 30-day readmission policy. We may review hospital admissions on a specific member if it appears that two or more admissions are related based on same DRG. The claim review, which includes a review of medical records if requested from the provider, may result in necessary adjustments. If so, we'll make all necessary adjustments to the claim (including recovery of payments) 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 us may be subject to a recoupment.

Important to Note:

- The review for admission is based on the DRG and not on diagnosis codes.
- Per diem information should be used in identifying readmissions instead of relying on diagnosis codes.
- Claims should be combined by the provider prior to submission. Providers are responsible for, and required to self-adjust, claims within the 30-day window.

Medical Management

Concurrent Review: Second Opinions

The following are important guidelines regarding obtaining a second opinion:

- The second opinion must be given by an appropriately-qualified healthcare professional.
- The second opinion must come from a provider of the same specialty as the first provider.
- The secondary specialist may be selected by the member.
- The secondary specialist must be within our network. When there is no network provider who meets the qualification, we may authorize a second opinion by a qualified provider outside of the network, upon request by the member or provider.

A second opinion regarding medical necessity is a covered service, offered at no cost to our members.

Medical Management

Denial of Service and Peer-to-Peer Review

Only a medical or behavioral health physician with an active professional license or certification may deny services for lack of medical necessity, including the denial of:

- Procedures.
- Hospitalization.
- Equipment.

When a request is determined to be not medically necessary, the requesting provider will be notified of:

- The decision.
- The process for appeal.
- How to reach the reviewing physician for peer-to-peer discussion of the case.
- How to request the criteria and guidelines on which the decision was based.

Requesting physicians may wish to speak with the Wellpoint reviewing physician. This peer-to-peer discussion may be initiated by calling the peer-to-peer number at **844-227-8345** within two business days. A peer-to-peer is not required to appeal an adverse decision.

Medical Management

Referrals to Specialists

The Medical Management department is available to assist providers in identifying a network specialist and/or arranging for specialist care. Please keep in mind that specialists must be Iowa Medicaid-certified, whether in-network or out-of-network. Also keep in mind the following Medical Management guidelines.

Authorization is:

- Required when referring a member to an out-of-network specialist.
- Required for an out-of-network referral when an in-network specialist is not available in the geographical area.
- Not required if referring a member to an in-network specialist for consultation or a nonsurgical course of treatment.

Provider responsibilities include documenting referrals in the member's chart and requesting the specialist to provide updates about diagnosis and treatment.

Please note: Obtain a precertification approval number before referring members to an out-of-network provider. For out-of-network providers, we require precertification for the initial consultation and each subsequent service.

Medical Management

Additional Services: Behavioral Health

Wellpoint is committed to providing a continuum of care management from initial contact to coordination of care and interventions. Our behavioral healthcare managers work closely with our medical case managers to support the behavioral health services needed by our members. The key to this support system is our three-tiered system:

- **Tier 1:** Member Services and outreach calls to members.
- **Tier 2:** Increased interaction with members to assist with provider referrals, problem-solving and removing obstacles to receiving treatment.
- **Tier 3:** Intensive case management offering interventions on an episodic basis or triggered by a long length of stay, medical and behavioral health comorbidity, and/or multiple admissions.

Contact the Medical Management department for more information and precertification of all behavioral health, facility-based care, including:

- Inpatient admissions.
- Intensive outpatient program.
- Emergency department visits.
- Partial hospitalization programs.
- Pharmacological management.

Please have the following information ready when requesting a referral:

- Clinical information supporting the request
- Diagnosis with ICD code
- First date of outpatient service or date of hospital admission
- Procedure with CPT and/or HCPCS codes
- Specialist or attending provider name

Medical Management

Chronic Condition Health Home and Integrated Health Home

Chronic Condition Health Home (CCHH) eligibility criteria require members to have two chronic conditions, or one chronic condition and the risk of developing another from the following list:

- Mental health condition
- Substance use disorder
- Asthma
- Diabetes
- Heart disease
- BMI over 25
- Chronic Pain
- COPD
- Hypertension
- Child BMI > 85th percentile

An Integrated Health Home (IHH) is a team of professionals working together to provide person-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). Eligibility for IHH services includes either a diagnosis of Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) with severe functional impairment.

Eligibility criteria include:

- Members who get full Medicaid benefits.
- Members who get full Medicaid benefits and also have Medicare.
- Members enrolled in the Iowa Health and Wellness Plan and are determined to be medically exempt.
- Members enrolled in the 1915(j) Habilitation program.
- Members enrolled in the 1915(c) Children's Mental Health Waiver.

Health Home Providers

Health Home providers are selected based on meeting provider standards as described in the Iowa State Plan Amendment to CMS with initial approval on June 08, 2012, for chronic health conditions, and Integrated Health Home for Adults and Children, with initial approval on June 18, 2013.

- a) CCHH providers are registered with the state and practitioners operating within a Health Home Practice agree to adhere to the Health Home Provider Standards. Health Home Practices may include but are not limited to primary care practices, Community Mental Health Centers, Federally Qualified Health Centers, and Rural Health Clinics. CCHHs include staff to fill the following roles:
 - i) Designated practitioner
 - ii) Nurse Practitioner / Physician Assistant
 - iii) Dedicated care coordinator
 - iv) Health coach
- b) IHH providers will meet Iowa certification and accreditation standards, be able to provide community-based mental health services, and in conjunction with Wellpoint, include a physician and a psychiatrist who hold an active Iowa license that may be employed by Wellpoint or the Health Home partner. The Health Home partner will have a:
 - i) Nurse care manager
 - ii) Care coordinator
 - iii) Peer support specialist or family support specialist

Wellpoint provides supports, consultation and training for Health Home providers as outlined in the Health Home State Plan Amendments. Wellpoint serves as the Lead Entity and:

- Develops a network of Health Homes
- Educates and supports providers
- Provides training, technical assistance, expertise, and oversight to the Health Homes
- Provides oversight and technical support for Health Home providers to coordinate with primary care providers
- Provides infrastructure and tools to Health Home providers
- Provides outcome tools and measurement protocols to assess effectiveness
- Provides clinical guidelines and other decision support tools
- Provides a repository for member data
- Supports providers to share data
- Develops and offers learning activities
- Performs data analysis at the member level and program-wide to inform continuous quality improvement
- Offers performance measure program which may include incentives
- Reimburses providers
- Identifies and enrolls members

For more information, refer to the Health Homes Supplemental Provider Manual located at <https://providers.wellpoint.com/ia>.

Payment and Incentive Payments

Health Home providers are paid a monthly payment per enrollee/per month, based on a tiered approach with an eligible bonus for meeting quality standards (to be defined in the provider contract).

Medical Management

Additional Services: Vision Care

Members have access to basic vision care services through Superior Vision Care providers. For confirmation of vision services, contact Superior Vision Care at **866-819-4298**.

CHAPTER 9: HEALTH SERVICES PROGRAMS

Health Services Programs

Overview

At Wellpoint, we're proud of our joint efforts with the community-based health organizations to maximize healthcare services for our members. These service organizations include the following:

- Diabetes Prevention program
- Iowa Department of Health and Human Services
- Local health departments
- Prenatal care coordination agencies
- School-based service providers

Our approach is collaborative, results-oriented, community-based, and member-centered.

We encourage providers to work with these community organizations to coordinate care, ensure continuity and provide culturally appropriate services to our members enrolled in IA Health Link. Our agreements offer clear guidelines for sharing clinical data that can help our members lead healthier lives.

The intent of our collaboration with our community partners is to supplement providers' treatment plans. When combined with our own Health Services programs, they can improve our members' overall health by informing, educating, and encouraging self-care. The targeted programs are divided into four categories:

- Preventive care programs, including Taking Care of Baby and Me® for mothers-to-be, Well Woman for keeping women healthy at any stage of life, and HealthCheck, a health screening and immunization program for members under the age of 21.
- Health management programs that promote knowledge and encourage self-care for specific medical conditions and chronic disease, including diabetes, asthma, and heart disease.
- Health education, including our Wellpoint on Call phone line, available 24 hours a day, 7 days a week for all health-related questions.
- Telehealth, a unique healthcare delivery method utilizing computers and videoconferencing equipment to connect providers to specialists in different locations.

Health Services Programs

Preventive Care: Initial Health Assessments

The initial health assessment (IHA) offers a baseline for providers to assess and manage a member's physical condition. Providers then offer the educational support necessary to allow members to become more actively engaged in their own treatment and preventive healthcare.

We encourage our members to schedule a visit with their new PCP as soon as possible after enrollment. The IHA should include the following categories of patient information:

- Demographics
- Patient history
- Physical examination
- Developmental assessment
 - Self-perceived health status
 - Behavioral change strategies
 - Special needs (for example, hearing/vision impairment and language preferences)

Health Services Programs

Preventive Care: Well Woman

The Well Woman program was designed to remind and encourage women to have regular cervical and breast cancer screenings. PCP responsibilities for the care of female members include:

- Educating members on **Preventive Health Care Guidelines** for women
- Informing and referring members for cervical and breast cancer screenings
- Scheduling screening exams for members

If the PCP is not a women's health specialist, Wellpoint will offer female members direct access to women's health specialists within the network for covered, routine and preventive healthcare services.

Members have the right to receive family planning services, in addition to routine care, from any Medicaid provider. Members also have the right to receive tuberculosis, sexually transmitted infection (STI) and HIV/AIDS care from any public health agency.

Health Services Programs

Preventive Care: Taking Care of Baby and Me®

Taking Care of Baby and Me is a proactive case management program for all expectant members and their newborns. We use several resources to identify pregnancies as early as possible. Sources of identification include, state enrollment files, claims data, hospital census reports, the Availity Maternity form, and notification of pregnancy forms, as well as provider and member self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk.

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. Case managers collaborate with community agencies to ensure pregnant members have access to necessary services.

When it comes to our pregnant members, we are committed to keeping both parent and baby healthy. That is why we encourage all our pregnant and postpartum members to take part in our Taking Care of Baby and Me program, a comprehensive case management and care coordination program which offers:

- Individualized, one-on-one case management support for pregnant members at the highest risk
- Care coordination for those who may need a little extra support
- Digital perinatal educational tools
- Information on community resources
- Incentives to keep up with prenatal and postpartum checkups and well-child visits after the baby is born

As part of the Taking Care of Baby and Me program, perinatal members have access to a digital maternity program. The digital program provides pregnant and postpartum members with proactive, culturally appropriate education via a smartphone app. Once members are identified as being pregnant, they will receive an invitation to access this program by downloading the app. After the app is installed and the member registers, they are asked to complete a pregnancy screener. The answers provided in the screener allows Wellpoint to assess their pregnancy risk.

After risk assessment is complete, the digital program delivers gestational-age-appropriate education directly to the member. This program does not replace the high-touch, individual case management approach for our highest risk pregnant members; however, it does serve as a supplementary tool to extend our health education outreach. The goal of the expanded outreach is to ensure maternity education is

available to all perinatal members and help Wellpoint to identify members who experience a change in risk acuity throughout the perinatal period.

We request notification of pregnancy at the first prenatal visit and notification of delivery following birth. You may choose to complete the notification of pregnancy and delivery in Availity or fax the forms to Wellpoint at **800-964-3627**.

In addition to submitting the *Notification of Pregnancy* form, we also encourage providers to complete the Maternity form in Availity Essentials:

- **Perform an Eligibility and Benefits (E&B) request on the desired member.**
- **Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.**
- **Before the benefit results screen, you will be asked if the member is pregnant. Choose “Yes,” if applicable. If you indicate “Yes,” provide the estimated due date, if it is known, or leave it blank if the due date is unknown. You may update the estimated due date as soon as it is known.**
- **After submitting your answer, the E&B will display. If the member was identified as pregnant, a Maternity form will be generated. Once generated, you may access the form in the Maternity work queue.**
- **After delivery, go into the Maternity Work Queue and update details, complete the questions in the form, and SUBMIT the form for all PENDING status forms.**

We encourage healthcare providers to share information about the Taking Care of Baby and Me program and the digital maternity tools offered at Wellpoint with members. Members may access information about the products that are available by visiting the Wellpoint member website.

For more information about the Taking Care of Baby and Me program or the digital maternity tools, reach out to your OB Practice Consultant or Provider Services at **833-731-2143**, or refer to our website at <https://provider.wellpoint.com/iowa-provider/patient-care/maternal-child-services>.

NICU Case Management

For parents with infants admitted to the Neonatal Intensive Care Unit (NICU), the health plan offers the NICU Case Management program.

Highly skilled and specialized NICU case managers work closely with the child’s parents to help them cope with the day-to-day stress of having an infant in the NICU, encourage them to stay actively involved in their child’s care, and assist them in preparing themselves and their homes for their child’s upcoming discharge from the NICU.

After the NICU member is safely discharged from the hospital, the case manager continues to provide parents with education and support to effectively guide them to appropriate community resources, foster improved member outcomes, and prevent unnecessary hospital readmissions.

The stress of having an infant in the NICU may result in post-traumatic stress disorder (PTSD) symptoms for parents and loved ones. To reduce the impact of PTSD among our members, we assist by:

- Guiding parent(s) into hospital-based support programs, if available.
- Screening parent(s) for PTSD approximately one month after their baby’s date of birth.
- Referring parent(s) to behavioral health program resources, if indicated.
- Reconnecting with a one-month follow-up call to assess if the parent(s) received benefit from initial contact and PTSD awareness.

Our case managers are here to help you. If you have a patient in your care that would benefit from NICU Case Management program, please call Provider Services at **833-731-2143**. Members can also call Wellpoint on Call at **866-864-2544** (English) (TTY: 711) or **866-864-2545** (Spanish), available 24 hours a day, 7 days a week.

Health Services Programs

Preventive Care: Long-acting Reversible Contraception

IA Health Link members have access to immediate postpartum placement of long-acting reversible contraception (intrauterine devices [IUDs] and etonogestrel implants) during their inpatient delivery admission. Physicians may implant the device of the patient’s choice. Facilities and providers will receive the same reimbursement as if the device were implanted on an outpatient basis.

To help ensure the devices are immediately available to patients, postpartum facilities are encouraged to stock obstetrical units with the LARC devices. The device HCPCS codes and insertion CPT codes for the inpatient procedure are noted below:

HCPCS code	Description
J7300	Intrauterine copper contraceptive
J7301	Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies
J7297	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, three-year duration
J7298	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, five-year duration
J7296	Levonorgestrel-releasing intrauterine contraceptive system, 19.5 mg, five-year duration (Kyleena)
CPT code	Description
11981	Insertion, non-biodegradable drug delivery implant
58300	Insertion of IUD

Unintended pregnancies continue to be a major health problem in the United States. These unintended pregnancies are associated with higher rates of maternal and neonatal complications of pregnancy. Long-acting methods are more effective at preventing unintended pregnancies, have significantly greater continuation rates than oral contraceptives, the vaginal contraceptive ring, or the contraceptive patch, and have very low rates of serious side effects.

We respectfully ask providers to discuss reproductive life planning, and if appropriate, the option of immediate postpartum placement of the IUD or implant with their patients. It is suggested these discussions take place early on, during the third trimester of pregnancy. Please provide additional counseling and support to your teenage and young patients (ages 13-19), as this group is at the greatest risk for early discontinuation of contraception. It appears there is lower discontinuation at two years of IUDs as compared to the etonogestrel implant. When clinically appropriate, IUDs should be considered over the implant.

If you have questions regarding providing this new service to your patients, please contact Provider Services at **833-731-2143**, Monday through Friday, from 7 a.m.-6:30 p.m. Central time. You may also visit our website at <https://providers.wellpoint.com/ia>.

Health Services Programs

Health Management: Condition Care

Our Condition Care (CNDC) programs are based on a system of coordinated care management interventions and communications designed to assist physicians and others in managing members with chronic conditions. We also offer weight management and smoking cessation education to members with a CNDC condition. The programs include a holistic, member-centric care management approach focusing on the needs of the member through telephonic and community-based resources. Motivational interviewing techniques used in conjunction with member self-empowerment, and the ability to manage more than one condition to meet the changing healthcare needs of our member population. Please note a member must have a qualifying CNDC condition in order to enroll in a program.

Our Condition Care programs include:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disorder (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder – Adult
- Major depressive disorder – Child and Adolescent
- Schizophrenia
- Substance use disorder

Program Features

- Proactive identification process
- Program content is based on evidence-based *Clinical Practice Guidelines*
- Collaborative practice models that include the physician and support providers in treatment planning
- Continuous self-management education, including primary prevention, coaching related by healthy behaviors compliance/monitoring, and case/care management for high-risk members
- Ongoing communication with primary and ancillary providers regarding patient status
- Nine of our Condition Care programs are National Committee for Quality Assurance accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care.

Wellpoint Condition Care *Clinical Practice Guidelines* are located at <https://providers.wellpoint.com/ia>. A copy of the guidelines can be printed from the website, or you can contact Provider Services at **833-731-2143** to request a copy.

Who is Eligible?

Members diagnosed with one or more of the conditions listed are eligible for Condition Care services.

Condition Care Provider Rights and Responsibilities

The provider has the right to:

- Have information about Wellpoint, including provided programs and services, our staff, and our staff's qualifications and any contractual relationships.

- Decline to participate in or work with the Wellpoint programs and services for his or her patients, depending on contractual requirements.
- Be informed of how Wellpoint coordinates our interventions with treatment plans for individual patients.
- Know how to contact the person responsible for managing and communicating with the Provider's patients.
- Be supported by the organization to make decisions interactively with patients regarding their healthcare.
- Receive courteous and respectful treatment from Wellpoint staff.
- Communicate complaints regarding Condition Care as outlined in the Wellpoint Provider Complaint and Grievance Procedure.

Hours of Operation

Wellpoint case managers are registered nurses are available Monday through Friday, from 8:30 a.m.-5:30 p.m. Central time. Confidential voicemail is available 24 hours a day.

Contact Information

Please call **888-830-4300** (TTY: 711) to reach a case manager or email us at Condition-Care-Provider-Referrals@wellpoint.com. Additional information about Condition Care can be obtained by visiting <https://providers.wellpoint.com/ia>.

Health Services Programs

Health Management: Healthy Families

Healthy Families is a six-month program for children 7-17 years of age who are overweight, obese or at risk of becoming overweight or obese. Healthy Families includes coaching using motivational interviewing, lifestyle education and written materials to support member-identified goals. Members can be referred to the program by calling **844-421-5661**.

Health Services Programs

Health Management: Women, Infants and Children

The special supplemental nutrition program for Women, Infants and Children (WIC) serves to safeguard the health of low-income women, infants, and children up to age 5 who are at nutritional risk. WIC provides nutritious foods to supplement diets, information on healthy eating, and referrals to healthcare.

Providers are responsible for:

- Identifying if a member is eligible for WIC and referring that member to the WIC program.
- Informing and educating eligible members of the availability of WIC services, including availability of food vouchers, nutrition education classes and community referrals.
- Providing written materials about WIC services in the provider's office.

Member eligibility is contingent upon meeting WIC's nutritional risk requirement* as well as:

- A woman who is pregnant, up to six weeks after the birth.
- A woman who is breastfeeding, up to the infant's first birthday.
- An infant, up to the infant's first birthday.
- A child, up to the child's fifth birthday and who is at nutritional risk.

* The nutritional risk requirement means an individual has medically based or dietary-based conditions.

Examples are as follows:

- Medically based conditions include anemia, underweight, or a history of poor pregnancy outcomes.
- Dietary-based conditions include a failure to meet dietary guidelines or inappropriate nutrition practices.

For more information about the WIC program, go to the WIC website at <http://idph.iowa.gov/wic>.

Health Services Programs

Health Education: Wellpoint on Call

We recognize that questions about healthcare prevention and management do not always come up during office hours. Wellpoint on Call, a phone line staffed by registered nurses, provides a powerful provider support system and is a component of after-hours care. Wellpoint on Call allows members to closely monitor and manage their own health by giving members the ability to ask questions whenever the need arises. Wellpoint on Call is available 24 hours a day, 7 days a week by calling **866-864-2544** (English) or **866-864-2545** (Spanish) (TTY: **711**).

Members may contact Wellpoint on Call for:

- Self-care information, including assistance with symptoms, medications and side-effects, and reliable self-care home treatments.
- Access to specialized nurses trained to discuss health issues specific to our teenage members.
- Information on more than 300 healthcare topics through Wellpoint on Call audio tape library.

Wellpoint on Call nurses have access to telephone interpreter services for callers who do not speak English. All calls are confidential.

Health Services Programs

Health Education: Drug Lock-In Initiative

In conjunction with our initiative to reduce inappropriate use of the emergency room (ER), we developed a lock-in program to decrease inappropriate use of the ER for pain management and drug-seeking behavior. Members receive information about the primary care hospitals and pharmacies they may use to receive services and procure pharmaceuticals. Providers assigned to the member receive information on members who are assigned to the lock-in program.

Health Services Programs

Health Education: Smoking Cessation

A member can enroll with the Wellpoint Smoking Cessation Program which offers Nicotine Replacement Therapy (NRT) and counseling. If a member is participating with the Wellpoint Smoking Cessation Program administered by National Jewish Health (NJH), **no prior authorization is required**.

To help a member enroll with Wellpoint Smoking Cessation Program:

The member can self-refer by calling Member Services **833-731-2140**. The provider can also refer the member by calling Provider Services at **833-731-2143**.

What happens when a member is referred to the Wellpoint Smoking Cessation Program?

- a. Wellpoint confirms member enrollment and the member's information is passed along to Wellpoint's vendor, National Jewish Health (NJH). NJH contacts the member within one business day of receiving the referral. Three attempts are made to reach the member. If the member is reached, counseling begins. After completion of the first call, the member is eligible for NRT product.
- b. If the member wants NRT, NJH conducts a medical screen for contraindications. If contraindication is indicated, NJH sends provider consent form to provider. The provider completes the form and returns it

to NJH as indicated on consent form via fax to 1-888- 827-7057 or mail Real Solutions Tobacco Cessation Program by Wellpoint c/o National Jewish Health 1400 Jackson St., S117A Denver, CO 80206).

- c. If the provider approved use of NRT or the member does not have any contraindications, NJH ships a 28-day supply of NRT directly to member's home. Under this program the member is allowed up to a two months' supply of patches, lozenges, or gum.

Health Services Programs

Provider Assessment of Smoking Use

The following are guidelines providers should use to help members quit smoking:

- Assess members' smoking status and offer advice about quitting.
- Use the state's online Notification of Pregnancy form as a way to notify us, through the state, of pregnant women who smoke. Women are more likely to quit smoking during pregnancy.
- Offer members resources to stop smoking, including Clearing the Air program information from the National Cancer Institute.
- Refer members to the Wellpoint Smoking Cessation Program by having the member call Member Services **833-731-2140**. The provider can also refer the member by calling Provider Services at **833-731-2143**.

CHAPTER 10: CLAIMS SUBMISSION AND GUIDELINES

Claims Submission and Guidelines

Overview

Having a fast and accurate system for processing claims allows providers to manage their practices and our members' care more efficiently. With that in mind, Wellpoint has made claims processing as streamlined as possible. Share the following guidelines with your staff, billing service and electronic data processing agents:

- Submit "clean" claims, making sure the right information is on the right form
- Submit claims within the contracted filing time limit
- Submit corrected claims with the appropriate frequency code, within the contracted filing limit

You can check the status of a claim anytime by logging in to Availity Essentials at <https://www.availity.com> and selecting **Claims & Payments** > Claim Status

When viewing the status of a claim on Availity, there may be options available to submit medical records or an itemized bill or to dispute the claim.

In this chapter, we also provide a detailed list of the following:

- Covered services
- Clinical submission categories
- Common reasons for rejected and returned claims
- Reimbursement policies

Claims Submission and Guidelines

Submitting "Clean" Claims

Claims are defined as "clean" when they are submitted without any defects, with all required information required for processing and in the timely filing period.

A claim submitted with incomplete or invalid information may be returned. If you use the Electronic Data Interchange (EDI), claims will be returned for incomplete or invalid information. Claims may be returned if they are not submitted with the proper HIPAA-compliant code set. In each case, an error report would be generated and sent to the provider for claims not accepted. You and your staff are responsible for working with your EDI vendor to ensure "errored out" claims are corrected and resubmitted. If you use a vendor work with them to receive your EDI reporting.

Generally, there are two types of forms you'll need for reimbursement:

- CMS-1500 for professional services: <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1188854.html>
- CMS-1450 (UB-04) for institutional services: <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1196256.html>

Using the wrong form or not filling out the form correctly or completely causes the claim to be returned, resulting in processing and payment delays.

Electronic Data Interchange (EDI)

Availity is our exclusive partner for managing all Electronic Data Interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient, and cost-effective way for providers to do business.

Use Availity for the following EDI transactions:

- Healthcare Claim: Professional (837P)

- Healthcare Claim: Institutional (837I)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Availity's EDI submission Options

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, visit – www.availity.com > Provider Solutions > EDI Clearinghouse.
- Use your existing vendor for your EDI transactions (work with your vendor to ensure connection to the Availity EDI Gateway)

EDI Response Reports

Claims submitted electronically will return response reports that may contain rejections. If using a Clearinghouse or Billing Vendor, please work with them to ensure you are receiving all reports. It's important to review rejections as they will not continue through the process and require correction and resubmission. For questions on electronic response reports contact your Clearinghouse or Billing Vendor or Availity at **800-AVAILITY (800-282-4548)**.

Availity EDI Payer ID WLPNT

Note: If you use a clearinghouse, billing service or vendor, please work with them directly to determine payer ID.

Electronic Remittance Advice (ERA)

The 835 eliminates the need for paper remittance reconciliation.

Use Availity to register and manage ERA account changes with these three easy steps:

- Log in to **Availity** <https://apps.availity.com/availity/web/public.elegant.login>
- Select **My Providers**
- Select **Enrollment Center** and select **Transaction Enrollment**

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERA's.

Contact Availity Essentials

Contact Availity Client Services with any questions at **800-AVAILITY (282-4548)**.

Electronic Funds Transfer (EFT)

Electronic claims payment through electronic funds transfer (EFT) is a secure and fastest way to receive payment reducing administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

Use EnrollSafe (<https://enrollsafe.payeehub.org/>) to register and manage EFT account changes.

After submitting electronic claims, monitor claim status by doing the following:

- Access Availity Essentials, the secure provider portal, on our website at <https://providers.wellpoint.com/ia>. Select **Login** or **Register** to access the secure site.
- Watch for and confirm electronic response reports from your vendor/clearinghouse to ensure your claims have been accepted by Wellpoint. If rejections occur correct and resubmit.

EDI Submission for Corrected Claims

For corrected electronic claims:

- Use frequency type (7) - Replacement of Prior Claim
- Submit original claim number for the corrected claim

EDI segments required:

- Loop 2300- CLM - Claim frequency code
- Loop 2300 - REF - Original claim number

Work with your vendor on how to submit corrected claims.

Claims Submission and Guidelines

Please note: Some claims may require additional attachments. Be sure to include all supporting documentation when submitting your claim.

If the claim contains all required information, Wellpoint accepts the claim into the claims system for processing and sends you either a remittance advice (RA) or a claims disposition notice (CDN) when the claim is finalized.

Claims Submission and Guidelines

National Provider Identifier

The NPI is a 10-digit, all numeric identifiers. NPIs are issued only to providers of health services and supplies. As a provision of HIPAA, the NPI has been established to improve efficiency and reduce fraud and abuse. All Wellpoint participating providers must have an NPI number with the exception of atypical providers.

NPIs are divided into two types:

- **Type One:** Individual providers, including, but not limited to physicians, dentists, chiropractors, and pharmacists
- **Type Two:** Hospitals and medical groups, including but not limited to hospitals, group practices, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Using your NPI for claims and billing has several advantages due to simplification, for example:

- **Billing process:** Maintaining and using legacy identifiers for each of the healthcare plans is no longer necessary.
- **Provider changes:** Modifying provider information is easier, such as changing a business address or phone number.
- **Provider identification:** Using a single identification number for electronic transactions with any healthcare plan with which they are affiliated.

NPI: HIPAA requires the adoption of a standard unique provider identifier for healthcare providers. All Wellpoint participating providers must have an NPI number, with the exception of atypical providers. The NPI is a 10-digit intelligence-free numeric identifier. Intelligence-free means the numbers do not carry information about healthcare providers, such as the state in which they practice or their specialty.

Providers may apply for an NPI online at the National Plan and Provider Enumeration System (NPPES) website: <https://nppes.cms.hhs.gov/#/>. Or request a paper application by calling NPPES at **800-465-3203**.

The following websites offer additional NPI information:

- CMS: <https://www.cms.gov>
- NPPES: <https://nppes.cms.hhs.gov/#/>
- Workgroup for Electronic Data Interchange: www.wedi.org
- National Uniform Claims Committee: www.nucc.org

Atypical Providers

Atypical providers include individuals or businesses that are not healthcare providers and do not meet the definition of a healthcare provider according to the NPI rules. These types of providers do not require an NPI number. Examples of atypical providers include but are not limited to the following:

- Home delivered meals
- Consumer Directed Attendant Care, Individual and Agency
- Homemaker services
- Companion services
- Home modification/repair services
- Transportation services

Claims Submission and Guidelines

Enrollment in Iowa Medicaid

To be reimbursed for services by Wellpoint, providers must successfully complete Iowa Medicaid's provider enrollment process. Providers enroll by completing an online enrollment application at www.dhs.iowa.gov/iqrs/forms.

Claims Submission and Guidelines

ICD-10 Clinical Modification (CM)

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements and in accordance with the rule issued by the U. S. Department of Health and Human Services (HHS).

What is ICD-10?

International Classification of Diseases, 10th Revision (ICD-10) is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes; and in the United States, the codes are the foundation for documenting the diagnosis and associated services provided across healthcare settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:

- ICD-10-CM (Clinical Modification) used for diagnosis coding
- ICD-10-PCS (Procedure Coding System) used for inpatient hospital procedure coding; a variation from the WHO baseline and unique to the United States

ICD-10-CM replaced the code sets, ICD-9-CM, Volumes 1 and 2 for diagnosis coding, and ICD-10-PCS will replace ICD-9-CM, Volume 3 for inpatient hospital procedure coding.

Claims Submission and Guidelines

Claim Filing Limits

Filing limits are determined as follows:

- If Wellpoint is the primary payer, the time period is 180 days.
- If Wellpoint is the secondary payer, the time period is 365 days for an in-network provider and 365 days for an out-of-network provider.

The time period is determined from the last date of service on the claim through the Wellpoint receipt date. If Wellpoint is the secondary payer, the 180-day period will not begin until the provider receives notification of the primary payer's responsibility. This is outlined in the Provider Agreement. Claims must be submitted within the contracted filing limit to be considered for payment. Claims submitted after that time period will be denied for timely filing.

Please note: Wellpoint is not responsible for a claim never received. If a claim is submitted inaccurately, prolonged periods before resubmission may cause you to miss the filing deadline. Claims must pass basic edits to be considered received. To avoid missing deadlines, submit clean claims as soon as possible after delivery of service.

The following table outlines which form to use for different services and the time limit to file.

Claims Submission and Guidelines

Claim Forms and Filing Limits

Refer to the provider contract to confirm the time limits to file.

Form	Type of Service to be Billed	Time Limit to File
CMS-1500 Claim Form	<p>Physician and other professional services. Specific ancillary services, including the following:</p> <ul style="list-style-type: none"> • Ambulance • Ambulatory surgical center • Area education agencies • Audiologists • Birthing centers • Certified registered nurse anesthetists • Chiropractors • Clinics • Community mental health clinics • Dialysis • Durable medical equipment (DME) • Diagnostic imaging centers • Federally qualified health clinics • Family planning clinics • HCBS • Hearing aid dispensers • Home infusion • Hospice • Independently practicing physical therapists • Laboratories • Lead investigation agency • Maternal health centers • Medical equipment and supply dealers • Nurse midwives • Occupational therapy • Opticians / optometrists • Orthotics / Orthopedic shoe dealers • Physical therapy • Prosthetics • Rural health clinics • Screening centers • Skilled nursing facilities (SNFs) • Speech therapy <p>Some ancillary providers may use a CMS-1450 form if they are ancillary institutional providers. Ancillary charges by a hospital are considered facility charges.</p>	Submit within 180 days of service date.
CMS-1450 Claim Form	Hospitals, institutions, and home health services.	Submit within 180 days of service date.

Claims Submission and Guidelines

Other Filing Limits

Action	Description	Time Frame
Third-Party Liability or Coordination of Benefits (COB)	If the claim has third-party liability, COB or requires submission to a third party before submitting to Wellpoint, the filing limit starts from the date of service.	365 days from the date of the explanation of payment (EOP)
Checking Claim Status	Check claim status at any time by calling Provider Services or accessing our secure Provider portal, Availity, through our website at https://providers.wellpoint.com/ia . Refer to the <i>Monitoring Submitted Claims</i> section of this chapter for details.	
Claim Follow-Up	Submitting a corrected claim after Wellpoint requests additional information, or a correction to a claim.	Return the requested information within 90 days of the date of the request.
Provider Dispute	To request a provider dispute, submit your request through www.availity.com or send your written request to: Payment Dispute Unit Wellpoint P.O. Box 61599 Virginia Beach, VA 23466-1599	Submit within 180 days of receipt of the Wellpoint remittance advice (RA) of the notice of action.
Retro Eligible Members	In instances where a member is made retro-eligible to Wellpoint, the provider must submit the claims within 90 days of the date that they are made retro-eligible. However, the provider is responsible for obtain and authorization for any services on a go forward basis.	Submit the claim within 90 days of the date the member is made retro eligible. The claims may deny for timely filing initially but contact your provider relations representative for assistance if needed in these circumstances or contact Provider Services.

Claims Submission and Guidelines

Claims from Noncontracted Providers

The filing limit for out-of-network provider submissions of claims to the contractor is 12 months from the date of service. This conforms with the filing limit under the Medicaid state plan (42 C.F.R. § 447.45[d][4]). Wellpoint accepts the following claims from noncontracted providers under certain conditions and within certain time frames:

- Emergency services: 365 days from date of service or discharge date
- Medicaid enrolled: 365 days with precertification if services are not available in Iowa
- Newly Medicaid enrolled: Within 365 days of the date the new provider identifier is issued, and within 365 days of the date of service

Claims Submission and Guidelines

Balance Billing

Providers contracted with Wellpoint may not balance bill members for covered services above the amount Wellpoint pays to the provider.

Providers may balance bill a member when precertification of a covered service is denied. The provider must establish and demonstrate compliance with the following:

- Establish that precertification was requested and denied before rendering service.
- Request a review of the authorization decision made by Wellpoint.

- Notify the member that the service requires precertification and that Wellpoint has denied authorization. If out-of-network, the provider also must explain to the member that covered services may be available without cost when provided by an in-network provider. In such cases, precertification of service is required.
- Inform the member of his or her right to file a grievance if the member disagrees with the decision to deny authorization.
- Inform the member of his or her responsibility for payment of nonauthorized services.
- If the provider uses a waiver to establish member responsibility for payment, the waiver must meet the following requirements:
 - The waiver is signed only after the member receives appropriate notification and before services are rendered
 - The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment
 - A waiver must be obtained for each encounter or member visit that falls under the scenario of the noncovered services. Providers may not use nonspecific patient waivers
 - The waiver must specify the date services were provided and which services fall under the waiver's application
- The waiver must show the cost of the services and have a payment plan established
- The provider has the right to file a payment dispute for an Wellpoint payment resulting from a denial of authorization.

Claims Submission and Guidelines

Client Participation/Member Liability

Some members have a member liability, also referred to as client participation, they are required to contribute to their cost of care. HHS has the responsibility for determining the member liability amount. This includes a portion of members eligible for Medicaid on the following bases: (i) members in an institutional setting; and (ii) 1915(c) HCBS waiver enrollees. Through the HHS eligibility and enrollment files, the state will notify Wellpoint of any applicable member liability amounts. This information will be made available to providers. Providers will be required to collect this amount from the member and bill gross/full charges. Wellpoint will adjudicate the claim and deduct the patient liability amount. In the event the sum of any applicable third-party payment and a member's financial participation equals or exceeds the reimbursement amount established for services, Wellpoint will make no payment to the provider. You may refer to the section on [Client Participation](#) for more details on the process.

Claims Submission and Guidelines

Coordination of Benefits

If a member carries insurance through multiple insurers, Wellpoint will coordinate the benefits to ensure maximum coverage without duplication of payments. Providers must submit coordination of benefits (COB) claims to the primary carrier before submitting to Wellpoint. After submitting the claim to the primary carrier, submit a claim for the total billed charges to Wellpoint along with a copy of the primary carrier's remittance advice. Indicate the *Other Coverage* information on the appropriate claim form. If you need to coordinate benefits, include at least one of the following items from the other healthcare program:

- Third-party RA
- Third-party letter explaining either the denial of coverage or reimbursement

COB claims received without at least one of these items will be mailed back to you with a request to submit to the other healthcare program first. Make sure the information you submit explains all coding listed on the other carrier's remittance advice or letter. We cannot process the claim without this information.

There will be limited number of claims which do not automatically crossover to Wellpoint from the primary carrier. It will be the provider's responsibility to submit the crossover claim to Wellpoint Iowa for reimbursement in these instances.

Cost Avoidance Exceptions

Providers are not always required to coordinate first with the liable third party. In the following situations, we will first pay the provider and then coordinate with the liable third party: or (ii) when the claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program. Following reimbursement to the provider in these cost avoidance exception cases, we will actively seek reimbursement from responsible third parties and adjust claims accordingly.

Coordination of Benefits Agreement

CMS developed the Coordination of Benefits Agreement (COBA), which standardizes the way eligibility and Medicare claims payment information within a claims crossover context is exchanged. In accordance with our participation in this agreement, we submit our Medicaid enrollment data to CMS to obtain Medicare claim payment information. The exchange is used to create a claim to process coordination of benefits.

Claims Submission and Guidelines

Subrogation

Personal injury and workers' compensation claims: If a provider treats a recipient for injuries or illness sustained in an event for which liability may be contested or during the course of employment, the provider may elect to bill Medicaid for services provided without regard to the possible liability of another party or the employer. Alternatively, the provider may elect to seek payment by joining in the recipient's personal injury claim or workers' compensation claim, but in no event may the provider seek payment from both Medicaid and a personal injury or workers' compensation claim. After the provider accepts the Medicaid payment for services provided to the recipient, the provider shall not seek or accept payment from the recipient's personal injury or workers' compensation claim.

Providers must choose which method of payment they will pursue at the time of treatment and submit claims either to Wellpoint or to the member's personal injury/workers' compensation carrier. The law does not allow providers to submit claims to both carriers. If a provider submits to both carriers, receives payment from both carriers, and subsequently sends a refund to Wellpoint, submission of the refund still could be considered a fraudulent action. Seeking or accepting payment from both carriers is prohibited by law.

Wellpoint agrees to first pay the provider and then coordinate with the liable third party. We will not require providers to bill the third party prior to Wellpoint in the following situations: (i) the claim is for coverage derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency and the provider of service has not received payment from the third party within 30 calendar days after the date of service; or (ii) the claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program. Following reimbursement to the provider in these cost avoidance exception cases, we will actively seek reimbursement from responsible third parties and adjust claims accordingly.

Claims Submission and Guidelines

Claims Filed With the Wrong Plan

If you file a claim with the wrong insurance carrier, Wellpoint will process your claim within 180 days from the date of service. If the claim or claim dispute includes an explanation for the delay or other evidence that establishes the reason, Wellpoint will determine good cause based primarily on that statement or evidence

and/or if the evidence leads to doubt about the validity of the statement. Wellpoint will contact the provider for clarification or additional information necessary to make a good cause determination.

Claims Submission and Guidelines

Payment of Claims

After filing an electronic claim, you should receive a response from Wellpoint within 30 business days after we receive the claim. If the claim contains all required information, Wellpoint accepts the claim into the claims system for processing and sends you either a remittance advice (RA) or a claims disposition notice (CDN) when the claim is finalized.

A “clean claim” is one in which all information required for processing is present. If a claim is denied because more information was required to process the claim, the claim denial notice shall specifically describe all information and supporting documentation needed to evaluate the claim for processing.

Claims Submission and Guidelines

Monitoring Submitted Claims

After submitting claims, you can monitor and make changes to the claim by:

- Checking claim status on the secure provider website at <https://providers.wellpoint.com/ia>. Select **Login** or **Register** to access the secure site.
- Calling Provider Services.
- Confirming receipt of Plan Batch Status Reports from your vendor/clearinghouse to ensure claims have been accepted by Wellpoint.
- Correcting and resubmitting Plan Batch Status Reports and error reports electronically.
- Correcting errors and immediately resubmitting to prevent denials due to late filing.

Claims Submission and Guidelines

Electronic Fund Transfer

Wellpoint allows electronic funds transfers (EFTs) for claims payment transactions, meaning that claims payments are deposited directly into a previously selected bank account. Enroll in this service by calling Provider Services at **833-731-2143**.

Claims Submission and Guidelines

Electronic Remittance Advice

Wellpoint providers can choose to receive electronic remittance advices (ERAs). ERAs are received through an electronic mailbox that has been set up between Wellpoint, the provider and/or the provider's clearinghouse. For more information call Provider Services at **833-731-2143**.

Claims Submission and Guidelines

Claims Overpayment Recovery Procedure

Refund notifications may be identified by two entities — either Wellpoint/our contracted vendors or the providers. If Wellpoint/our contracted vendors identify the refund notification, we'll research and notify the provider of an overpayment and request a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by Wellpoint, Wellpoint will notify the provider of the overpayment. The overpayment notification will include instructions on how to refund the overpayment. If a provider identifies an overpayment and submits a refund, a completed Refund Notification Form specifying the reason for the return must be included. This form can be found on the provider website at <https://providers.wellpoint.com/ia>. The submission of the Refund Notification Form will allow Cost

Containment to process and reconcile the overpayment in a timely manner. The provider can also complete a Recoupment Notification Form, which gives Wellpoint the authorization to adjust claims and create claim offsets. This form can also be found on the provider website at <https://providers.wellpoint.com/ia>. For questions regarding the refund notification procedure or recoupment process, please call Provider Services at **833-731-2143**.

In instances where we're required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. Wellpoint will determine the cumulative adjusted reimbursement amount based on the new rates. In the event the outcome of this reconciliation results in a net amount owed to Wellpoint, Wellpoint will work with the provider and provide the appropriate notice prior to commencement of any recovery activities including through an offset against future claims payments. Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement.

Changes addressing the topic of overpayments have taken place with the passage of the Patient Protection and Affordable Care Act (PPACA), commonly known as the Healthcare Reform Act. The provision directly links the retention of overpayments to false claim liability.

The language of 42 U.S.C.A. § 1320a-7k makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act including treble damages. In order to avoid such liability, healthcare providers and other entities receiving reimbursement under Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the PPACA.

Provision 42 U.S.C.A. § 1320a-7k, entitled "Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments," clarifies the uncertainty left by the 2009 Fraud Enforcement and Recovery Act. This provision of the Healthcare Reform Act applies to providers of services, suppliers, and Medicaid MCOs.

Claims Submission and Guidelines

Third-Party Recovery

Providers may not interfere with or place any liens upon the rights of the state of Iowa or Wellpoint (acting as Iowa's agent) to recovery from third-party billing.

Claims Submission and Guidelines

Claim Resubmissions

If you have not heard from Wellpoint regarding a submitted claim after 30 business days from the submission of the claim, contact us to determine the status. To determine whether you need to resubmit a claim:

- Check the secure provider website at <https://providers.wellpoint.com/ia>. Select **Login** or **Register** to access the secure site.
- Contact Provider Services at **833-731-2143**.

Claims Submission and Guidelines

Claims Returned for Additional Information

Wellpoint will send you a request for additional or corrected information when the claim cannot be processed due to incomplete, missing, or incorrect information. Wellpoint also may request additional

information retroactively for a claim already paid. If you receive a request from Wellpoint for additional information, you must provide that information within 90 days of the date of the request, or your claim may be denied.

To submit additional or corrected information, you must send:

- All supporting documentation you believe to be important or that is specifically requested by Wellpoint.
- A copy of the original, corrected CMS-1500 or CMS-1450 claim form.

Please note: Many of the claims returned for further information are returned for common billing errors.

Claims Submission and Guidelines

Reference: Covered Services

For a listing of covered services, please see the [Covered and Noncovered Services](#) chapter.

Claims Submission and Guidelines

Reference: Clinical Submissions Categories

The following is a list of claims categories for which we routinely may require submission of clinical information before or after payment of a claim. If the claim:

- Involves precertification, predetermination, or some other form of utilization review, including but not limited to claims that are:
 - Pending for lack of precertification.
 - Involving medical necessity or experimental/investigative determinations.
 - Involving drugs administered in a physician's office requiring precertification.
- Requires certain modifiers.
- Includes unlisted codes.
- Is under review to determine if the service is covered. Benefit determination cannot be made without reviewing medical records. This category includes, but is not limited to, specific benefit exclusions.
- Involves termination of pregnancy: All termination of pregnancy claims require review of medical records to determine if the pregnancy is the result of an act of rape or incest. Or, in cases where the woman suffers from a physical disorder, physical injury, or physical illness, including a physical condition that endangers the woman's life and is caused by or arising from the pregnancy itself. This condition would, as certified by a provider, place the woman in danger of death unless a termination of pregnancy is performed.
- Involves possible inappropriate or fraudulent billing.
- Is the subject of an internal or external audit, including high-dollar claims.
- Involves individuals under integrated case management or condition care.
- Is the subject of a dispute, including claims being mediated, arbitrated, or litigated.

Other situations in which clinical information might be requested include:

- Accreditation activities
- Coordination of benefits
- Credentialing
- Quality improvement/assurance efforts
- Recovery/subrogation
- Requests relating to underwriting, including, but not limited to, member or provider misrepresentation/fraud reviews and stop-loss coverage issues

Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.

Claims Submission and Guidelines

Reference: Common Reasons for Rejected and Returned Claims

Many of the claims returned for further information are returned for common billing errors.

Problem	Explanation	Resolution
Member's Identification (ID) Number is Incomplete		Use the member's ID number on the IA Health Link card.
Duplicate Claim Submission	Overlapping service dates for the same service create a question about duplication. Claim was submitted to Wellpoint twice without additional information for consideration.	List each date of service, line by line, on the claim form. Avoid spanning dates, except for inpatient billing. Read RAs and CDNs for important claim determination information before resubmitting a claim. Additional information may be necessary.
Missing Codes for Required Service Categories	Current Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) manuals must be used because changes are made to the codes quarterly or annually. Manuals may be purchased at any technical bookstore, or through the American Medical Association (AMA) or the Practice Management Information Corporation.	Verify all services are coded with the correct codes (see lists provided). Check the codebooks or ask someone in your office who is familiar with coding.
Unlisted Code for Service	Some procedures or services do not have an associated code; use an unlisted procedure code.	Wellpoint needs a description of the procedure and medical records to calculate reimbursement. DME, prosthetic devices, hearing aids or blood products require a manufacturer's invoice. For drugs/injections, the National Drug Code (NDC) number is required.
By Report Code for Service	Some procedures or services require additional information.	Wellpoint needs a description of the procedure and medical records to calculate reimbursement. DME, prosthetic devices, hearing aids or blood products require a manufacturer's invoice. For drugs/injections, the NDC number is required.

Problem	Explanation	Resolution
Unreasonable Numbers Submitted	Unreasonable numbers, such as “9999”, may appear in the Service Units fields.	Check your claim for accuracy before submission.
Submitting Batches of Claims	Stapling claims together may make the subsequent claims appear to be attachments, rather than individual claims.	Clearly identify each individual claim and do not staple to another claim.

Claims Submission and Guidelines

Reimbursement Policies

Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member’s Wellpoint benefit plan. These policies can be accessed on the provider site. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as the member’s state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines including using industry standard, compliant codes on all claims submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes which indicate the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Wellpoint may:

- Reject or deny the claim
- Recover and/or recoup the claim payment
- Adjust the reimbursement to reflect the appropriate service and/or procedures performed.

Wellpoint reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements. System logic or set up may prevent the loading of policies into the claims platforms in the same manner as described; however, Wellpoint strives to minimize these variations.

Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity/clinical criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Review Schedules and Updates to Reimbursement Policies

Reimbursement policies undergo reviews for updates to state contracts, state, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to an Wellpoint business decision. We reserve the right to review and revise our policies when necessary. When there’s an update, we’ll publish the most current policies to our provider website.

Medical Coding

The Medical Coding department ensures correct coding guidelines have been applied consistently throughout Wellpoint. Those guidelines include but are not limited to:

- Use of the correct modifier.
- Effective date of transaction code sets is included (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.).
- Code editing rules are appropriately applied and within regulatory requirements.
- Analysis of codes, code definition and appropriate use.

Reimbursement by Code Definition

Wellpoint allows reimbursement for covered services based on their procedure code definitions or descriptors unless otherwise noted by state, federal or CMS contracts and/or requirements. There are eight CPT sections:

1. Evaluations and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services, or procedures

Provider Reimbursement and Fee Schedules

Wellpoint reimburses providers based on state Medicaid reimbursement methodologies and monitors the state website for any changes in fee schedules. Upon notification either by the state or through monitoring of the state website, Wellpoint would initiate the steps needed to update our systems to implement fee schedule and reimbursement changes.

Where the state does not have a rate established, Wellpoint will use CMS methodologies as applicable to establish a rate.

Fee schedule providers include the following:

- Ambulance
- Ambulatory surgical
- Assertive Community Treatment
- Audiologist
- Behavioral Health
- Birthing center
- Certified nurse midwife
- Certified registered nurse anesthesiologist
- Chiropractor
- Clinic
- Clinical Social Worker
- Community Based ICF/MR
- Community mental health center
- Crisis Response Services
- Family planning clinic
- Habilitation service
- Hearing Aid Dealer
- Independent Lab
- Independent Speech Pathologist
- Indian Health Services
- Lead Inspection Agencies
- Maternal Health Center
- Medical Supplies
- Nurse Practitioner
- Optician
- Optometrist
- Orthopedic Shoe Dealer
- Pharmacy
- Physical Therapist
- Physician
- Podiatrist
- Psychologist
- Psychiatric Medical Institute for Children
- Psychologist

- Public Health Agencies
- Rehabilitation Agency
- Screening Center
- Subacute Mental Health Services

Claims Submission and Guidelines

Acute Care Hospitals/Critical Access Hospitals

Inpatient Services

Inpatient payment is based on the prospective payment system (PPS), which uses provider specific diagnostic related group (DRG) base rates. The base rate is multiplied by the Iowa-specific DRG weight to determine the final payment.

DRG payment: DRG provider specific base rate x DRG weight.

Graduate medical education (GME) will be a flat rate add-on based on a provider specific payment rate.

Cost Outliers

An inpatient claim qualifies for a cost outlier payment when costs of service (not including any add-on amounts for direct or indirect medical education or for disproportionate-share costs) exceed the cost threshold. This cost threshold is the greater of either:

- Two times the statewide average DRG payment for that case.
- The hospital's individual DRG payment for that case plus \$75,000.

Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established for the case.

Long-Stay Outlier

Reimbursement for long-stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day threshold. Payment for long-stay outliers is made at 100 percent of the calculated amount when the claim is originally filed for DRG payment.

Short-Stay Outlier

Short-stay outliers are incurred when a member's length of stay is greater than two standard deviations below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short-stay outliers is 200 percent of the average daily rate for each day the member qualifies, up to the full DRG payment.

Outpatient Services

Outpatient reimbursement is based on the ambulatory payment classification (APC) payment. The APC payment is calculated by multiplying the applicable APC relative weight by the provider specific APC rate. The APC payment is multiplied by a discount factor percent and by the units of service when applicable.

Effective January 1, 2023, Critical Access Outpatient hospitals must bill claims with Type of Bill 85x

Hospital Outlier Payment Requests

Cost outlier requests must be submitted to Wellpoint for review within 90 days from the date of the explanation of payment (EOP) of the initial DRG payment for both participating and nonparticipating hospitals. The request must include supporting information, including medical records, as indicated below:

Iowa Hospital Request Checklist	Items to provide
1	Outlier dispute cover letter naming the hospital contact person (make sure to indicate on the cover letter that this is regarding an Iowa Outlier Request)
2	Copy of the original claim
3	Copy of the paid remittance(s) advice (RA)
4	Detailed itemized charges with revenue codes
5	Charges documented on itemized bill that correlate with UB-04 claim
6	Itemized bill numbered by provider and quantities billed
7	Check that total charges and DOS match on itemized bill, RA and UB-04
8	Charges documented in the itemized bill but not billed on the UB-04 are identified and marked through on the itemized bill.
9	Utilization review notes documenting severity of illness and intensity of service criteria met; notes signed and dated
10	Physician discharge summary
11	Physician orders
12	Operating room procedure notes (if applicable)
13	Physical/occupational/speech/radiology orders/respiratory therapy notes (if applicable)
14	Chart organized and labeled for review. (Please do not include tabs or insert tabs; however, it is acceptable to insert a page indicating documents that will proceed.)
15	Other documents (for example, laboratory reports, anesthesiology records, etc.)
16	Request submitted within deadline of paid remittance advice
17	Indicate total number of pages submitted for review

Note: The outlier request submissions must include **all** of the documentation detailed above for proper consideration.

Upon receipt, the outlier request of the hospital is reviewed to see if it initially meets the requirements for outlier review. The request must be submitted within the timelines stated above. It must meet the threshold requirements for the DRG under which the claim is computed, and it is processed to pay the initial DRG payment. If the request meets the qualifications, then all the information provided by the hospital is forwarded to a vendor contracted by Wellpoint for a forensic review.

Upon the review, a response with the applicable supporting documents is sent to the provider that submitted the outlier request. The forensic review lists the categories of the exceptions with exhibits providing line item details in the particular areas or revenue codes as applicable.

If the provider disagrees with the review that was performed based on the documents that were received with the initial request, the following will apply:

- Outliers that do not meet the threshold of the reviewed documentation and have no additional payment can be disputed within 30 days of the date of the letter sent to the provider. The dispute must include any additional supporting documentation and the reason for the second-level dispute.
- Outliers that have reduced charges and an outlier payment being paid to the hospital can be disputed within 30 days of the date of the EOP. The dispute must include any additional supporting documentation and the reason for the second-level dispute.

Requests should be sent to the contact information in the letter.

If you have questions, please contact our Provider Services team at **833-731-2143**. You may also use the contact information listed on the letter with the outlier review results and findings.

Claims Submission and Guidelines

Ambulatory Service Center

Reimbursement is based on the ambulatory service center (ASC) fee schedule. Each procedure code is assigned to one of the nine ASC levels. Each of the nine levels is assigned to a separate reimbursement fee. If multiple procedures are medically necessary, payment will be made to the ASC procedure that is the most costly according to the fee schedule. The primary ASC procedure will be reimbursed at 100 percent and the secondary ASC procedure will be paid at 50 percent of the fee for that procedure.

Claims submissions are required on the CMS-1500 for ASC claims.

Claims Submission and Guidelines

Behavioral Health Facility

Services are reimbursed based on the Behavioral Health Fee Schedule or per diems as defined by state reimbursement.

Claims Submission and Guidelines

Federally Qualified Health Center (FQHC) and Rural Health Clinics (RHC)

Reimbursement is based on Prospective Payment System (PPS) rates.

Claims Submission and Guidelines

Intermediate Care Facility

Reimbursement is based on a per diem rate that is derived from a cost-based provider specific case mix adjusted rate.

Claims Submission and Guidelines

Intermediate Care Facility for Individuals Who Are Intellectually Disabled

Reimbursement is based on 100 percent of the Wellpoint rate(s) for nursing facility, intermediate care facility and state resources centers.

Claims Submission and Guidelines

Skilled Nursing Facility

Reimbursement is based on a per diem rate that is derived from a cost-based provider specific case mix adjusted rate. Provider assessment pass-through payment and add-on amount will be included in the reimbursement.

Claims Submission and Guidelines

Hospice

Reimbursement is based on the state Medicaid rates.

Hospice Room and Board

Effective November 1, 2020, hospice providers must submit the NPI of the residing nursing facility in box 77. This is specific to Revenue Code 0658 when billed with HCPCS codes T2046, Q5001, Q5002, Q5003 or Q5004.

- Providers must obtain the NPI for the facility where the patient is receiving care and report the facility's NPI in box 77 of the UB-04 claim form. Report only the 11-digit NPI in this field. Do not input facility name, address, or any other notes in this field.
 - Failure to submit the NPI in this field will result in denials—
- Required HCPCS code(s): Hospice room and board claims, when billed with revenue code 0658, must have a HCPCS code of T2046, Q5001, Q5002, Q5003 or Q5004 submitted with the claim. Failure to follow this guidance will result in claims denials.
- Occurrence codes: Claims will deny if the following elements are missing or not filled out appropriately:
 - The begin date of the applicable hospice election period is missing.
 - The date of service billed is not within the election period.
 - The Occurrence Code 27 is not present on the claim.

Interim Billing

Interim facility/hospital claims are allowed in some long-term scenarios, which will span over 30 days.

When interim billing on facility claims, the type of bill frequency (third digit) must match the patient status code. If the type of bill frequency does not match an appropriate patient status code, the claim is subject to denial and/or an overpayment recovery.

- If there is indication of an interim or continuing claim, where the third digit frequency is indicated as two or three, it would be inappropriate to bill a patient status code that indicates a discharge, such as patient codes 1 to 5.
- A claim where the member is indicated as having been discharged from a facility, such frequency code one or four, it would be inappropriate to bill patient status code 30, indicating the member is still a patient.
- All claim form coding is required to match the patient's medical records and chart notes.

Outlier Reimbursement Audit And Review Process

Requirements and Policies

This section includes guidelines on reimbursement to Providers and Facilities for services on claims paid by DRG with an outlier paid at percent of billed charge or where the entire claim is paid at percent of billed charge.

In addition to any header in this section, please refer to all other service specific sections which may have more stringent guidelines. There may be multiple sections that apply to any given reimbursable service.

Audits/Records Requests

At any time, a request may be made for on-site, electronic, or hard copy medical records, utilization review documentation and/or itemized bills related to Claims for the purposes of conducting audit or reviews.

Blood, and Blood Products

Administration of Blood or Blood Products are not separately reimbursable on inpatient claims.

Administration charges on outpatient claims are separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage and processing, thawing fees charges, irradiation, and other processing charges, are also not separately reimbursable.

Emergency Room Supplies and Services Charges

The Emergency Room level reimbursement includes all monitoring, equipment, supplies, and time and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services.

Facility Personnel Charges

Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), professional therapy functions, including Physical, Occupational, and Speech call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Charges for Outpatient Services for facility personnel are also not separately reimbursable. The reimbursement is included in the payment for the procedure or Observation charge.

Implants

Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors, and radioactive seeds, in addition to non-soluble, or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the Member's body upon discharge from the inpatient stay or outpatient procedure.

Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices, and supplies shall not be considered implants. Implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member will not be reimbursed.

IV sedation and local anesthesia

Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the Operating Room ("OR") time/procedure reimbursement. Medications used for IV sedation and local anesthesia are separately reimbursable.

Lab Charges

The reimbursement of charges for specimen are considered facility personnel charges and the reimbursement is included in the room and board or procedure/Observation charges. Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws.

Processing fees, handling fees, and referral fees are considered included in the procedure/lab test performed and not separately reimbursable.

Labor Care Charges

Reimbursement will be made for appropriately billed room and board or labor charges. Payment will not be made on both charges when billed concurrently.

Nursing Procedures

Fees associated with nursing procedures or services provided by Facility nursing staff or unlicensed Facility personnel (technicians) performed during an inpatient ("IP") admission or outpatient ("OP") visit will not be reimbursed separately. Examples include, but are not limited to, intravenous ("IV") injections or IV fluid administration/monitoring, intramuscular ("IM") injections, subcutaneous ("SQ") injections, IV or PICC line insertion at bedside, nasogastric tube ("NGT") insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, etc.) and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration or OP chemotherapy administration which are submitted without observation/treatment room charges.)

Operating Room Time and Procedure Charges

The operating room ("OR") charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes. The operating room charge will reflect the cost of:

- The use of the operating room
- The services of qualified professional and technical personnel

Personal Care Items and services

Personal care items used for patient convenience are not separately reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste, bedpans, chux, hot water bottles, icepacks, pillows, sitz baths, and urinals.

Pharmacy Charges

Reimbursement will be made for the cost of drugs prescribed by the attending physician. Additional separate charges for the administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel will not be reimbursed separately. All other services are included in the drug reimbursement rate. Example of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy ("Rx") cart.

Portable Charges

Portable Charges are included in the reimbursement for the procedure, test, or x-ray, and are not separately reimbursable.

Pre-Operative Care or Holding Room Charges

Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure and are not separately reimbursed. In addition, nursing care provided in the pre-operative care areas will not be reimbursed separately.

Preparation (Set-Up) Charges

Charges for set-up, equipment, or materials in preparation for procedures or tests are included in the reimbursement for that procedure or test.

Recovery Room Charges

Reimbursement for recovery room services (time or flat fee) includes the use of all and/or available services, equipment, monitoring, and nursing care that is necessary for the patient's welfare and safety during his/her confinement. This will include but is not limited to cardiac/vital signs monitoring, pulse oximeter, medication

administration fees, nursing services, equipment, supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Recovery Room services related to IV sedation and/or local anesthesia

Separate reimbursement will not be made for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II recovery (step-down) Examples of procedures include arteriograms and cardiac catheterization.

Supplies and Services

Items used for the patient which are needed as a direct result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable.

Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately reimbursable in the inpatient and outpatient environments.

Special Procedure Room Charge

Special procedure room charges are included in the reimbursement for the procedure. If the procedure takes place outside of the OR suite, then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: ICU, GI lab, etc.

Stand-by Charges

Standby equipment and consumable items which are on standby, are not reimbursable. Standby charges for facility personnel are included in the reimbursement for the procedure and not separately reimbursable.

Stat Charges

Stat charges are included in the reimbursement for the procedure, test, and/or X-ray. These charges are not separately reimbursable.

Supplies and Equipment

Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, Oxygen, and isolation carts and supplies are not separately reimbursable.

Telemetry

Telemetry charges in ER/ ICU/CCU/NICU or telemetry unit (step-down units) are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable.

Time Calculation

- **Operating Room ("OR"):** Time should be calculated on the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.
- **Hospital/ Technical Anesthesia:** Reimbursement of technical anesthesia time will be based on the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse's notes. The time the anesthesiologist spends with the patient in pre-op and the recovery room will not be reimbursed as part of the hospital anesthesia time.
- **Recovery Room:** The reimbursement of Recovery Room charges will be based on the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit ("PACU") record.
- **Post Recovery Room:** Reimbursement will be based on the time the patient leaves the Recovery Room until discharge.

Video or Digital Equipment used in Operating Room

Charges for video or digital equipment used in a surgery are included in the reimbursement for the procedure and are not separately reimbursable. Charges for batteries, covers, film, anti-fogger solution, tapes etc., are not separately reimbursable.

Additional Reimbursement Guidelines for Disallowed Charges

The disallowed charges (charges not eligible for reimbursement) include, but are not limited to, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by your specific agreement. Please refer to your contractual fee schedule for payment determination.

The tables below illustrate examples of non-reimbursable items/services codes.

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0990 – 0999	Personal Care Items Courtesy/Hospitality Room Patient Convenience Items (0990) Cafeteria, Guest Tray (0991) Private Linen Service (0992) Telephone, Telegraph (0993) TV, Radio (0994) Non-patient Room Rentals (0995) Beauty Shop, Barber (0998) Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	Supplies and Equipment

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	<p>Blood Pressure cuffs/Stethoscopes Thermometers, Temperature Probes, etc. Pacing Cables/Wires/Probes Pressure/Pump Transducers Transducer Kits/Packs SCD Sleeves/Compression Sleeves/Ted Hose Oximeter Sensors/Probes/Covers Electrodes, Electrode Cables/Wires Oral swabs/toothettes; Wipes (baby, cleansing, etc.) Bedpans/Urinals Bed Scales/Alarms Specialty Beds Foley/Straight Catheters, Urometers/Leg Bags/Tubing Specimen traps/containers/kits Tourniquets Syringes/Needles/Lancets/Butterflies Isolation carts/supplies Dressing Change Trays/Packs/Kits Dressings/Gauze/Sponges Kerlix/Tegaderm/OpSite/Telfa Skin cleansers/preps Cotton Balls; Band-Aids, Tape, Q-Tips Diapers/Chucks/Pads/Briefs Irrigation Solutions ID/Allergy bracelets Foley stat lock Gloves/Gowns/Drapes/Covers/Blankets Ice Packs/Heating Pads/Water Bottles Kits/Packs (Gowns, Towels and Drapes) Basins/basin sets Positioning Aides/Wedges/Pillows Suction Canisters/Tubing/Tips/Catheters/Liners Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) Preps/prep trays Masks (including CPAP and Nasal Cannulas/Prongs) Bonnets/Hats/Hoods Smoke Evacuator Tubing Restraints/Posey Belts OR Equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.)</p>

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, heparin, and saline flushes, etc.)
0220 – 0222, 0229, 0250	Pharmacy Administrative Fee (including mixing meds) Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility) Patient transport fees
0223	Utilization Review Service Charges
0263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) Medication prep Nonspecific descriptions Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges IV Solutions 250 cc or less, except for pediatric claims

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	Miscellaneous Descriptions Non-FDA Approved Medications
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	Specimen collection Draw fees Venipuncture Phlebotomy Heel stick Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399) Thawing/Pooling Fees
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment Oxygen Instrument Trays and/or Surgical Packs Drills/Saws (All power equipment used in O.R.) Drill Bits Blades IV pumps and PCA (Patient Controlled Analgesia) pumps Isolation supplies Daily Floor Supply Charges X-ray Aprons/Shields Blood Pressure Monitor Beds/Mattress Patient Lifts/Slings Restraints Transfer Belt Bair Hugger Machine/Blankets SCD Pumps Heal/Elbow Protector Burrs Cardiac Monitor EKG Electrodes Vent Circuit Suction Supplies for Vent Patient Electrocautery Grounding Pad

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	Bovie Tips/Electrodes Anesthesia Supplies Case Carts C-Arm/Fluoroscopic Charge Wound Vacuum Pump Bovie/Electro Cautery Unit Wall Suction Retractors Single Instruments Oximeter Monitor CPM Machines Lasers Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia Nursing care Monitoring Intervention Pre- or Post-evaluation and education IV sedation and local anesthesia if provided by RN Intubation/Extubation CPR
0410	Respiratory Functions: Oximetry reading by nurse or respiratory Respiratory assessment/vent management Medication Administration via Nebs, Metered dose (MDI), etc. Charges Postural Drainage Suctioning Procedure Respiratory care performed by RN
0940 – 0945	Education/Training

CHAPTER 11: BILLING PROFESSIONAL AND ANCILLARY CLAIMS

Billing Professional and Ancillary Claims

Overview

Providers can depend on efficient claims handling and faster reimbursement when they follow the Wellpoint professional and ancillary billing requirements. These requirements include using industry standardized codes for most health services. This chapter is broken down into health service categories to help you find the specific billing requirements and codes you will need for each.

You also will find information on billing members for services that are not medically necessary or not covered, billing for services for which the member is willing to pay, as well as information about completing the CMS-1500 claim form.

To help you navigate the various billing requirements and codes, we have organized the service categories as follows:

- Adult preventive care
- Behavioral health
- Emergency services
- Family planning services
- Hospital readmission policy
- Hysterectomies
- Immunizations covered by the Vaccines For Children (VFC) program
- Initial health assessments (IHAs)
- Maternity services
- Newborns
- Preventive medicine services: new patient
- Preventive medicine services: established patient
- Sensitive services
- Sterilization
- Termination of pregnancy

For the most efficient claims processing, accurately completed claims are essential. Follow these general guidelines for claims filing:

- Indicate the provider's NPI number in Box 24J of the CMS-1500 form when appropriate. Missing or invalid numbers may result in nonpayment.
- Submit only state certified NPIs.
- Use the member's identification number from the IA Health Link ID card.
- Federally Qualified Health Centers (FQHCs) should put the individual rendering provider NPI (if applicable) in 24j, and the billing/group NPI number in Box 33.

Billing Professional and Ancillary Claims

Coding

To process claims in an orderly and consistent manner, we use standardized codes. The HCPCS, sometimes referred to as National Codes, provides coding for a wide variety of services.

The principal coding levels are referred to as Level I and Level II:

- Level I: CPT codes maintained by the American Medical Association (AMA) and represented by five numeric digits.
- Level II: Codes that identify products, supplies and services not included in the CPT codes, such as ambulance supplies and durable medical equipment (DME). Level II codes

sometimes are called the alphanumeric codes because they consist of a single alphabetical letter followed by four numeric digits.

In some cases, two-digit/character modifier code(s) should accompany the Level I or Level II coding. Reference guides useful for coding claims are:

- The CPT manual published by the AMA.
- The HCPCS manual published by the CMS.

Billing Professional and Ancillary Claims

Initial Health Assessments

The Wellpoint primary medical groups (PMGs) function as a member’s “Health Home.” For that reason, we encourage our members to request an initial health assessment (IHA) as soon as possible after enrollment. The IHA should consist of a complete history, a physical exam, and preventive services. When billing for IHAs, use the following ICD codes:

- Codes: Z00.121- Z00.129 for children (newborn to 18 years old)
- Codes: Z00.00-Z00.01 for adults (19 years and older)

Billing Professional and Ancillary Claims

Adult Preventive Care

The following is a list of codes specific to adult preventive care. Reimbursement is subject to change based on Iowa’s Medicaid Fee Schedule:

HCPCS/CPT	Description
82270	Fecal occult blood test (lab procedure code only)
82465	Total serum cholesterol (lab procedure code only)
84153	PSA (lab procedure code only)
86580	Tuberculosis (TB) screening (PPD)
88150	Pap smear (lab procedure code only)
90658	Flu shot
90732	Pneumovax

Billing Professional and Ancillary Claims

Preventive Medicine Services: New Patient

Preventive medicine services for a new patient include an initial, comprehensive preventive medical evaluation. This evaluation includes an age- and gender-appropriate history, examination, counseling, risk factor interventions, and the ordering of appropriate immunizations, laboratory, and diagnostic procedures. Reimbursement is subject to change based on the Iowa Medicaid Fee Schedule.

HCPCS/CPT	Description
99381	Infant (under 1 year)
99382	Early childhood (ages 1-4)
99383	Late childhood (ages 5-11)
99384	Adolescent (ages 12-17)
99385	Ages 18-39
99386	Ages 40-64
99387	Ages 65 and older

Billing Professional and Ancillary Claims

Preventive Medicine Services: Established Patient

Preventive medicine services for an established patient involve re-evaluation and management of existing conditions, if any. This exam includes an age- and gender-appropriate history, examination, counseling, risk factor interventions, and the ordering of appropriate immunizations, laboratory, and diagnostic procedures. Reimbursement is subject to change based on the Iowa Medicaid Fee Schedule.

HCPCS/CPT	Description
99391	Infant (under 1 year)
99392	Early childhood (ages 1-4)
99393	Late childhood (ages 5-11)
99394	Adolescent (ages 12-17)
99395	Ages 18-39
99396	Ages 40-64
99397	Ages 65 and older

Billing Professional and Ancillary Claims

Behavioral Health

Bill all claims for behavioral health services to Wellpoint. See the **Covered and Noncovered Services** chapter in this manual for more detailed information about behavioral health benefits. Wellpoint Behavioral Health has contracted with a network of hospitals, group practices and independent behavioral health providers to offer behavioral health services to our members. When rendering medically necessary behavioral health services, please bill Wellpoint using behavioral health CPT codes.

Billing Professional and Ancillary Claims

Emergency and Related Professional Services

Emergency services, as defined by state and local law, the *Provider Agreement*, and our *Member Handbook*, are reimbursed in accordance with the Wellpoint Provider Agreement.

Please note: Precertification is not required for medically necessary emergency services.

Emergency: Any condition manifesting itself by acute symptoms of sufficient severity such that a layperson possessing an average knowledge of health and medicine could reasonably expect that the absence of immediate medical care could:

- Place the member's health in serious jeopardy or, with respect to a pregnant woman, the health of the woman and her unborn child.
- Cause serious impairment to bodily functions.
- Cause serious dysfunction to any bodily organ or part.

Covered emergency services include:

- Hospital-based emergency department services (room and ancillary) needed to evaluate or stabilize the emergency medical or behavioral health condition.
- Services by emergency providers.

All members should be referred back to their PCP for follow-up care. Unless clinically required, follow-up care should never occur in a hospital emergency room.

Hospitals will be reimbursed for emergency services billed with the following codes:

- 99284
- 99285
- 99281
- 99282
- 99283

Reimbursement of CPT codes is subject to change based on the Iowa Medicaid Fee Schedule.

Billing Professional and Ancillary Claims

Family Planning Services

The following is a list of diagnostic codes specific to family planning services:

ICD-10	Description
T83.31XA	Breakdown (mechanical) of intrauterine contraceptive device, initial encounter
T83.32XA	Displacement of intrauterine contraceptive device, initial encounter
T83.39XA	Other mechanical complication of intrauterine contraceptive device, initial encounter
Z92.0	Personal history of contraception
Z30.011	Encounter for initial prescription of contraceptive pills
Z30.018	Encounter for initial prescription of other contraceptives
Z30.019	Encounter for initial prescription of contraceptives, unspecified
Z30.09	Encounter for other general counseling and advice on contraception
Z30.430	Encounter for insertion of intrauterine contraceptive device
Z30.2	Encounter for sterilization
Z30.8	Encounter for other contraceptive management
Z30.40	Encounter for surveillance of contraceptives, unspecified
Z30.41	Encounter for surveillance of contraceptive pills
Z30.431	Encounter for routine checking of intrauterine contraceptive device
Z30.49	Encounter for surveillance of other contraceptives
Z30.42	Encounter for surveillance of injectable contraceptive
Z30.49	Encounter for surveillance of other contraceptives
Z30.8	Encounter for other contraceptive management
Z30.9	Encounter for contraceptive management, unspecified
Z31.0	Encounter for reversal of previous sterilization
Z31.89	Encounter for other procreative management
Z31.42	Aftercare following sterilization reversal
Z31.61	Procreative counseling and advice using natural family planning
Z31.69	Encounter for other general counseling and advice on procreation
Z98.51	Tubal ligation status
Z98.52	Vasectomy status
Z31.81	Encounter for male factor infertility in female patient
Z31.82	Encounter for Rh incompatibility status
Z31.83	Encounter for assisted reproductive fertility procedure cycle
Z31.84	Encounter for fertility preservation procedure
Z31.89	Encounter for other procreative management
Z31.9	Encounter for procreative management, unspecified
Z97.5	Presence of (intrauterine) contraceptive device

The following is a list of self-referable family planning codes payable without precertification requirements. Reimbursement is subject to change based on the Iowa Medicaid Fee Schedule.

HCPCS/CPT	Description
00840	Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy
00851	Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy, tubal ligation/transaction
00921	Anesthesia for intraperitoneal procedures in lower abdomen, including urinary tract, vasectomy, unilateral or bilateral
11976	Norplant removal
11981	Insertion, non-biodegradable drug delivery implant
55250	Vasectomy
57170	Diaphragm fitting
58300	IUD insertion
58301	IUD removal only
58600	Ligation or transection of fallopian tubes, abdominal or vaginal approach, unilateral or bilateral
58615	Occlusion of fallopian tubes by device (for example, band, clip, Falope ring), vaginal or suprapubic approach
81025	Pregnancy test
84703	Chorionic gonadotropin assay
89320	Semen analysis; complete (volume, count, motility, and differential)
J7300	Intrauterine copper contraceptive
J7301	Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies

Billing Professional and Ancillary Claims

Immunizations Covered by the Vaccines for Children (VFC) Program

Wellpoint providers who administer vaccines to children 0-18 years of age may enroll in the VFC program. Wellpoint will reimburse only the administration fee for any vaccine available through the VFC program.

When billing immunizations, use the CMS-1500 form and do the following:

- In box 23, insert the PCP name
- On a line of Box 24D, use the appropriate CPT code
- On another line of Box 24D, use the appropriate administration procedure code (90471 through 90474)

The following immunizations are covered under the VFC program. Reimbursement for the administration is subject to change based on the Iowa Medicaid Fee Schedule:

HCPCS/CPT Code	Description
90632	Hepatitis A vaccine, adult dosage, for intramuscular use
90633	Hepatitis A vaccine, pediatric/adolescent dosage - 2-dose schedule, for intramuscular use
90636	Hepatitis A and Hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use
90647	Haemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3-dose schedule), for intramuscular use
90648	Haemophilus influenza b vaccine (Hib), PRP-T conjugate (4-dose schedule), for intramuscular use
90649	HPV (Gardasil) vaccine for members age 9-26
90655	Influenza virus vaccine, split virus, preservative free, for children 6–35 months of age, for intramuscular use
90657	Influenza virus vaccine, split virus, for children 6–35 months of age, for intramuscular use

HCPCS/CPT Code	Description
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), for use in individuals younger than 7 years, for intramuscular use
90702	Diphtheria and tetanus toxoids (DT) adsorbed, for use in individuals younger than 7 years, for intramuscular use
90707	Measles, mumps, and rubella virus vaccine (MMR), live, for subcutaneous use
90710	Measles, mumps, rubella, and varicella vaccine (MMRV)
90713	Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use
90714	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individuals 7 years or older, for intramuscular use
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (TdaP), for use in individuals 7 years or older, for intramuscular use
90716	Varicella virus vaccine, live, for subcutaneous use
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Haemophilus influenza b vaccine (DtaP-Hib), for intramuscular use
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult, or immuno-suppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use
90733	Meningococcal polysaccharide vaccine (any groups), for subcutaneous use
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
90743	Hepatitis B vaccine, adolescent (2-dose schedule), for intramuscular use
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3-dose schedule), for intramuscular use
90746	Hepatitis B vaccine, adult dosage, for intramuscular use
90748	Hepatitis B and Haemophilus influenza b vaccine (HepB-Hib), for intramuscular use
SK	Members of high-risk population

Billing Professional and Ancillary Claims

Immunizations Coding

When billing for immunizations, use the CMS-1500 form and do the following:

- On a line of Box 24D, use the appropriate CPT code.
- On another line of Box 24D, use the appropriate administration procedure code.

Billing Professional and Ancillary Claims

Maternity Services

Wellpoint will reimburse up to the maximum amount of the appropriate prenatal package when a provider bills for the following:

- Individual obstetrics visits
- Delivery care
- Postpartum care

Wellpoint requires itemization of maternity services when submitting claims for reimbursement. Please use the CMS-1500 claim form with the appropriate CPT and HCPCS codes, along with ICD diagnosis codes. Also, include the applicable Evaluation and Management (E&M) code and coding for all other procedures performed.

Maternity billing requirements are as follows:

- Bill separately all laboratory tests, pregnancy tests and radiology services provided during pregnancy within the contract filing limit.
- Use the appropriate E&M, antepartum or postpartum, and CPT codes necessary for appropriate reimbursement. Indicate the estimated date of confinement (EDC) in Box 24D of the CMS-1500 claim form.
- If a member is admitted to the hospital during the course of her pregnancy, the diagnosis necessitating the admission should be the primary diagnosis on the claim.
- If a pregnancy is high-risk, document the high-risk diagnosis on the claim form.
- Identify the nature of a high-risk care visit in the diagnosis field in Box 21 of the CMS-1500 claim form, or in the appropriate field.
- Use the CMS-1500 claim form with itemized E&M codes.

Billing Professional and Ancillary Claims

Maternity Services: Newborns

Request your patients to take these important steps as soon as their babies are born:

- Immediately contact the HHS or their social worker to request the required paperwork.
- Fill out and return the required paperwork to HHS to enroll their newborn in Medicaid.

Hospitals may bill for newborn delivery and other newborn services separately from the claims for services they provide for the mother.

Billing Professional and Ancillary Claims

Newborns: Circumcision

All circumcisions performed on members more than 12 months after birth will require precertification from our Medical Management department and will be subject to a medical necessity review. Circumcision charges should be billed with appropriate CPT codes. Reimbursement is subject to change based on the Iowa Medicaid Fee Schedule.

HCPCS/CPT	Description
54150	Circumcision, using clamp or other device - newborn
54160	Circumcision, surgical excision other than clamp, device, or dorsal split - newborn
54161	Circumcision, surgical excision other than clamp, device, or dorsal split - except newborn

Billing Professional and Ancillary Claims

Sensitive Services

The following is a list of codes specific to sensitive healthcare services. Reimbursement is subject to change based on the Iowa Medicaid Fee Schedule:

HCPCS/CPT	Description
46608	Anoscopy; with removal of foreign body
57415	Removal of impacted vaginal foreign body (separate procedure) under anesthesia
59840	Dilation and curettage - used to induce a first trimester abortion, for termination of a pregnancy in the first 12-14 weeks of gestation
59841	Dilation and curettage - used to induce a second trimester abortion, for termination of a pregnancy after 12-14 weeks of gestation

HCPCS/CPT	Description
99170	Anogenital examination with colposcopic magnification in childhood for suspected trauma

The following is a list of procedure codes, including other sensitive services for minors over the age of 12 and through the age of 18 (plus 364 days). Reimbursement is subject to change based on the Iowa Medicaid Fee Schedule:

HCPCS/CPT	Description
80346-80347	Benzodiazepines
80173	Haloperidol
80184	Phenobarbital
80320-80322	Alcohol (ethanol); any specimen except breath
82075	Alcohol (ethanol); breath
82120	Amines, vaginal fluid, qualitative
83992	Phencyclidine

Billing Professional and Ancillary Claims

Sterilization

Sterilization is any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing. Sterilization does not include medical procedures that may have the effect of producing sterility but were performed for an entirely different purpose, such as removal of a cancerous uterus or prostate gland. To qualify for reimbursement, the following conditions must be met:

- 30 full days must elapse between the date of the consult and the date of surgery, but not more than 180 days
- Prior to sterilization, the provider must complete the Consent for Sterilization form (form 470-0835 or 470-0835S [Spanish]), available on the HHS website at www.dhs.iowa.gov/iqrs/forms.

Please note: Payment cannot be made to providers of associated services, including hospitals, anesthesiologists, pathologists, and radiologists, unless the consent form is completed in an accurate and timely manner. The HHS will ask for recoupment of fees from Wellpoint, which will subsequently be recouped from the provider.

The following are required before performing sterilization:

- Patient has voluntarily given his or her consent to be sterilized.
- Patient was at least 21 years of age on the date of consent.
- Patient is not mentally incompetent.
- Patient is not institutionalized.
- At least 30 days, but no more than 180 days, have elapsed between the date of consent and the sterilization.
- Consent form used was the same form provided by HHS; no other form may be substituted.
- Dates on the consent form cannot be altered.

The following are the exceptions to the 30-day waiting period:

- Emergency abdominal surgery when the patient signs an informed consent at least 72 hours prior to surgery

- Premature labor when the patient has given informed consent at least 30 days prior to the expected date of confinement. The provider must indicate the expected date of confinement on the consent form

The provider must follow these sterilization procedures for Wellpoint to pay the claim:

- At the time of the sterilization consult, the nurse verifies the patient is a member of Wellpoint. The nurse then attaches the appropriate consent form to the front of the patient's chart.
- The patient completes, signs, and dates the section titled Consent for Sterilization.
- If an interpreter is necessary, the interpreter signs the consent form.
- The provider completes, signs, and dates the section titled Statement of Person Obtaining Consent. Include the name and address of the facility where the procedure will be performed.
- The scheduling nurse schedules surgery. If anything is not in order, the procedure is postponed until the issue is resolved.
- At the post-operative visit, the provider follows the instructions for use of alternative final paragraphs, signs and dates the Physician Statement, on the Sterilization Consent form.
- The provider forwards a copy of the signed Sterilization Consent form to the facility where the procedure was performed.
- The provider files the original, signed Sterilization Consent form in the member's chart.
- The provider sends a signed copy of the Sterilization Consent form to Wellpoint, either submitted with the claim or sent separately to the Claims department.

Billing Professional and Ancillary Claims

Hysterectomy

Payment will be made only for a medically necessary hysterectomy that is performed for a purpose other than sterilization and only when one or more of the following conditions are met:

- A member or her representative has signed an acknowledgment that she has been informed orally and in writing from the provider authorized to perform the hysterectomy that the hysterectomy will make the member permanently incapable of reproducing.

This statement may be added to either the surgery consent form, written on the claim form, or on a separate sheet of paper. The member or her representative receiving the explanation must sign the statement.

The following language is satisfactory for such a statement:

Before the surgery, I received a complete explanation of the effects of this surgery, including the fact that it will result in sterilization.

(Date) (Signature of member or person acting on her behalf)

The vehicle for transmitting the acknowledgment that the member received the explanation before the surgery should not be the Consent for Sterilization Form (470-0835 or 470-0835S [Spanish]). This statement must be submitted to Wellpoint with the related Medicaid claim.

The member was already sterile before the hysterectomy: The provider must certify in writing that the member was already sterile at the time of the hysterectomy and must state the cause of the sterility. The following language is satisfactory for such a statement:

Before the surgery, this patient was sterile, and the cause of that sterility was

_____.
(Physician's signature) (Date)

This statement may be added to either the Surgery Consent Form, the claim form, or a separate sheet of paper. A physician must sign any document stating the cause of sterility. This includes a history and physical, operative report, or claim form. This statement must be submitted to Wellpoint with the related Medicaid claim.

The hysterectomy was performed as the result of a life-threatening emergency in which the physician determined that prior acknowledgment was not possible: The physician must include a description of the nature of the emergency.

If the physician certifies that the hysterectomy was performed for a life-threatening emergency and includes a description of the nature of the emergency, the claim will be reviewed on an individual basis. Payment will be permitted only in extreme emergencies.

Where the member is about to undergo abdominal exploratory surgery or a biopsy, and removal of the uterus could be a potential consequence of the surgery, the member should be informed of this possibility and given an opportunity to acknowledge in writing the receipt of this information. This includes C-sections when there is a reasonable expectation a hysterectomy will be performed, such as in the event of an acreta.

Billing Professional and Ancillary Claims

Termination of Pregnancy

Abortions may only be authorized in the following situations:

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

The provider must complete a Certification Regarding Abortion Form (470-0836) attesting to one of the circumstances listed above. In the case of rape or incest, the provider must include evidence that the crime was reported to law enforcement authorities. The Certification Regarding Abortion Form must be submitted to the Wellpoint Claims department along with progress notes and any law enforcement documentation. Wellpoint will forward this information to the HHS for a final decision regarding coverage. After the HHS has made its decision, Wellpoint will notify the provider's office of the decision.

Locate the Certification Regarding Abortion Form on the Iowa HHS website at www.dhs.iowa.gov/iqrs/forms. In the *Search HHS Forms Library* field, enter search criteria (for example, "abortion certification") and select **Search**.

Please note: A termination of pregnancy must be scheduled and performed at an Iowa Medicaid-certified facility.

When a termination of pregnancy meets criteria for coverage, all other medically necessary services are covered as well. Complications arising from a termination of pregnancy, whether or not the termination of pregnancy is covered, are covered services.

Services incidental to a noncovered termination of pregnancy are not covered. Such services include but are not limited to any of the following when directly-related to a noncovered termination of pregnancy:

- Interpretation services
- Laboratory testing
- Recovery room services
- Routine follow-up visits
- Transportation (prenatal visits are covered)
- Ultrasound services

Billing Professional and Ancillary Claims

Billing Members for Services Not Medically Necessary

Providers may bill an Wellpoint member for a service that is not medically necessary if all of the following conditions are met:

- The member requests a specific service or item that, in your opinion, may not be reasonable or medically necessary.
- The member requests a specific service or item that, in our opinion, may not be reasonable or medically necessary.
- The provider obtains a written acknowledgement verifying that you notified the Wellpoint member of financial responsibility for services rendered.
- The member signs and dates the acknowledgement, indicating that the member has been notified of their responsibility to pay for the requested service prior to services being rendered.

Billing Professional and Ancillary Claims

Recommended Fields for CMS-1500

All professional providers and vendors should bill Wellpoint using the most current version of the CMS-1500 claim form. Please review the Electronic Data Interchange (EDI) Companion guide for assistance at <https://providers.wellpoint.com/Pages/edi.aspx>.

CHAPTER 12: BILLING INSTITUTIONAL CLAIMS

Billing Institutional Claims

Overview

Billing for hospitals and other healthcare facilities and services can require special attention because major services have their own set of billing requirements. Throughout this chapter, specific billing requirements are broken down into the following service areas:

- Emergency room visits
- Urgent care visits
- Maternity
- Termination of pregnancy
- Inpatient acute care
- Inpatient sub-acute care
- Outpatient laboratory, radiology, and diagnostic services
- Outpatient surgical services
- Outpatient infusion therapy visits and pharmaceuticals

We also have included helpful billing guidelines for the ancillary services used most often by providers, including diagnostic imaging. These ancillary services include the following:

- Ambulance services
- Ambulatory surgical centers
- Physical, speech and occupational therapy
- Durable medical equipment
- Dialysis
- Home infusion therapy
- Laboratory and diagnostic imaging
- Skilled nursing facilities
- Home healthcare
- Hospice
- Nursing facilities
- Intermediate care facility for individuals who are intellectually disabled (ICF/IDs)
- Nursing facilities for individuals who are mentally ill (NF/MI)

Please note: A member's benefits may not cover some of these services; confirm coverage before providing service.

And finally, this chapter will take a look at specific coding guidelines for the CMS-1450 (UB-04) claim form for hospital and healthcare facilities.

Billing Institutional Claims

Basic Billing Guidelines

In general, the basic billing guidelines for institutional claims submitted to Wellpoint include:

- Use Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) codes or revenue codes. Valid HCPCS, CPT or revenue codes are required for all line items billed, whether sent on paper or electronically.
- Provide medical records. Medical records for certain procedures may be requested for determination of medical necessity.
- Use modifiers in accordance with your specific billing instructions.
- Use codes for unlisted procedures. Because some provider services or procedures are not found in CPT, specific code numbers for reporting unlisted procedures have been designated. When using an

unlisted procedure code, include a description of the service to help us calculate the appropriate reimbursement. We may request the member's medical records.

- Complete the appropriate billing for supplies and materials. Do not use CPT code 99070, which is for supplies and materials provided over and above those usually included with an office visit or other services. Wellpoint does not accept CPT code 99070. Healthcare providers must use HCPCS Level II codes, which provide a detailed description of the service.

Please note: System edits are in place for electronic claims. Claims submitted improperly cannot be processed easily and most likely will be returned.

Billing Institutional Claims

Emergency Room Visits

The billing requirements for an emergency room visit apply to the initial treatment of a medical or psychiatric emergency, but only if the patient does not remain overnight. If the emergency room visit results in an admission, all services provided in the emergency room must be billed in conformity with the guidelines and requirements for inpatient acute care.

The billing requirements for emergency room treatment cover all diagnostic and therapeutic services, including, but not limited to the following:

- Equipment
- Facility use, including nursing care
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Other services incidental to the emergency room visit

Precertification is not required for medically necessary emergency services. Specific coding is required for emergency room billing. Use the following guidelines:

- Bill each service date as a separate line item.
- Perform a screening examination on the member, regardless of copay.
- Use CPT codes 99284 or 99285 for emergency room billing.
- Use ICD principal diagnosis codes, as required, for all services provided in an emergency room setting.
- Use revenue codes 0450-0452 and 0459, as required.

Please note: Unless clinically required, follow-up care should never occur in the emergency department. Members should be referred back to their PCP and correct billing should follow standard, nonemergency guidelines.

Billing Institutional Claims

Urgent Care Visits

The billing requirements for urgent care visits apply to all urgent care cases treated and discharged from the hospital outpatient department or emergency room.

Urgent care: Nonscheduled, nonemergency hospital services required to prevent serious deterioration of a patient's health as a result of an unforeseen illness or injury.

Urgent care billing should detail all diagnostic and therapeutic services, including but not limited to:

- Equipment
- Facility use, including nursing care
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Other services incidental to the visit

Specific coding is required for urgent care billing. Use the following guidelines:

- Bill each service date as a separate line item.
- Use current ICD principal diagnosis codes, as required, for all services provided in an urgent care setting or designated facility.
- Use the required CPT codes 99281-99283.
- Use the required revenue codes 045X, 0516, 0526, 0700, 072X.

Please note: Urgent care billing does not apply when the member is admitted and treated for inpatient care following urgent care treatment. If the member is admitted following urgent care, the billing shifts to acute or subacute care.

Billing Institutional Claims

Maternity Services

The billing requirements for maternity care apply to all live and stillbirth deliveries. Payment for services includes but is not limited to the following:

- Room and board for mother, including nursing care
- Nursery for baby, including nursing care
- Delivery room/surgical suites
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Other services incidental to admission

The maternity care rate covers the entire admission. If an admission is approved for extension beyond the contracted time limit for continuous inpatient days, the billing requirement for the entire admission shifts to inpatient acute care. This applies to each approved and medically necessary service day. Therapeutic termination of pregnancy, treatment for ectopic and molar pregnancies and similar conditions are excluded from payment under this rate.

Billing Institutional Claims

Termination of Pregnancy

Reimbursement for termination of pregnancy may only be authorized in the following situations:

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

The provider must complete and submit a Certification Regarding Abortion Form (470-0836) attesting to one of the circumstances listed above. In the case of rape or incest, the provider must include evidence that the

crime was reported to law enforcement authorities. The Certification Regarding Abortion Form (470-0836) must be submitted to the Wellpoint Claims department along with progress notes and any law enforcement documentation. Wellpoint will forward this information to the HHS for a final decision regarding coverage. After has made its decision, Wellpoint will notify the provider's office of the decision.

Locate the Certification Regarding Abortion Form on the Iowa HHS website at <https://www.dhs.iowa.gov/iqrs/forms>. In the *Search HHS Forms Library* field, enter search criteria (for example, "abortion certification") and select **Search**.

Please note: Failure to submit the Certification Regarding Abortion Form correctly will result in denial of the claim.

Billing Institutional Claims

Inpatient Acute Care

The billing requirements for inpatient acute care apply to each approved and medically necessary service day in a licensed bed. These requirements include, but are not limited to:

- Room and board, including nursing care
- Emergency room, if connected to admission
- Urgent care, if connected to admission
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Surgical and recovery suites
- Other services incidental to the admission

Please note: Precertification is required for all admissions except standard vaginal delivery and Cesarean sections.

Special billing instructions and requirements:

- Medical Management approval is required for all admissions except routine deliveries.
- Observation room, or outpatient billing with an inpatient stay, should be completed on the CMS 1450 claim form. Complete the "From" box of form locator 6 (FL 6) and form locator 17 (FL 17) correctly to ensure the claim is processed. Note the following requirements:
 - Ensure the date reported in (FL 6) corresponds with the information provided in (FL 17)
 - Verify the charges in (FL 6) reflect the date the patient was admitted to the hospital.
 - Do not use (FL 6) and to include the date of any observation stay or outpatient charges that occurred prior to inpatient admission. This usage is incorrect and may cause processing delays.

Billing Institutional Claims

Inpatient Sub-acute Care

The billing requirements for inpatient sub-acute care include each approved and medically necessary service day in a licensed and accredited facility at the appropriate level of care.

Sub-acute care: Includes levels of inpatient care less intensive than those required in an inpatient acute care setting.

Covered services include, but are not limited to:

- Room and board, including nursing care
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Other services incidental to the admission

Please note: All sub-acute admissions require precertification and a treatment plan.

The treatment plan must accompany the admission and include:

- Functional, reasonable, objective, and measurable goals within a predictable time frame for each skilled discipline
- A discharge plan and customized options, identified and implemented from the admission date
- Weekly summaries for each discipline
- Biweekly conference reports

Billing Institutional Claims

Outpatient Laboratory, Radiology and Diagnostic Services

Specific billing requirements for services related to outpatient laboratory, pathology, radiology, and other diagnostic tests include, but are not limited to the following:

- Facility use
- Nursing care, including incremental nursing
- Equipment
- Professional services
- Specified supplies and all other services incidental to the outpatient visit

Please note: Outpatient radiation therapy is excluded from this service category and should be billed under the requirements of the “Other Services” category.

Billing Institutional Claims

Outpatient Surgical Services

Specific billing requirements related to outpatient surgical services include, but are not limited to the following:

- Facility use, including nursing care
- Blood
- Equipment
- Imaging services
- Implantable prostheses
- Laboratory
- Pharmaceutical
- Radiology
- Supplies
- All other services incidental to the outpatient surgery visit

Please note: Even if a service is classified by the hospital as an outpatient service, if the member is receiving that service as of 12 a.m., bill the service at the inpatient diagnostic related group (DRG) rate.

Specific dates, codes and medical records may be required for billing. Use the following guidelines:

- Follow the billing requirements for outpatient surgery when the respiratory therapy department performs an ECG, EEG or EKG. Do not apply the outpatient therapy billing requirements.
- Include service dates for each procedure (both principal and other).
- Include CPT/HCPCS codes for each surgical procedure in form locators 44 (HCPCS/RATES).
- Provide medical records when Wellpoint needs to review and determine the correct grouping for services not defined in the surgery grouping.
- Use billing field entry 13X.
- Use revenue codes 036X, 0480, 0481, 0490, 070X, 071X, 075X, 076X, 079X and 0975, as required, along with the appropriate CPT/HCPCS code.
- Use the CPT/HCPCS code, as mandated by the HIPAA, for outpatient surgery billing.

Billing Institutional Claims

Outpatient Infusion Therapies and Pharmaceuticals

This section covers the following topics:

- Outpatient infusion therapies
- Outpatient infusion pharmaceuticals

Outpatient Infusion Therapies

Billing requirements for outpatient infusion therapy visits apply to each outpatient hospital visit and include, but are not limited to:

- Facility use, including nursing care
- Equipment
- Intravenous solutions, excluding pharmaceuticals
- Kinetic dosing
- Laboratory
- Professional services
- Radiology
- Supplies, including syringes, tubing, line insertion kits, etc.
- Other services incidental to the outpatient infusion therapy visit

Outpatient Infusion Pharmaceuticals

Special billing requirements for outpatient infusion pharmaceuticals apply to drugs such as chemotherapy, hydration and antibiotics used during each outpatient infusion therapy visit. An important exception is for blood and blood products, which are billed under the “Other Services” category. Special outpatient infusion pharmaceuticals billing instructions are listed below.

Specific codes and service dates are required, including:

- Use revenue codes 026X, 028X, 0331, 0335 or 0940, as required, for each outpatient infusion therapy visit.
- Use revenue code 0940 or 0949 with CPT/HCPCS codes 36511-36513, 36515-36516 or 36522 when billing for therapeutic aphaeresis claims.
- List each drug for each visit as a separate line item and include the service date.
- Use HCPCS codes, as required, for all pharmaceuticals when:
 - Billed with revenue codes 0250-0252, 0256-0259, or 063X. Include the units with pharmaceutical CPT/HCPCS codes
 - Billed with revenue codes 026X, 028X, 0331, 0335, 0940
- When using an unlisted CPT/HCPCS code, provide the name of the drug or medication in Box 43 of the CMS-1450 claim form.

Note: A freestanding home infusion pharmacy that only bills for drugs and equipment should use a CMS-1500 form. Home health and home infusion companies should use a CMS-1450 form.

Billing Institutional Claims

Ancillary Billing Overview

Most ancillary claims are submitted for laboratory and diagnostic imaging or durable medical equipment (DME). The following sections provide special billing requirements for each.

Please note: Because the member's benefits may not cover all of the services listed, confirm benefit coverage first.

Billing Institutional Claims

Ambulance Services

Ambulance providers, including municipalities, should use the CMS-1500 form to bill for ambulance services. Use the appropriate two-digit origin and destination codes that describe the "to" and "from" locations.

Billing Institutional Claims

Ambulatory Surgical Centers

Most outpatient surgery delivered in an ambulatory surgery center requires precertification. Ambulatory Surgical Centers bill on the CMS-1500 form.

Billing Institutional Claims

Physical, Speech and Occupational Therapies

The physical, speech or occupational therapy setting determines the correct billing form:

- CMS-1500 claim form: When providing services in an office, clinic, or outpatient setting
- CMS-1450 claim form: When providing services in a rehabilitation center or for physical, speech, or occupational therapists affiliated with home health agencies, providing services in a patient's home

Home health is subject to the Electronic visit verification (EVV) requirement. To Learn more about the EVV requirement, visit the Iowa Medicaid web site at <https://hhs.iowa.gov/programs/welcome-iowa-medicaid/current-projects/evv>.

Please note: The treatment is limited to 60 visits per therapy discipline per enrollment year for Iowa Health and Wellness Plan (IHAWP) members. All physical, speech or occupational therapy for members requires precertification. Contact the Wellpoint Medical Management department at **833-731-2143**.

Billing Institutional Claims

Durable Medical Equipment

Billing for custom-made durable medical equipment (DME), prescribed to preserve bodily functions or prevent disability, requires preservice review. Without such review, claims for DME will be denied. Prior to dispensing, please contact the Wellpoint Medical Management department at **833-731-2143**.

Please note: The presence of an HCPCS code does not necessarily mean that the benefit is covered or that payment will be made. Some DME codes may be *By Report* (customized) and therefore require additional information for preservice review and processing. A DME purchase may require PA. This does not apply to DMS.

DME billing requires a differentiation between rentals and purchased equipment, as well as specific codes and modifiers. Special guidelines for DME billing:

- Use HCPCS codes for DME or supplies.
- Use an unlisted or miscellaneous code, such as E1399, when a HCPCS code does not exist for a particular item of equipment.
- Use valid codes for DME and supplies. If valid HCPCS codes exist, unlisted codes will not be accepted.
- Attach the manufacturer's invoice to the claim if using a miscellaneous or unlisted code. The invoice must be from the manufacturer, not the office making the purchase.

Please note: Catalogue pages are not acceptable as a manufacturer's invoice.

Billing Institutional Claims

Durable Medical Equipment: Rentals

Most DME is dispensed on a rental basis and requires medical documentation from the prescribing provider. Rented items remain the property of the DME provider until the purchase price is reached. Charges for rentals exceeding the reasonable charge for a purchase are not accepted. Rental extensions may be obtained only on approved items.

Please note: DME providers should use normal equipment collection guidelines. Wellpoint is not responsible for equipment not returned by members.

Billing Institutional Claims

Durable Medical Equipment: Purchase

DME may be reimbursed on a rent-to-own basis, unless otherwise specified at the time of review by our Medical Management department.

Billing Institutional Claims

Durable Medical Equipment: Wheelchairs and Wheeled Mobility Aids

At Wellpoint, we follow Medicaid guidelines for calculating By Report (customized) wheelchair claims. Claims must include the following:

- Catalogue number
- Item description
- Manufacturer's name
- Model number

Mark each catalogue page or invoice line so we can match each item to the appropriate claim line. Enter the total MSRP of the wheelchair in the Reserved for Local Use field (Box 19) on the CMS-1500 claim form. The total MSRP includes:

- Accessories
- Modifications or replacement parts

Also provide the name of the Rehabilitation and Assistive Technology of America (RESNA)-certified technician.

Billing Institutional Claims

Dialysis

Dialysis centers and other entities performing dialysis should use the CMS-1450 claim form to bill for dialysis services.

Billing Institutional Claims

Home Infusion Therapy

Home infusion therapy requires precertification. When billing for home infusion therapy, use the CMS-1500 form and follow these guidelines:

- Obtain precertification, as required, from the Wellpoint Medical Management department for all infusion therapy.
- Submit all claims within the contracted filing limit.
- Use the appropriate HCPCS codes to bill for all injections.
- Use HCPCS code J3490 along with the National Drug Code (NDC) for billing injections only if an appropriate injection code is not found.

Billing Institutional Claims

Laboratory and Diagnostic Imaging

For laboratory and diagnostic imaging, use the CMS-1500 form and refer to the basic billing guidelines found in the **Overview** section of this chapter.

Billing Institutional Claims

Skilled Nursing Facilities

All skilled nursing facility care requires precertification. Contact the Wellpoint Medical Management department for precertification at **833-731-2143** and bill using the CMS-1450 form.

Billing Institutional Claims

Home Health Care

All home health care requires precertification from our Medical Management department before delivery of service. When billing for a home health care visit, use the CMS-1450 form. The Wellpoint Medical Management department phone is **833-731-2143**.

Home health is subject to the Electronic visit verification (EVV) requirement. To Learn more about the EVV requirement, visit the Iowa Medicaid web site at <https://hhs.iowa.gov/programs/welcome-iowa-medicaid/current-projects/evv>.

Please note: When billing for supplies and equipment used in a home health care visit, please refer to the **Durable Medical Equipment** section of this chapter for billing requirements.

Billing Institutional Claims

Hospice

Hospice services no longer require precertification. When billing for hospice services, use the CMS-1450 form. For information regarding billing, member qualification and coverage information, please call our Medical Management department at **833-731-2143**.

Billing Institutional Claims

Additional Billing Resources

The following reference books provide detailed instructions on uniform billing requirements:

- CPT, published by the American Medical Association (AMA)
- HCPCS, National Level II (current year), published by CMS
- ICD (current edition) Volumes 1,2,3 (current year), published by the Practice Management Information Corporation

Billing Institutional Claims

CMS-1450 Claim Form

All state sponsored business approved facilities should bill Wellpoint using the most up-to-date version of the CMS-1450 claim form. All fields must be completed using standardized code sets. These code sets are used to ensure that claims are processed in an orderly and consistent manner. HCPCS provides codes for a variety of services and consists of Level I and Level II codes:

- Level I: CPT codes determined by the AMA and represented by five numeric digits.
- Level II: Other codes identifying products, supplies and services not included in the CPT codes, such as ambulance services and DME. Sometimes referred to as the alphanumeric codes because they consist of a single alphabetical letter followed by four numeric digits.

In some cases, two-digit/character modifier codes should accompany the Level I or Level II coding.

Billing Institutional Claims

CMS-1450 Revenue Codes

CMS-1450 revenue codes are required for all institutional claims.

Billing Institutional Claims

Institutional Inpatient Coding

For institutional inpatient coding, use the guidelines in the following code manuals:

- Use current ICD procedure codes in Boxes 74-74e of the CMS-1450 claim form when the claim indicates that a procedure was performed.
- Use modifier codes when appropriate; refer to the current edition of the provider's CPT manual published by the AMA.
- Refer to your Provider Agreement for diagnostic related group (DRG) information.

Billing Institutional Claims

Institutional Outpatient Coding

For institutional outpatient coding, use the guidelines in the following code manuals:

- The CPT manual published by the AMA
- The HCPCS published by CMS

Please note: When using an unlisted CPT/HCPCS code, provide the name of the drug or medication in Box 43 of the CMS-1450 claim form.

Billing Institutional Claims

Recommended Fields for CMS-1450

For assistance in completing the CMS-1450 form, please review the Electronic Data Interchange (EDI) Companion guides at <https://providers.wellpoint.com/Pages/edi.aspx>.

Billing Institutional Claims

Consumer-Directed Attendant Care (CDAC) Provider Billing

Below are the requirements when completing a claim form in order for payment to be made. You must:

- Check in through the Electronic Visit Verification (EVV) system
- Be an enrolled provider with both the IME and the member's MCO.
- Ensure the case/care manager has approved the CDAC Agreement, which is also signed by the provider and the member.

For questions, please call Provider Services at **833-731-2143**.

CHAPTER 13: MEMBER TRANSFERS AND DISENROLLMENT

Member Transfers and Disenrollment

Overview

At Wellpoint, our members have the freedom to choose their most important link to quality healthcare: their doctor. After enrollment, we strongly encourage our members to select a PCP and remain with that provider because we believe in the positive impact of having a medical “home.” This home establishes a centralized hub from which all healthcare can be coordinated, no matter how many other caregivers become involved.

Occasionally, members may encounter barriers to effective relationships with their PCP. These obstacles may arise from geographical access, cultural and language differences, or simply personal preferences. Our members may change their PCP at any time, for any reason.

Members also have the right to change healthcare plans, following specific rules and timelines. If a member requests disenrollment, Wellpoint will provide information and assistance in the disenrollment process. We are committed to supporting providers’ practices as well. Providers have the right to request that a member be reassigned to another PCP, under certain conditions and following specific guidelines.

Wellpoint notifies PCPs of changes in member assignments through PCP Assignment Reports. These reports are available on Availity Essentials, our secure provider portal, at <https://providers.wellpoint.com/ia>. Select **Login** or **Register** to access the secure site. Providers may also call Provider Services at **833-731-2143**.

Cause for Disenrollment

If a managed long-term services and supports member would have to change their residential, institutional or employment support provider based on the provider’s change in status from an in-network to an out-of-network provider, the member has a cause for disenrollment.

Member Transfers and Disenrollment

PCP-Initiated Member Transfers

A PCP may request member reassignment to a different PCP by completing and submitting the Provider Request for Member Deletion from PCP Assignment form located at <https://providers.wellpoint.com/ia> > Medical > Forms.

Wellpoint will conduct a thorough review of the request for reassignment to determine whether the cause and documentation are sufficient to approve the request. This review includes monitoring to ensure consistency with our guidelines and policies.

The provider is expected to coordinate service for up to 30 days after the date Wellpoint receives the change request form. Upon completing the PCP assignment change, we will forward the form and any other information related to the case to the Member Services representative. This representative informs the member of the change within five working days. The change will be effective the day Wellpoint enters the change into the system.

Member Transfers and Disenrollment

PCP-Initiated Member Disenrollment

The disenrollment process for abusive behavior and failure to follow a prescribed treatment plan is as follows:

- Complete the Provider Request for Member Deletion from PCP Assignment form located at <https://providers.wellpoint.com/ia> > Medical > Forms.
- Mail or fax (preferred) the form to:
Wellpoint
P.O. Box 62429
Virginia Beach, VA 23466-2429
Fax: **800-964-3627**
- Continue to manage the member's care as required until we can reassign the member to another PCP, or not more than 30 days from the day we receive the Provider Request for Member Deletion from PCP Assignment form, whichever comes first.

Following our receipt of the Provider Request for Member Deletion from PCP Assignment form, we:

- Scan and log the form into the system for tracking purposes.
- Reassign the member to a new PCP for continuity of care. The effective date is no later than 30 days from the date on the Provider Request for Member Deletion from PCP Assignment form.
- Log the new PCP assignment into the tracking system.
- Send an identification (ID) card and fulfillment material to the member indicating the newly assigned PCP's name, address, and phone number.
- Document any abusive behavior and notify the Wellpoint Fraud and Abuse department if the abusive behavior continues.
- Send a warning letter to the member stating that if the behavior continues, Wellpoint will file a disenrollment request with the HHS. If the HHS grants approval, Wellpoint proceeds with the disenrollment process.

Prior to disenrollment, we will make every attempt to resolve issues and keep the member in our healthcare plan. If these attempts fail, we will reassign the member to another PCP or forward the disenrollment request form to the appropriate state agency requesting member reassignment to another healthcare plan.

Member Transfers and Disenrollment

State Agency-Initiated Member Disenrollment

Contracted state agencies inform Wellpoint of membership changes by sending daily and monthly enrollment reports. These reports contain all active membership data and incremental changes to eligibility records and Wellpoint disenrolls members not listed on the report.

State-initiated disenrollment may occur due to changes in circumstances including:

- Ineligibility for Medicaid, Hawki or the Iowa Health and Wellness Plan. If the member becomes ineligible and is later reinstated to these programs, MCO enrollment will also be reinstated.
- The member transfers to an eligibility group excluded from managed care organization enrollment.
- A shift to an eligibility category not covered by the contract.
- A change of place of residence to another state.
- The Iowa HHS determines participation in the Health Insurance Premium Payment program (HIPP) is more cost-effective than enrollment in the contract.
- Death.

Member Transfers and Disenrollment

Member-Initiated PCP Reassignment

Members have the right to change their PCP at any time. When a member enrolls in Wellpoint, he or she may select a PCP or allow their PCP to be assigned. After that, if the member wants to make a change, he or she is instructed to call our Member Services to request an alternate PCP.

Wellpoint accommodates member requests for PCP reassignment whenever possible. Our staff will work with the member to make the new selection, focusing on special needs. Our policy is to maintain continued access to care and continuity of care during the transfer process.

When a member calls to request a PCP change:

- The Member Services representative checks the availability of the member's choice. If the member can be assigned to the selected PCP, the Member Services representative will do so. If the PCP is not available, the representative will assist the member in finding an available PCP. If the member advises the representative that he or she is hospitalized, the PCP change will take effect upon discharge.
- Wellpoint notifies PCPs of member transfers through the PCP Assignment Report. These reports are available on Availity Essentials through the Provider Online Reporting application located on Payer Spaces, our secure provider portal, at <https://providers.wellpoint.com/ia>. Select **Login** or **Register** to access the secure site.
- The effective date of a PCP change will be the same as the date of the member request.

Member Transfers and Disenrollment

Member-Initiated Disenrollment Process

When members enroll in our program, we provide instructions on disenrollment procedures. Disenrollments become effective the last day of the calendar month following administrative cut-off or are subject to the HHS cut-off dates. If a member asks a provider how to disenroll from Wellpoint, the provider should direct the member to call Member Services at **833-731-2140** (TTY: **711**).

Please note: Providers may not take retaliatory action against any member for requesting transfer or disenrollment.

When Member Services receives a call from a member who wants to disenroll, we attempt to find out the reason for the request and determine if we can resolve the situation. If we cannot resolve the situation, we inform the member that the disenrollment process will take 15-45 days and refer the member to the HHS.

If the state chooses to limit disenrollment, Wellpoint must allow a member to request disenrollment as follows:

- For cause, at any time
- Without cause, at the following times:
 - During the 90 days following the date of the member's initial enrollment into Wellpoint or during the 90 days following the date the state sends the member notice of that enrollment, whichever is later
 - At least once every 12 months thereafter
 - Upon automatic reenrollment under 42 CFR 438.56 if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity
 - When the state imposes the intermediate sanction specified in § 438.702(a)(4)

Members may request disenrollment from Wellpoint as follows:

- **During the first 90 days following the date of the member's initial enrollment with Wellpoint:** The member may request disenrollment for any reason, in writing or by calling Wellpoint.
- **After the 90 days following the date of the member's enrollment with Wellpoint:** When the member is requesting disenrollment due to good cause, the member will first make a verbal or written filing of the issue through the Wellpoint grievance process. If there's no resolution, Wellpoint will direct the member to the enrollment broker. The enrolled member may request disenrollment in writing or by calling the enrollment broker's toll-free member telephone line to request a good-cause change for enrollment. Good-cause changes include the following:
 - Wellpoint does not, because of moral or religious objections, cover the service the member seeks.
 - The member needs related services to be performed at the same time, and not all related services are available within the network. In addition, the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk.
 - Other reasons, including but not limited to poor quality of care, lack of access to services covered under the contract, lack of access to providers experienced in dealing with the member's healthcare needs, or eligibility and choice to participate in a program not available in managed care (for example, PACE).

Use of Wellpoint Grievance Procedures

The state requires that the member seeks amends through our grievance process before making a determination on the member's request.

The grievance process must be completed in time to allow the disenrollment, if approved, to be no later than the first day of the second month following the month in which the member requests disenrollment. Wellpoint follows the timelines of an expedited grievance.

The state makes the final decision for disenrollment.

Member Transfers and Disenrollment

Member Transfers to Other Plans

Members may choose a different healthcare plan on an annual basis during the open enrollment period. As required by federal regulations, the open enrollment period lasts for 90 days for IA Health Link members. Upon initial enrollment, a member has 90 days to switch plans and once a year there after, they will have an opportunity to switch plans.

However, members retain the right to change their healthcare plan when they have "just cause," which can be any of the following:

- The member has a lack of access to necessary services covered under the healthcare plan's contract.
- The member has a lack of access to providers experienced in dealing with the member's healthcare needs.
- The healthcare plan does not, for moral or religious objections, cover the services the member seeks.
- The member has concerns over quality of care.
- The member requires related services to be performed at the same time, and not all related services are available within the healthcare plan's network.
- The member's PCP leaves the healthcare plan and participates with another healthcare plan under contract with the state of Iowa, and the member requests the transfer to remain with the PCP.

The member, Wellpoint or the HHS may initiate member disenrollment. If the request comes from a member and includes a member grievance, the grievance will be processed separately through the grievance process. Disenrollment may result in the following:

- Enrollment with another healthcare plan
- Termination of eligibility
- Return to traditional Medicaid for continuity of care if the member's benefits fall into a voluntary aid code

Member Transfers and Disenrollment

Wellpoint-Initiated Member Disenrollment

Wellpoint can't disenroll members or encourage members to disenroll for any reason, including issues around the member's healthcare needs or change in healthcare status or because of the member's utilization of medical services, diminished capacity, or uncooperative or disruptive behavior resulting from the member's special needs (except when the member's continued enrollment seriously impairs our ability to furnish services to either this particular member or other members).

In instances where the exception applies, Wellpoint will provide evidence to Iowa HHS that continued enrollment of the member seriously impairs our ability to furnish services to either this particular member or other members. We have methods by which Iowa HHS is assured that disenrollment is not requested for another reason other than those permitted under the state contract. All our requests for the state to disenroll a member will be in writing and specify the basis for the request.

If applicable, our request must document that reasonable steps were taken to educate the member regarding proper behavior, and the member refused to comply. Iowa HHS will review and approve all Wellpoint-initiated requests for disenrollment; the state retains sole authority for determining if conditions for disenrollment have been met and disenrollment will be approved. In accordance with 42 CFR 438.56, disenrollment requested by Wellpoint must comply with the following:

- All disenrollment requests must specify the reason(s) Wellpoint is requesting the member's disenrollment.
- Wellpoint may not request disenrollment because of an adverse change in the member's health status or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs our ability to furnish services to either this particular member or other members).
- All disenrollment requests must specify the methods by which we assure Iowa HHS we didn't request disenrollment for reasons other than those permitted under the contract.

Wellpoint may also request disenrollment for a member who has moved permanently out of the state. When a member moves out of our service area, he or she is responsible for notifying the HHS of the new permanent address. The HHS will disenroll the member from Wellpoint.

Disenrollment Effective Date

The effective date of a state-approved disenrollment must be no later than the first day of the second calendar month after the month in which:

- The member requests disenrollment pursuant to subrule 73.4(1).
- The state notifies the member and Wellpoint of disenrollment pursuant to subrule 73.4(2).
- Wellpoint requests disenrollment pursuant to subrule 73.4(3).

The member will remain enrolled and Wellpoint will be responsible for services covered under the contract until the effective date of disenrollment unless the member is in an inpatient setting at the time of disenrollment. If the member is in an inpatient setting at the time of disenrollment, Wellpoint is responsible for the inpatient services for 60 days or until the member is discharged.

Time Frame for Disenrollment Determinations

Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the member requests disenrollment or Wellpoint submits the request to the state.

If Wellpoint or the state (whichever is responsible) fails to make the determination within the time frames specified in 42 CFR 438.56, the disenrollment is considered approved for the effective date that would have been established had the state or Wellpoint complied with the specified time frames.

CHAPTER 14: RECONSIDERATIONS, DISPUTES, GRIEVANCES AND APPEALS

Reconsiderations, Disputes, Grievances and Appeals

Overview

We encourage providers and members to seek resolution of issues through our grievances and appeals process. Verbal complaints and written grievances are tracked and trended, resolved within established time frames and referred to peer review when needed. The Wellpoint grievances and appeals process meets all state of Iowa requirements and federal laws. The member, or member's authorized representative with written consent, has a right to be informed about 1) how to obtain a hearing and the representation rules involved; 2) filing grievances and appeals and the requirements and time frames for filing; 3) assistance available with filing grievances and appeals; 4) the toll-free number to file oral grievances and appeals; 5) the right to request continuation of benefits during an appeal or state fair hearing filing although the member may be liable for the costs of any continued benefits if the action is upheld; and 6) any state-determined appeal rights to challenge the failure of the organization to cover a service. The building blocks of this resolution process are the grievance and the appeal.

A **grievance** is an expression of dissatisfaction about any matter other than an adverse benefit determination as defined below. Examples include but are not limited to:

- The member is unhappy with the quality of the care.
- The doctor the member wants to see does not have a contract with us to provide services to the member.
- The member is not able to receive culturally competent care.
- The member got a bill from a provider for a service that should be covered by Wellpoint.
- Rights and/or dignity were not respected.
- The member is recommending changes in policies and services.
- Any other access to care issues exists.

The term is also used to refer to the overall system of grievances and appeals handled by Wellpoint as well as access to the state fair hearing process. The NCQA classifies grievance requests as stages in the appeal process.

The member may file a grievance at any time. An urgent grievance concerns urgent or emergency care services.

An **appeal** is a request for a review of an adverse benefit determination. It is a clear expression by the member, or the member's authorized representative with written consent, following an Wellpoint decision that the member wants the decision reconsidered or reviewed. Examples of an adverse benefit determination or Wellpoint decisions a member may choose to appeal include but are not limited to:

- Denial or limited authorization of a requested service, including the type and level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to provide services in a timely manner as defined by the agency.
- Failure of Wellpoint to act in the required time frames set forth in the contract.
- For a resident of a rural area with only one MCO, the denial of the member's request to obtain services outside the network.

The provider or an authorized representative, with the written consent of the member, can request an appeal, file a grievance, or request a state fair hearing on behalf of a member. Members have a right to ask for support in filing a grievance. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter

capability. Providers may appeal on a member's behalf related to adverse determinations and nonmedical necessity claims determinations. This can only be done with the member's written consent.

If a member has a grievance, we would like to hear about the issue either by phone or in writing. Members have the right to file a grievance regarding any aspect of our services. The member or member's authorized representative (including a provider, **with the member's written consent**) can file a grievance or appeal. Member grievances and appeals include but are not limited to:

- Access to healthcare services.
- Care and treatment by a provider.
- Issues having with how we conduct business.

Wellpoint does not discriminate against providers for filing a grievance or an appeal on the member's behalf. In addition, providers are prohibited from penalizing a member in any way for expressing a complaint or filing a grievance.

Please note: Wellpoint offers an expedited appeal for decisions involving urgently needed care. Standard and expedited appeals are never reviewed by a person who is subordinate to the initial decision-maker.

Grievances

Members: Filing a Grievance

To help ensure Wellpoint members' rights are protected, all members are entitled to a grievances and appeals process. Our goal is to resolve verbal and written grievances in a timely and equitable manner and in accordance with state and federal regulations. Members are encouraged to discuss their concerns with the Member Services department, who can help the member submit a grievance. The representative interviews the member and records details in the Member Services tracking system.

The member may file a grievance verbally with our Member Services department or they can submit a written grievance at any time with as much information as possible, including:

- Who is part of the grievance.
- What happened.
- When the incident happened.
- Where the incident happened.
- Why the member was not happy with the healthcare services.

To file a grievance verbally, the member can reach Member Services at:

- **833-731-2140** (TTY 711) during normal business hours.
- **866-864-2545** (TTY 711) for after-hours support in Spanish.

The member should attach documents that will help us investigate the problem and should fax or mail the written grievance to the Wellpoint Grievances and Appeals department at:

- Fax: **844-400-3465**
- Mail:
Grievances and Appeals Department
Wellpoint
4800 Westown Parkway, Regency Building 3, Suite 200
West Des Moines, IA 50266

The following are guidelines surrounding grievances:

- The Grievances and Appeals department may request medical records or an explanation from the provider(s) involved in the case.

- The Grievances and Appeals department notify providers of the need for additional information either by phone, mail, or fax. Written correspondence to providers includes a signed and dated letter.
- Providers are expected to respond to requests for additional information within 10 days.
- If the Grievances and Appeals department is unable to resolve the grievance within the 30-day period, we will notify the member in writing and explain the reason for the delay. This may extend the case up to an additional 14 days for members. If the time frame is extended, for any extension not requested by the member, Wellpoint will give the member written notice of the reason for the delay.

Interpreter services and translation of materials into non-English languages and alternative formats are available, at no cost, to support members with the grievance and appeals process.

Grievances and Appeals

Members: Resolution

Wellpoint investigates the member's grievance to develop a resolution in a nondiscriminatory manner. After we make a determination, we send a resolution letter to the member outlining our findings.

Grievances

Confidentiality

All grievances are handled in a confidential manner. We do not discriminate against a member for filing a grievance or requesting a state fair hearing. We notify members of our grievances process in the Member Handbook. Members may request a translated version in languages other than English by calling **833-731-2140** (TTY: **711**).

Grievances

Discrimination

Wellpoint does not engage in, aid, or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates based on race, color, or national origin in providing aid, benefits, or services to beneficiaries. Wellpoint does not utilize or administer criteria having the effect of discriminatory practices based on gender or gender identity. Wellpoint does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of, or subjecting them to discrimination based on gender or gender identity. In addition, in compliance with the Age Act, Wellpoint may not discriminate against any person based on age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Wellpoint provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, sexual orientation, physical or mental disability, or type of illness or condition.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when an Wellpoint representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so if the member requests assistance. We document, track, and trend all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201
- By phone at: **800-368-1019** (TTY/TTD: **800-537-7697**)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Wellpoint provides free tools and services to people with disabilities to communicate effectively with us. Wellpoint also provides free language services to people whose primary language isn't English (for example, qualified interpreters and information written in other languages). These services can be obtained by calling the customer service number on their member ID card.

If you or your patient believe that Wellpoint has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, sexual orientation, age, disability, gender, or gender identity, you can file a grievance with our grievance coordinator via:

- Mail: 4800 Westown Parkway, Regency Building 3, West Des Moines, IA 50266
- Phone: **833-731-2140**

Equal Program Access on the Basis of Gender

Wellpoint provides individuals with equal access to health programs and activities without discriminating on the basis of gender. Wellpoint must also treat individuals in a manner that is consistent with their gender identity, and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (in other words, race, color, national origin, sexual orientation, gender, gender identity, age or disability).

Wellpoint may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual based on the fact that a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

Payment Disputes

Providers: Claim Payment Dispute Process

If you disagree with the outcome of a claim, you may begin the Wellpoint provider payment dispute process. The simplest way to define a claim payment dispute is when the claim is *finalized*, but you disagree with the outcome.

There are three common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, these are briefly defined below. They are:

- **Claim inquiry:** A question about a claim but not a request to change a claim payment
- **Claim correspondence:** When Wellpoint requests further information to finalize a claim
 - Typically, these requests include medical records, itemized bills, or information about other insurance a member may have.
- **Medical necessity appeals:** A pre-service appeal for a denied service. For these, a claim has not yet been submitted.

For more information on each of these, please refer to the appropriate section in this provider manual. The Wellpoint payment dispute process consists of two internal steps. You will **not** be penalized for filing a claim payment dispute, and no action is required by the member.

1. **Claim payment reconsideration:** This is first step in the Wellpoint provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.

2. **Claim payment appeal:** This is the second step in the Wellpoint provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.

A claim payment dispute may be submitted for multiple reason(s), including:

- Contractual payment issues.
- Disagreements over reduced or zero-paid claims.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code-editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Claim data issues.
- Timely filing issues.*

* Wellpoint will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

Claim Payment Reconsideration

The first step in the Wellpoint claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally and through our provider web portal within 180 calendar days from the date on the *Explanation of Payment (EOP)* (see below for further details on how to submit). Reconsiderations filed more than 180 days from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect.

If a reconsideration requires clinical expertise, it will be reviewed by appropriate clinical Wellpoint professionals.

Wellpoint will make every effort to resolve the claims payment reconsideration within 30 business days of receipt of all necessary information. If additional information is required to make a determination, the determination date will be 30 business days from the date we receive all information.

We will send you our decision in a determination letter, which will include:

1. A statement of the provider's reconsideration request.
2. A statement of what action Wellpoint intends to take or has taken.
3. The reason for the action.
4. Support for the action, including applicable statutes, regulations, policies, claims, codes, or provider manual references.
5. An explanation of the provider's right to request a claim payment appeal within 30 business days of the date of the reconsideration determination letter.
6. An address to submit the claim payment appeal.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

Claim Payment Appeal

If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal.

We accept claim payment appeals through our provider website or in writing within 30 business days of the date on the reconsideration determination. Claim payment appeals received more than 30 business days after the *EOP* or the claims reconsideration determination letter will be considered untimely and upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. Please note, we cannot process a claim payment appeal without a reconsideration on file.

If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical Wellpoint professionals.

Wellpoint will make every effort to resolve the claim payment appeal within 30 business days of receipt of all necessary information. If additional information is required to make a determination, the determination date will be 30 business days from the date we receive all information.

The claim payment appeal determination letter will include:

1. A statement of the provider's claim payment appeal request.
2. A statement of what action Wellpoint intends to take or has taken.
3. The reason for the action.
4. Support for the action including applicable statutes, regulations, policies, claims, codes, or provider manual references.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

How to Submit a Claim Payment Dispute

We have several options when filing a claim payment dispute:

- **Verbal (reconsideration only):** Verbal submissions may be submitted by calling Provider Services at **833-731-2143**.
- **Online (for reconsiderations and claim payment appeals):** Use the secure provider Availity Appeal application at <https://www.availity.com>. Through Availity, you can upload supporting documentation and receive immediate acknowledgement of your submission:
 - For appeals, your Availity Essentials user account will need the *Claim Status* role. To send attachments from Claim Status, you'll need the *Medical Attachments* role.
- **Written (reconsideration and claim payment appeal):** Written reconsiderations and claim payment appeals should be mailed to:
Provider Payment Disputes
Wellpoint
P.O. Box 61599
Virginia Beach, VA 23466-1599

Required Documentation for Claims Payment Disputes

Wellpoint requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email, and either your NPI or TIN
- The member's name and their Wellpoint or Medicaid ID number

- A listing of disputed claims, which should include the Wellpoint claim number and the date(s) of service(s)
- All supporting statements and documentation

Claim Inquiries

Providers: Claim Inquiries

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Provider Experience program helps you with claim inquiries. Just call **833-731-2143** and select the claims prompt within our IVR. We connect you with a dedicated resource team called the Provider Service Unit (PSU) to ensure:

- The availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact issue resolution rates.
- Significantly improved turnaround time of inquiry resolutions.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you with determining the appropriate process to follow for resolving your claim issue.

Claim Correspondence

Providers: Claim Correspondence

Claim correspondence is different from a payment dispute. Claim correspondence is when Wellpoint requires more information to finalize a claim. Typically, Wellpoint makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, Wellpoint will use it to finalize the claim.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of Issue	What Do I Need to Do?
Rejected claim(s)	Contact Availity Client Services at 800-282-4548 when your claim was submitted electronically but was never paid or was rejected. If you use a vendor work with them to ensure you are receiving your EDI response reports.
<i>EOP</i> requests for supporting Documentation (<i>Sterilization/Hysterectomy/Abortion Consent Forms</i> , itemized bills, and invoices)	Submit a <i>Claim Correspondence Form</i> , a copy of your <i>EOP</i> and the supporting documentation at https://www.availity.com .
<i>EOP</i> requests for medical records	Submit a <i>Claim Correspondence Form</i> , a copy of your <i>EOP</i> and the medical records at https://www.availity.com .
Need to submit a corrected claim due to errors or changes on original submission	Submit a <i>Claim Correspondence Form</i> and your corrected claim to at https://www.availity.com . Clearly identify the claim as corrected, utilizing the appropriate frequency codes and claim ID to be adjusted We will return claims that have been altered with an explanation of the reason for the

Type of Issue	What Do I Need to Do?
	return. Provided the claim was originally timely received, a corrected claim must be received within 365 days of the date of service, with a maximum limit of 2 years past date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Wellpoint to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI <i>EOB</i> . Corrected claims are never accepted in bulk submissions.
Submission of coordination of benefits (COB)/third-party liability (TPL) information	Submit a <i>Claim Correspondence Form</i> , a copy of your <i>EOP</i> and the COB/TPL information to at https://www.availity.com .
Emergency room payment review	Submit a <i>Claim Correspondence Form</i> , a copy of your <i>EOP</i> and the medical records to at https://www.availity.com .

Appeals

Medical Necessity Appeals

Medical necessity appeals/prior authorization appeals are different from claim payment disputes. For more information, refer to the **Members: Appeals** section in this manual.

Disputes

Providers: Nonmedical Necessity Claims Determinations

Claim payment disputes also may include retrospective medical necessity reviews. Requests for this kind of review must be submitted with all pertinent information, within 365 days of a claim disposition and be submitted in writing to Wellpoint to:

Payment Dispute Unit
Wellpoint
P.O. Box 61599
Virginia Beach, VA 23466-1599

Claim payment dispute requests are resolved within 30 days of receipt of the written request in one of the following ways:

- Wellpoint changes a previous claim disposition: The provider will be notified of the final disposition through an RA notice indicating the additional payment due to the provider.
- Wellpoint upholds a previous claim disposition: The provider will receive a resolution letter with the details of the decision.

Disputes

Providers: Mediation and Arbitration

If the provider is not satisfied with the outcome of a review conducted through the appeal process on the member's behalf, additional steps may be taken as stated in the Provider Agreement:

- Mediation
- Arbitration

If these processes have been exhausted and the provider has the member's consent, the provider may request a state fair hearing with the Department of Health and Human Services:

Appeals Department

Iowa Department of Health and Human Services
1305 E. Walnut St., 5th Floor
Des Moines, IA 50319

Dissatisfaction or Concerns Relating to Plan Operations

A provider may be dissatisfied or concerned about another provider, a member, or an operational issue, including claims processing and reimbursement.

An explanation must be submitted in writing up to 60 days from the date the provider became aware of the issue and include the following:

- Provider's name
- Date of the incident
- Description of the incident

Submit the explanation to the following address:

Wellpoint
4800 Westown Parkway, Suite 200
West Des Moines, IA 50266

Providers may also fax explanations to **515-267-1278**.

Wellpoint may request medical records or an explanation of the issues raised in the explanation in the following ways:

- Phone
- Fax, with a signed and dated letter
- Mail, with a signed and dated letter

Providers are notified in writing of the issue resolution. Findings or decisions of peer review or quality of care issues are not disclosed.

When to Expect Resolution for an Issue

Wellpoint will investigate and resolve provider issues within 60 business days of receipt of the explanation. For expedited issues, Wellpoint will investigate and respond within three business days of receipt to resolve.

Appeals

Members: Appeals

An **adverse benefit determination** is a denial, modification or reduction of services based on eligibility, benefit coverage or medical necessity. It can mean any of the following:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner as defined by the state
- The failure of Wellpoint to act within the time frames in § 438.408(b) (1) (2) regarding the standard resolution of grievances
- For a resident of a rural area with only one MCO: the denial of a member's request to exercise his or her right, under § 438.52(b) (2) (ii), to obtain services outside the network

Wellpoint informs members of their grievance, appeal, and state fair hearing rights in the member enrollment materials. If a member would like to file an appeal, the member, or member's authorized representative with the member's consent, must notify us within 60 calendar days of the date on the Notice of Adverse Benefit Determination letter. The request for an appeal may be verbal or written. Providers may submit appeals on a member's behalf **with written consent**. When a provider, or provider on member behalf, expresses dissatisfaction about an adverse determination involving a clinical issue, the case is handled automatically as an appeal rather than a complaint.

All appeals are acknowledged in writing within three business days of receipt. Appeals are divided into two categories:

- **Standard appeal:** The appropriate process when a member, or his or her representative with written consent, requests that Wellpoint reconsider the denial of a service or payment for services, in whole or in part. Iowa's standard appeal process requires resolution within 30 calendar days of receipt of the appeal request or within an additional 14 (44 total) calendar days if the member requests an extension, or if Wellpoint and the HHS determine it's in the best interest of the member to extend the decision time frame.
- **Expedited appeals:** An appeal when the amount of time necessary to complete a standard appeal process could jeopardize the member's life, health, or the ability to maintain or regain maximum function. Iowa's expedited appeal process requires resolution within 72 hours of receipt of the expedited appeal request.

Members have the right to appeal an Wellpoint denial of services or payment for services, in whole or in part. A denial of this type is called an adverse benefit determination. A member, or his or her representative with written consent, may submit a verbal or written appeal regarding an adverse benefit determination within 60 calendar days from receipt of the denial letter.

Wellpoint provides the member and their representative the opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents or records considered during the appeals process. Providers and members are notified in writing of their right for an appeal, if any. Findings or decisions of peer review or quality of care issues are not disclosed. Upon determination of the appeal, Wellpoint ensures there is no delay in notification or mailing to the member (and if applicable, the member's representative) about the appeal decision. The appeal decision notice shall describe the actions taken, the reasons for the action, the member's right to request a state fair hearing and the process for filing a state fair hearing request.

A **first-level review** is the appeal process that must be exhausted through Wellpoint before a state fair hearing is granted. Once the first-level review process is complete, a notice of decision will be issued by us and will identify further appeal rights, if applicable.

Providers cannot file an appeal on their own behalf.

Appeals

Members: Time Frames

Members and authorized representatives have 60 calendar days to file an appeal from the date of the Notice of Adverse Benefit Determination letter.

All appeals are acknowledged in writing within three business days of receipt. Upon receipt of the notice of appeal, Wellpoint will send an acknowledgment of receipt of the appeal to the member, member's representative, or both. We'll keep a copy of the acknowledgment of receipt of appeal on file. Appeal decisions must be in writing and resolved within the following time frames:

- Pre-service and post-service appeals: within 30 calendar days of receipt of the appeal request

- Expedited appeals: within 72 hours of receipt of the appeal request

Wellpoint complies with NCQA, state and federal standards.

Appeals

Members: Response to Standard Appeals

After Wellpoint receives a verbal or written appeal request, the Grievances and Appeals department takes the issue into consideration and investigates the case. The member, his or her representative and the provider are given the opportunity to submit written comments and documentation relevant to the appeal. Wellpoint may request medical records or a provider explanation of the issues raised in the appeal by phone or by fax or mail, with a signed and dated letter.

Providers are expected to comply with the request for additional information within 10 days.

When the appeal is the result of a medical necessity determination, a physician reviewer of the same or similar specialty who was not involved in the initial decision and has experience treating the condition being appealed reviews the case. The physician reviewer contacts the provider, if needed, to discuss possible alternatives.

Appeals

Members: Resolution of Standard Appeals

Standard appeals are resolved within 30 calendar days of receipt of the initial written or verbal request. Members are notified in writing of the appeal resolution, including their right to further appeal, if any.

Appeals

Members: Extensions

The resolution time frame for an appeal not related to an ongoing hospitalization or emergency may be extended up to 14 calendar days if:

- The member or his or her representative requests an extension.
- Wellpoint shows that there is a need for additional information and that the delay is in the member's interest.

If we extend the time frame and it was not at the request of the member, we must notify the member/representative in writing of the extension and reason for the delay and must complete all of the following:

- Make reasonable efforts to give the member prompt oral notice of the delay.
- Within two calendar days, give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision.
- Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

Appeals

Members: Expedited

If the amount of time necessary to participate in a standard appeal process could jeopardize the member's life, health, or ability to attain, maintain or regain maximum function, the member may request an expedited appeal. Wellpoint will inform the member of the limited time frame available for providing information, as well as that the duration for submitting an expedited appeal is limited.

When an expedited appeal is requested, Wellpoint will inform the member and member's authorized representative of the limited time available to present evidence and allegations of fact or law. Wellpoint ensures that punitive action is not taken against a provider who either requests an expedited resolution or supports a member's appeal.

Appeals

Members: Timeline for Expedited Appeals

Members have the right to request an expedited appeal within 60 calendar days of receipt of the denial letter. Expedited appeals are acknowledged by phone and in writing.

If Wellpoint denies a request for an expedited appeal, we must:

- Transfer the appeal to the time frame for standard resolution, which is 30 calendar days.
- Make a reasonable effort to give the member prompt verbal notice of the denial and follow up within two days with written notice.

Appeals

Members: Response to Expedited Appeals

Wellpoint may request medical records or a provider explanation of the issues raised in an expedited appeal by phone or by fax or mail, with a signed and dated letter.

Providers are expected to comply with the request for additional information within 24 hours.

Appeals

Members: Resolution of Expedited Appeals

Wellpoint resolves expedited appeals as quickly as possible and within 72 hours of the request. The member is notified by phone, whenever possible, as well as in writing within two days of the expedited appeal decision.

Appeals

Members: State Fair Hearing

Members, or the member's representative with written consent, may request a state fair hearing after they have exhausted our internal appeal process. The request must be filed within 120 calendar days of the resolution letter.

Members, or the member's representative with written consent, may appeal in person, by phone or in writing. To appeal in writing, they may complete an appeal electronically at <http://dhs.iowa.gov/node/966> or write a letter telling HHS why they disagree with our appeal resolution. If the member does not want to complete the form online, he or she may mail, fax, or take the appeal letter to:

Appeals Section
Department of Health and Human Services
1305 E. Walnut St., 5th Floor
Des Moines, IA 50319
Fax: 515-564-4044

Members (or the member's representative) may also appeal by phone by calling the HHS Appeals Section at **515-281-3094**.

The process is as follows:

- The state sends a notice of the hearing request to Wellpoint.
- Upon receipt of the request, we forward all documents related to the request to the state.
- The state of Iowa schedules a hearing, which is held by teleconference, unless the member requested an in-person hearing.
- The state notifies all parties of the date, time, and place of the hearing. Representatives from our administrative, medical, and legal departments may attend the hearing to present testimony and arguments. Our representatives may cross-examine witness and offer rebutting evidence.
- An Administrative Law Judge renders a decision in the hearing.
- If any party disagrees with the judge's decision, they can request a Director's review and a decision will be rendered after the review is complete.
- If our position is overturned, we must adhere to the final decision and ensure the decision is carried out.

Please note: If the member needs special arrangements to attend the hearing due to a disability or needs language translation services, please call **515-281-8774**.

Appeals

Confidentiality

All appeals are handled in a confidential manner. We do not discriminate against a member, their representative or provider appealing on a member's behalf with written consent for requesting a state fair hearing. We notify members of our appeals process in the Member Handbook; members may request a translated version in languages other than English.

Appeals

Continuation of Benefits during Appeal

Members must file a request within 10 days of receiving a Notice of Adverse Benefit Determination letter from Wellpoint regarding a decision to reduce, limit, terminate or suspend benefits. We will tell the member that they may be liable for the costs of that care if the HHS upholds our decision. If the member requests that we continue coverage, the following conditions apply:

- If the HHS reverses our decision, we are responsible for covering services provided during the state fair hearing process.
- If the HHS upholds our decision, we may pursue reimbursement for all services provided to the member, to the extent that services were rendered solely because of this requirement.

Members can continue receiving covered services while their appeal or the state fair hearing process is pending if all of the following apply:

- An appeal is filed timely (in other words, on or before the effective date of the adverse benefit determination or within 10 calendar days of the date Wellpoint sent the notice of adverse benefit determination). The date the notice is received is considered to be five days after the date on the notice unless the member shows he or she did not receive the notice within the five-day period.
- The appeal or state fair hearing request is filed either:
 - Within 10 calendar days from the date, we mailed the Notice of Adverse Benefit Determination letter.
 - Before the effective date of this notice.
- The services were ordered by an authorized provider.
- The authorization period for the services has not ended.
- The member asks that the service continues.

If a member's benefits are continued while an appeal or state fair hearing request is pending, the services must be continued until one of the following happens:

- The member decides not to continue the appeal or state fair hearing.
- The member does not request a state fair hearing within 10 days of the level 1 decision.
- The authorization for services expires or service authorization limits are met.
- A hearing decision is issued in the state fair hearing that is adverse to the member.

CHAPTER 15: CREDENTIALING AND RECREDENTIALING

Credentialing is the process of validating the professional competency and conduct of providers and health delivery organizations. Providers and health delivery organizations must meet rigorous credentialing standards to be part of the Wellpoint provider network. The credentialing process involves verifying licensure, board certification and education. The process also involves identifying malpractice or negligence claims through the applicable Iowa state agencies and the National Practitioner Database.

We require recredentialing every three years to stay current with your professional information. Recredentialing is also essential to our members, who depend on the accuracy of the information in the Wellpoint Provider Directory.

The Wellpoint Provider Directory includes information for these provider types:

- Physicians (including specialists)
- Hospitals
- Pharmacies
- Behavioral health providers
- LTSS providers as appropriate

Hard copies of the provider directories are updated at least monthly. Electronic provider directories are updated no later than 30 calendar days after Wellpoint receives updated provider information. Provider directories are posted on the Wellpoint website in a machine-readable file and format.

We streamlined the credentialing process by teaming up with the Council for Affordable Quality Healthcare (CAQH), which is nationally recognized for its thoroughness in collecting provider data. It is the medical director's or other designated physician's responsibility to participate in the credentialing program.

Council for Affordable Quality Healthcare

Wellpoint encourages Iowa providers to use CAQH's ProView for initial credentialing and periodic recredentialing. CAQH is a not-for-profit alliance of the nation's leading healthcare plans and networks whose mission is to improve healthcare quality and access for more than 165 million Americans covered by these plans. The CAQH data collection system of 800,000 providers allows administrative requirements to be streamlined.

CAQH's ProView meets industry standards for collecting the provider data used in credentialing. Providers in all 50 states and the District of Columbia are able to enter information free of charge, reducing paperwork for more than 550 participating healthcare plans. ProView allows providers to fill out one application to meet the credentialing data needs of multiple organizations. For both Wellpoint and providers, recredentialing through ProView is helpful because this process:

- Supports Wellpoint administrative streamlining and paper reduction efforts.
- Helps to ensure the accuracy and integrity of the provider database.
- Simplifies the credentialing application process, eliminating redundant application forms and streamlining paperwork for providers.
- Enables providers to utilize CAQH's database at no cost.

Our credentialing process for office-based providers is consistent with National Committee for Quality Assurance (NCQA) guidelines and the state of Iowa requirements to practice medicine. Practitioners are notified within 60 calendar days of the credentialing committee's decision.

CAQH/ProView Registration: First Time Users

All Providers applying for initial or continuing participation will be encouraged to complete and submit their credentialing and recredentialing applications through CAQH ProView by accessing the CAQH website. Below are some helpful hints and things to remember when using ProView.

To join CAQH ProView:

1. Go to <https://proview.caqh.org/pr>.
2. Select Register Now on the bottom right and follow the instructions.

If you already participate with CAQH and have completed your online application, ensure that you authorized Wellpoint access to your credentialing information. This can be completed in four easy steps. (If you selected Global Authorization, Wellpoint will already have access to your data.)

To authorize Wellpoint:

1. Go to <https://proview.caqh.org/pr> and enter your username and password.
2. Select the cog wheel in the upper right and then select Authorize.
3. Scroll down, locate Wellpoint and check the box beside Wellpoint.
4. Select Save to submit your changes.

For questions about ProView, call the CAQH help desk at **888-599-1771** or send an email to providerhelp@proview.CAQH.org.

Please note: Registration and completion of the online application are free.

CAQH/ProView Registration: Completing the Application Process

The ProView standardized application is a single, standard online form that meets the needs of all participating healthcare organizations. When completing the application, indicate which participating healthcare plans and healthcare organizations you authorize to access your application data. All of the data you submit through ProView is maintained by CAQH in a secure data center.

The following materials will be helpful while completing the ProView online application:

- Previously completed credentialing application
- List of previous and current practice locations
- Various identification numbers (Universal Provider Identification Number [UPIN], NPI, Medicare, Medicaid, etc.)
- State license(s) applicable to your provider type
- Current Drug Enforcement Administration (DEA) certificate, if applicable
- Current Controlled and Dangerous Substances certificate, if applicable
- Internal Revenue Service (IRS) W-9 form(s)
- Current malpractice insurance face sheet
- Summary of all pending or settled malpractice cases within the past 10 years
- History of refusal or cancellation of professional liability insurance
- Curriculum vitae
- Disclosure of ownership

After completing the online credentialing application, you will be asked to:

- Authorize access to your information. Check the box next to Wellpoint or select the **Global Authorization** option.
- Verify your data entry and attestation for accuracy and completeness.
- Submit supporting documents:
 - State license(s) applicable to your provider type

- Board certification or highest level of medical training or education
- Work history
- Admitting privileges at a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), National Integrated Accreditation for Healthcare Organizations (NIAHO), American Osteopathic Association (AOA) or a network hospital previously approved by the committee
- Current DEA certificate or plan to prescribe if no DEA certificate, if applicable
- Current Controlled and Dangerous Substances certificate, if applicable
- Copy of the professional liability insurance face sheet is required. Organizational providers are required to maintain professional liability insurance in the amounts specified in the Network Provider Agreement consistent with State law requirements and Wellpoint policy.
- Summary of all pending or settled malpractice case(s) within the past 10 years
- Curriculum vitae
- Current signed attestation
- Written protocol (advanced nurse practitioners only)
- Supervision form (physician assistants only)
- Hospital Coverage letter, required by Wellpoint from providers who do not have admitting privileges at a participating network hospital
- State or federal license sanctions or limitations
- Medicare, Medicaid, or Federal Employees Health Benefits Program (FEHBP) sanctions
- Disclosure of Ownership

The quickest, most efficient way of uploading these documents is directly to the CAQH portal at <https://proview.caqh.org/Login/Index?ReturnUrl=%2f>.

Please note: While the CAQH credentialing data set is substantially complete, Wellpoint may need to supplement, clarify or confirm certain responses on your application on a case-by-case basis. Providers may also submit additional documentation by email or mail if unable to upload to:

Email: documents@proview.caqh.org

Mail: CAQH

P.O. Box 696537

San Antonio, TX 78269

If you have any questions about accessing the ProView database, you may contact the CAQH Help Desk for assistance at **888-599-1771**.

CAQH/ProView Registration: Existing Users

If you are an existing CAQH/UPD user through participation in another health plan, log on to the ProView database and authorize Wellpoint to access your information by following these steps:

1. Go to the CAQH website at <https://www.caqh.org/solutions/caqh-proview>
2. **Select** the link titled **Providers**. Then, enter your username and password.
3. Click the **Authorize** tab located under the CAQH logo.
4. Scroll down, locate **Wellpoint** and check the box next to **Wellpoint**, or select the **Global Authorization** option.
5. Click **Save** to submit your changes.

For more information about the CAQH ProView database and application process, visit the CAQH website.

Additional CAQH Resources

CAQH contact information is as follows:

Phone: **888-599-1771** (Monday-Thursday, 7 a.m.-9 p.m. Central time; Friday, 7 a.m.-7 p.m. Central time)
Email: documents@proview.caqh.org

Please note: Providers with vision and/or hearing challenges may call the CAQH Help Desk and complete the application by phone.

Contracting Process for Hospital or Facility-Based Providers

Hospital or facility-based providers must submit a request for contracting and participating in the Wellpoint network. Eligible hospital or facility-based specialists include, but are not limited to:

- Anesthesiologist
- Emergency room provider
- Hospitalist
- Neonatologist
- Pathologist
- Radiologist

Hospital or facility-based providers must have the following:

- Hospital privileges
- Type 1 NPI number
- Iowa Medical Board license (temporary permit is acceptable) or appropriate Iowa licensure applicable to provider type Certificate/American Association of Nurse Anesthetists (AANA) number (applicable to CRNA Providers only)
- Certificate/AANA number (applicable to CRNA providers only)

Please note: Having an Wellpoint provider record ID does not automatically activate the Medicaid network. The effective date for Wellpoint providers is the date credentialing is complete and contracts are dually executed. A provider is considered participating and in-network on this effective date. Claims will be processed out-of-network until the provider has applied for network participation and has been approved and activated in the Medicaid network.

To complete the contracting process, hospital or facility-based providers must take the steps outlined in the following sections, as appropriate.

Medical Group Adding a Provider

If you are part of a medical group with a Group Medicaid Agreement, and this group is adding you as a facility-based provider: Complete and fax the Medicaid Facility-Based Provider Application to your local Network Management office for processing.

Provider or Medical Group Interested in Contracting with Wellpoint

If you are a provider or a medical group interested in contracting as a facility-based provider with the Medicaid network, and you do not currently have a Medicaid Agreement:

1. Complete the Online Agreement Request Form. Or request an agreement be mailed or faxed to you by contacting your local Network Management office.
2. Complete and sign either of the following documents:
 - a. Provider or Medical Group Agreement (as applicable). Return to your local Network Management office.
 - b. Medicaid Facility-Based Provider application. Return to your local Network Management office.

All providers are able to participate in the Medicaid program unless that provider has a sanction and is ineligible to participate. On a monthly basis, Wellpoint obtains updated information on sanctioned providers. If the provider is on probation, Wellpoint will request a written explanation from the provider which will be reviewed by the credentialing committee. If a provider is confirmed to have any sanctions, we reserve the right to immediately terminate the contract with that provider, as outlined in our policies.

CAQH Updates

You must inform CAQH and Wellpoint of changes to your practice; our members rely on the accuracy of the information in our online Provider Directory. CAQH will send you automatic reminders to review and attest to the accuracy of your data every 4 months. If you are a participating provider, submit most changes online by using the Change Your Information form available on the CAQH website at <https://www.caqh.org/solutions/caqh-proview/>

CAQH and Recredentialing

When you are scheduled for recredentialing, Wellpoint sends your name on the Wellpoint roster of providers to CAQH. We determine if you have completed the UPD credentialing process and have authorized Wellpoint to access your information or selected the **Global Authorization** option. If you have made this authorization, Wellpoint obtains your current information from the ProView database and completes the recredentialing process without contacting you.

If your recredentialing application is not available to Wellpoint through CAQH for any reason, CAQH mails you a Welcome Kit with access and registration instructions along with your personal CAQH provider ID. You may then obtain immediate access to the ProView database via the Internet to complete and submit your application. For detailed instructions, go to the section **CAQH/ProView Registration: Existing Users** in this chapter. After you have granted access to Wellpoint, recredentialing resumes.

Ownership Disclosure

As part of the initial and subsequent recredentialing process, Wellpoint follows the CMS process regarding ownership disclosure. You may be periodically required to submit a Disclosure of Ownership questionnaire, located on the CMS website at www.cms.gov.

Credentialing

Wellpoint Discretion

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Wellpoint discretion in any way to amend, change or suspend any aspect of Wellpoint's credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to Members. Wellpoint further retains the right to approve, suspend, or terminate individual physicians and healthcare professionals, and sites in those instances where it has delegated credentialing decision making.

Credentialing Scope

Credentialing requirements apply to the following:

1. Practitioners who are licensed, certified, or registered by the state to practice independently (without direction or supervision);
2. Practitioners who have an independent relationship with Wellpoint
 - An independent relationship exists when Wellpoint directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as primary care practitioners; and
3. Practitioners who provide care to Members under Wellpoint's medical benefits.

The criteria listed above apply to practitioners in the following settings:

1. Individual or group practices;
2. Facilities;
3. Rental networks:
 - That are part of Wellpoint's primary Network and include Wellpoint Members who reside in the rental network area.
 - That are specifically for out-of-area care and Members may see only those practitioners or are given an incentive to see rental network practitioners; and
4. Telemedicine.

Wellpoint credentials the following licensed/state certified independent healthcare practitioners:

- Medical Doctors (MD)
- Doctor of Osteopathic Medicine (DO)
- Doctor of Podiatry
- Chiropractors
- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral healthcare specialists who provide treatment services under the Health Benefit Plan
- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (for example, physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dietitians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Use Disorder Practitioners

Wellpoint credentials the following Health Delivery Organizations (HDOs):

- Hospitals
- Home Health agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance use disorder treatment in inpatient, residential or ambulatory settings, including:

- Adult Family Care/Foster Care Homes
- Ambulatory Detox
- Community Mental Health Centers (CMHC)
- Crisis Stabilization Units
- Intensive Family Intervention Services
- Intensive Outpatient – Mental Health and/or Substance Use Disorder
- Methadone Maintenance Clinics
- Outpatient Mental Health Clinics
- Outpatient Substance Use Disorder Clinics
- Partial Hospitalization – Mental Health and/or Substance Use Disorder
- Residential Treatment Centers (RTC) – Psychiatric and/or Substance Use Disorder
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
- End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission)
- Portable x-ray Suppliers (CMS Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)

Credentials Committee

The decision to accept, retain, deny, or terminate a practitioner’s or HDO’s participation in on one or more of Wellpoint’s networks or plan programs is conducted by a peer review body, known as Wellpoint’s Credentials Committee (the “CC”).

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated. In states or regions where an Wellpoint affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or an Wellpoint medical director designee and the vice-chair must be a lead medical officer or an Wellpoint medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (for example, nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair’s discretion. At least two of the physician committee members must be

credentialed for each line of business (for example, Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more Networks or Plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. Specifically, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulatory agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Wellpoint's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of their right to correct erroneous information or provide additional details regarding the issue and will include the process for submission of this additional information. Depending on the nature of the issue, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's or HDO's credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Upon request, the practitioner or HDO will be provided with the status of their credentialing or re-credentialing application.

Wellpoint may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Nondiscrimination Policy

Wellpoint will not discriminate against any applicant for participation in its Plan programs or provider Networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Wellpoint will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the Members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and

providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Wellpoint will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Wellpoint will take appropriate action to track and eliminate those practices.

Initial Credentialing

Each practitioner or HDO must complete a standard application form deemed acceptable by Wellpoint when applying for initial participation in one or more of Wellpoint’s networks or plan programs. For practitioners, the Council for Affordable Quality Healthcare (CAQH) ProView system is utilized. To learn more about CAQH, visit their web site at www.CAQH.org.

Wellpoint will verify those elements related to an applicants’ legal authority to practice, relevant training, experience, and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Wellpoint will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, NIAHO, CIHQ or HFAP accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state-controlled substance registrations <ul style="list-style-type: none"> • The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

Re-credentialing

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Wellpoint credentialing standards ("Credentialing Standards").

All applicable practitioners and HDOs in the Network within the scope of the Credentialing Program are required to be re-credentialed every three years unless otherwise required by applicable state contract or state regulations.

Health Delivery Organizations

New HDO applicants will submit a standardized application to Wellpoint for review. If the candidate meets Wellpoint screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail below, in the "Wellpoint Credentialing Program Standards" section, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Wellpoint may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

Ongoing Sanction Monitoring

To support certain Credentialing Standards between the re-credentialing cycles, Wellpoint has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with Credentialing Standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General ("OIG")
- Federal Medicare/Medicaid Reports
- Office of Personnel Management ("OPM")
- State licensing Boards/Agencies
- Member/Customer services departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Wellpoint departments
- Any other information received from sources deemed reliable by Wellpoint.

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

Appeals Process

Wellpoint has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Wellpoint's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Wellpoint may wish to terminate practitioners or HDOs. Wellpoint also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides

practitioners and HDOs with a process to appeal determinations terminating/denying participation in Wellpoint's Networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB).

Additionally, Wellpoint will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Wellpoint's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Wellpoint's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Wellpoint's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

Reporting Requirements

When Wellpoint takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its Networks or Plan programs, Wellpoint may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

Wellpoint Credentialing Program Standards

Eligibility Criteria

A. Healthcare practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

1. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;
2. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to Members;
3. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state; and
4. Meet the education, training and certification criteria as required by Wellpoint.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

1. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle

- Surgery (ABFAS), American Board of Podiatric Medicine (“ABPM”), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.
2. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
 3. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
 4. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.
 - a. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training, and certification requirement:
 - i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;
 - ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
 - iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Wellpoint’s network and the applicant’s professional activities are spent at that institution at least fifty percent (50%) of the time.
 - b. Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Wellpoint education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Wellpoint review and approval. Reports submitted by delegates to Wellpoint must contain sufficient documentation to support the above alternatives, as determined by Wellpoint.
 5. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO), Center for Improvement in Healthcare Quality (CIHQ), a Healthcare Facilities Accreditation Program (HFAP) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.
 6. For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

Criteria for Selecting Practitioners

New Applicants (Credentialing):

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
4. No evidence of potential material omission(s) on application.
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members.
6. No current license action.
7. No history of licensing board action in any state.
8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one state must have a valid DEA/CDS registration for each applicable state.
10. Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:
 - a. It can be verified that this application is pending.
 - b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber;
 - c. The applicant agrees to notify Wellpoint upon receipt of the required DEA/CDS registration.
 - d. Wellpoint will verify the appropriate DEA/CDS registration via standard sources.
 - i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day timeframe will result in termination from the Network.

Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Wellpoint's Members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:

- a. It can be verified that the applicant's application is pending; and
- b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
- c. The applicant agrees to notify Wellpoint upon receipt of the required DEA registration; and
- d. Wellpoint will verify the appropriate DEA/CDS registration via standard sources; and
- e. The applicant agrees that failure to provide the appropriate DEA registration within a 90-day timeframe will result in termination from the network.

Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:

- a. controlled substances are not prescribed within his/her scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and
 - b. he or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber; and
 - c. DEA/CDS registration is or was not suspended, revoked, surrendered, or encumbered for reasons other than those aforementioned.
11. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for Practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating Practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.
 12. No history of or current use of illegal drugs or history of or current substance use disorder.
 13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
 14. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.
 15. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
 16. A minimum of the past 10 years of malpractice claims history is reviewed.
 17. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Wellpoint's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
 18. No involuntary terminations from an HMO or PPO.
 19. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
 - a. Investment or business interest in ancillary services, equipment or supplies;
 - b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
 - c. Voluntary surrender of state license related to relocation or nonuse of said license;
 - d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
 - e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
 - f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window.
 - g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
 - h. History of a licensing board, hospital or other professional entity investigation that was closed

without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Participation Criteria and Exceptions for Non-Physician Credentialing

The following participation criteria and exceptions are for non-MD practitioners. It is not additional or more stringent requirements, but instead the criteria and exceptions that apply for these specific provider types to permit a review of education and training.

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
 - a. Master or doctoral degree in social work.
 - b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a Doctor of Social Work will be viewed as acceptable.
 - c. Licensure to practice independently.
2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC) or other master level license type:
 - a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
 - b. Master or doctoral degrees in divinity, master's in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
 - c. Practitioners with PhD training as a clinical psychologist can be reviewed.
 - d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
 - e. Licensure to practice independently or in states without licensure or certification:
 - i. Marriage & Family Therapists with a master's degree or higher:
 - a. Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).
 - ii. Mental Health Counselors with a master's degree or higher:
 - a. Provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) (proof of NBCC certification required) or meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).
3. Pastoral Counselors:
 - a. Master's or doctoral degree in a mental health discipline.
 - b. Licensed as another recognized behavioral health provider type (for example, MD/DO, PsyD, SW, RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.
 - c. A fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) OR meet all requirements to become a fellow or diplomat member of the ACPE [documentation of eligibility of ACPE required].

4. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
 - a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
 - b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
 - c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing, or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and
 - d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.

4. Clinical Psychologists:
 - a. Valid state clinical psychologist license.
 - b. Doctoral degree in clinical or counseling, psychology, or other applicable field of study.
 - c. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

5. Clinical Neuropsychologist:
 - a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
 - b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
 - c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
 - i. Transcript of applicable pre-doctoral training;
 - ii. Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
 - iii. Letters from supervisors in clinical neuropsychology (including number of hours per week);
or
 - iv. Minimum of five years' experience practicing neuropsychology at least ten hours per week.

6. Licensed Psychoanalysts:
 - a. Applies only to practitioners in states that license psychoanalysts.
 - b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Wellpoint Credentialing Policy (for example, psychiatrist, clinical psychologist, licensed clinical social worker).
 - c. Practitioner must possess a valid psychoanalysis state license.
 - (a) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
 - (b) Meet examination requirements for licensure as determined by the licensing state.

7. Process, requirements, and Verification – Nurse Practitioners:

- a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
- b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
- c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted, and not subject to probation, terms, or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
- d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Wellpoint procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
- e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
 - i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
 - ii. American Academy of Nurse Practitioners – Certification Program;
 - iii. National Certification Corporation;
 - iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner);
 - v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
 - vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Wellpoint is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

- f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.
- g. The NP applicant will undergo the standard credentialing processes outlined in Wellpoint's Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
- h. Upon completion of the credentialing process, the NP may be listed in Wellpoint's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
- i. NPs will be clearly identified:

- i. On the credentialing file;
 - ii. At presentation to the CC; and
 - iii. Upon notification to network services and to the provider database.
8. Process, Requirements and Verifications – Certified Nurse Midwives:
- a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training, and board certification.
 - b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
 - c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted, and not subject to probation, terms, or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
 - d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Wellpoint procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
 - e. All CNM applicants will be certified by either:
 - iv. The National Certification Corporation for Ob/Gyn and neonatal nursing; or
 - v. The American Midwifery Certification Board, previously known as the American College of Nurse Midwives.

This certification must be active and primary source verified. If the state licensing board primary source verifies one) of these certifications as a requirement for licensure, additional verification by Wellpoint is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.

- j. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
- k. The CNM applicant will undergo the standard credentialing process outlined in Wellpoint’s Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the Network.
- l. Upon completion of the credentialing process, the CNM may be listed in Wellpoint’s provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
- m. CNMs will be clearly identified:

- i. On the credentialing file;
- ii. At presentation to the CC; and
- iii. Upon notification to network services and to the provider database.

9. Process, Requirements and Verifications – Physician’s Assistants (PA):

- a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
- b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
- c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted, and not subject to probation, terms, or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
- d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Wellpoint procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
- e. All PA applicants will be certified by the National Commission on Certification of Physician’s Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Wellpoint is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Wellpoint Health Plan and submitted for individual review by the CC.
- f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
- g. The PA applicant will undergo the standard credentialing process outlined in Wellpoint’s Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
- h. Upon completion of the credentialing process, the PA may be listed in Wellpoint provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
- i. PA’s will be clearly identified:
 - iv. On the credentialing file;
 - v. At presentation to the CC; and
 - vi. Upon notification to network services and to the provider database.

Currently Participating Applicants (Re-credentialing)

- 1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;

2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Wellpoint's Plan programs or provider Networks, federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Wellpoint's other credentialed provider Networks.
4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or substance use disorder;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
 - a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
 - b. Voluntary surrender of state license related to relocation or nonuse of said license;
 - c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
 - d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
 - e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;
 - f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
 - g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
15. No quality improvement data or other performance data including complaints above the set threshold.
16. Re-credentialed at least every three years to assess the practitioner's continued compliance with Wellpoint standards.

*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for re-credentialing.

B. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Wellpoint may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Wellpoint may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member access need only when the CC review indicates compliance with Wellpoint standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are re-credentialed at least every three years to assess the HDO’s continued compliance with Wellpoint standards.

1. General Criteria for HDOs:

- a. Valid, current, and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
- b. Valid and current Medicare certification.
- c. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. **Note: If, once an HDO participates in Wellpoint’s Plan programs or provider Networks, exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Wellpoint’s other credentialed provider Networks.**
- d. Liability insurance acceptable to Wellpoint.
- e. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Wellpoint’s quality and certification criteria standards have been met.

2. Additional Participation Criteria for HDO by Provider Type:

HDO Type and Wellpoint Approved Accrediting Agent(s)

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, TCT, DNV/NIAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, DNV/NIAHO, TJC, TCT
Home Infusion Therapy (HIT)	ACHC, CHAP, TCT, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC

Facility Type (Behavioral Healthcare)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	DNV/NIAHO, HFAP, TJC, TCT

Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, HFAP
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Use Disorder	ACHC, CARF, COA, DNV/NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, HFAP, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Use Disorder	CARF, DNV/NIAHO, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Use Disorder	CARF, COA, DNV/NIAHO, HFAP, TJC

Facility Type (Behavioral Healthcare - Rehabilitation)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	TCT, DNV/NIAHO, HFAP, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Use Disorder Clinics	CARF, TJC, COA,

CHAPTER 16: ACCESS STANDARDS AND ACCESS TO CARE

Access Standards and Access to Care

Overview

This chapter outlines the Wellpoint standards for timely and appropriate access to quality healthcare. Following guidelines set by the National Committee for Quality Assurance (NCQA), the American College of Obstetricians and Gynecologists (ACOG) and the Iowa Department of Health and Human Services (HHS), these standards help ensure that medical appointments, emergency services and continuity of care for new and transferring members are provided fairly, reasonably and within specific time frames.

We recognize that cultural and linguistic barriers may affect our members' ability to understand or comply with certain instructions or procedures. To break through those barriers and ensure that our access standards can be met, we encourage providers to access the Wellpoint Cultural Competency Training and Cultural and Linguistic Toolkit called Caring for Diverse Populations. Locate this information on our website at <https://providers.wellpoint.com/ia> under Provider Resources & Documents > Training. Or for additional information on cultural diversity and interpreter services, please refer to **Chapter 24: Cultural Diversity and Linguistic Services** in this manual.

Wellpoint monitors provider compliance with access to care standards on a regular basis. Failure to comply may result in corrective action.

Access Standards and Access to Care

General Appointment Scheduling

Urgent, nonemergency: The existence of conditions due to an illness or injury which are not life threatening, but which require expeditious treatment because of the prospect of the condition worsening without clinical intervention.

Nature of Visit	Appointment Standards
Emergent or emergency visits	Immediately upon presentation, 24 hours a day, 7 days a week and without preauthorization
PCP urgent visits	Within 24 hours
PCP routine visits	Not to exceed four to six weeks from the date of a patient's request for a routine
Persistent symptoms	Within 48 hours
Specialist urgent visit	Within 24 hours
Specialist routine visit	Within 30 calendar days
Initial visit for pregnant women	Within 14 calendar days
Behavioral health urgent, nonemergency	Seen or referred to appropriate provider within one hour of presentation at a service delivery site or within 24 hours of telephone contact with provider or the contractor
Behavioral health emergency	Seen or referred to appropriate provider within 15 minutes of arrival
Behavioral health mobile crisis	Within one hour of presentation or request
Behavioral health persistent symptoms	Seen or referred to appropriate provider within 48 hours of reposting symptoms
Behavioral health routine	Seen or referred to appropriate provider within three weeks of requesting appointment
Substance use disorder and pregnancy	Within 48 hours of seeking treatment

Nature of Visit	Appointment Standards
Intravenous drug use	No later than 14 days after making the request for admission, or 120 days after the date of such request if no program has the capacity to admit the individual on the date of such request, and if interim services are made available to the individual no later than 48 hours after such request.

Emergency: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Iowa Medicaid requires providers to comply with the following standards:

Access Standards and Access to Care Services for Members under the Age of 21

Wellpoint strongly recommends that our members see their PCP as soon as possible after enrollment.

Nature of Visit	Appointment Standards
Initial Health Assessments (IHAs)	Newborns: within 14 days of enrollment Children: within 60 days of enrollment Adults (18-21): within 90 days of enrollment
Preventive care visits	Based on the American Academy of Pediatrics (AAP) Periodicity Schedule found within the Preventive Health Guidelines

Access Standards and Access to Care Services for Members 21 Years and Older

Nature of Visit	Appointment Standards
Initial Health Assessments (IHAs)	Within 90 days of enrollment
Preventive care visits after initial diagnosis	Within 60 days of request

Access Standards and Access to Care Prenatal and Postpartum Visits

Nature of Visit	Appointment Standards
Prenatal	Within 14 days of request
Third trimester	Within 5 business days of request, or immediately if an emergency
High-risk pregnancy	Within 14 business days of request, or immediately if an emergency
Postpartum exam	Between 3-8 weeks after delivery

Access Standards and Access to Care Wait Times

When a provider's office receives a call from an Wellpoint member during regular business hours for assistance and possible triage, the provider or another healthcare professional must take or return the call within 30 minutes.

Access Standards and Access to Care

Nondiscrimination Statement

Providers must post a statement in their offices detailing hours of operation. These hours of operation must not discriminate against Wellpoint members enrolled in IA Health Link. The statement must include the following:

- Waiting times for appointments
- Waiting times for care at facilities
- Languages spoken

Access Standards and Access to Care

Americans with Disabilities Act

Providers must comply with all applicable federal and state laws in assuring accessibility to all services for members with disabilities, pursuant to the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973, maintaining the capacity to deliver services in a manner that accommodates the needs of its members. Providers contracted with Wellpoint are required by law to provide disabled persons full and equal access to medical services.

Although a review of the requirements of the law and implementing regulations can be daunting, providing full and equal access to persons with disabilities can be achieved by:

- Removing physical barriers.
- Providing means for effective communication with people who have vision, hearing, or speech disabilities, including providing auxiliary aids as needed.
- Providing flexibility in scheduling to accommodate people with disabilities.
- Allowing extra time for members with disabilities to dress and undress, transfer to examination tables, and extra time with the provider in order to ensure the individual is fully participating and understands the information.
- Making reasonable modifications to policies, practices, and procedures.

For more information on making changes to a practice to ensure ADA compliance, providers can refer to these additional resources:

- <https://www.ada.gov>
- https://www.ada.gov/medcare_mobility_ta/medcare_ta.htm

Access Standards and Access to Care

Interpreter Services

Wellpoint will ensure that members who need interpreter services have access to interpreters 24 hours a day, 7 days a week. Services include, but are not limited to, face-to-face assistance during office visits at no cost to you or the member. Providers should strongly discourage the use of minors, friends and family members acting as interpreters.

Request telephonic interpreters for members needing language assistance as outlined below:

During business hours:

- Providers call Provider Services at **833-731-2143**
- Members call Member Services at **833-731-2140**

After-hours, providers, and members can call Wellpoint on Call at:

- Phone: **866-864-2544** (English)
- Phone: **866-864-2545** (Spanish)
- TTY: **711**

- Hours: 24 hours a day, 7 days a week, 365 days a year

Request face-to-face interpreters for members needing language assistance, including American Sign Language as outlined below.

During business hours:

- Providers call Provider Services at **833-731-2143**
- Members call Member Services at **833-731-2140 (TTY 711)**

Please note: To schedule face-to-face interpreter services, please allow 72 hours. To cancel, please provide a 24-hour notice.

Access Standards and Access to Care

Missed Appointment Tracking

When members miss appointments, providers must do the following:

1. Document the missed appointment in the member's medical record.
2. Make at least three attempts to contact the member to determine the reason for the missed appointment.
3. Provide a reason in the member's medical record for any delays in performing an examination, including refusals by the member.

Access Standards and Access to Care

After-Hours Services

Wellpoint policy, and the state of Iowa's requirement, is for our members to have access to quality healthcare services 24 hours a day, 7 days a week. This kind of access means PCPs must have a system in place to ensure members may call after-hours with medical questions or concerns. Wellpoint monitors PCP compliance with after-hours access standards on a regular basis. Failure to comply may result in corrective action.

PCPs must adhere to the answering service and answering machine protocols defined in the following sections.

Answering Service

Answering service or after-hours personnel must:

- Forward member calls directly to the PCP or an on-call provider or instruct the member that the provider will contact the member within 30 minutes.
- Ask the member if the call is an emergency. In the event of an emergency, immediately direct the member to dial 911 or proceed to the nearest hospital emergency room.
- Have the ability to contact a telephone interpreter for members with language barriers.
- Return all calls.

Answering machine messages:

- May be used when provider office staff or an answering service is not immediately available.
- Must instruct members with emergency healthcare needs to dial 911 or proceed to the nearest hospital emergency room.
- Must provide instructions on how to contact the PCP or an on-call provider in a nonemergency situation.
- Must provide instructions in English, Spanish and any other language appropriate to the PCP's practice.

We offer the following suggested language for answering machines:

Hello, you've reached [insert physician office name]. If this is an emergency, hang up and dial 911 or go to the nearest hospital emergency room. If this is not an emergency and you have a medical concern or question, please call [insert contact phone or pager number]. You will receive a return call from the on-call physician within [time frame].

Please note: Wellpoint prefers that PCPs use an in-network provider for on-call services. When this is not possible, PCPs must use their best efforts to ensure the covering on-call provider abides by the terms of the Provider Agreement.

Access Standards and Access to Care

Wellpoint on Call

Members may call Wellpoint on Call, our 24/7 information phone line, any time of the day or night, to speak to a registered nurse. Nurses provide health information and options for any of the following:

- Authorization requests
- Emergency instructions
- Health concerns
- Local healthcare services
- Medical conditions
- Prescription drugs
- Transportation needs
- Access to interpreter services

Phone: **866-864-2544** (English); TTY: 711

Phone: **866-864-2545** (Spanish); TTY: 711

Hours: 24 hours a day, 7 days a week, 365 days a year

Access Standards and Access to Care

Continuity of Care

Wellpoint provides continuity of care for members with qualifying conditions when healthcare services are not available within the network or when the member or provider is in a state of transition.

A qualifying condition is defined as a medical condition that may qualify a member for continued access to care and continuity of care.

Qualifying conditions include, but are not limited to the following:

- Acute conditions (for example, cancer)
- Degenerative and disabling conditions or diseases caused by a congenital or acquired injury or illness requiring a specialized rehabilitation program or a high level of service, resources or coordination of care in the community
- Newborns, who are covered retroactively to the date of birth
- Organ transplant or tissue replacement
- Pregnancy, with 12 weeks or less remaining before the expected delivery date, through immediate postpartum care
- Scheduled inpatient/outpatient surgery that was approved and/or precertified through the applicable HHS process
- Serious chronic conditions (hemophilia, for example)
- Terminal illness

States of transition may be when the member is any of the following:

- Newly enrolled
- Moving out of the service area
- Disenrolling from Wellpoint to another health plan
- Exiting Wellpoint to receive excluded services
- Hospitalized on the effective date of transition
- Transitioning through behavioral health services
- Scheduled for appointments within the first month of plan membership with specialists. These appointments must have been scheduled prior to the effective date of membership.

A state of transition also is applicable when the provider's contract terminates.

Wellpoint providers help ensure continuity and coordination of care through collaboration. This includes the confidential exchange of information between PCPs and specialists as well as behavioral health providers. In addition, Wellpoint coordinates care when the provider's contract has been discontinued to facilitate a smooth transition to a new provider.

Providers must maintain accurate and timely documentation in the member's medical record including but not limited to the following:

- Consultations
- Precertification
- Referrals to specialists
- Treatment plans

All providers share responsibility in communicating clinical findings, treatment plans, prognosis, and the member's psychosocial condition as part of the coordination of care process. Medical Management nurses review member and provider requests for continuity of care. These nurses facilitate continuation with the current provider until a short-term regimen of care is completed or the member transitions to a new provider.

Please note: Only Wellpoint can make adverse determination decisions regarding continuity of care. Adverse determination decisions are sent in writing to the member and provider within two business days of the decision. Members, and providers with the member's written consent, may appeal the decision by following the procedures in the **Grievances and Appeals** chapter. Reasons for continuity of care denials include, but are not limited to the following:

- Course of treatment is complete
- Member is ineligible for coverage
- Condition is not a qualifying condition
- Request is for change of PCP only and not for continued access to care
- Requested services are not covered
- Services rendered are covered under a global fee
- Treating provider currently is contracted with our network

Please note: Wellpoint does not impose any pre-existing condition limitations on its Medicaid members, nor require evidence of insurability to provide coverage to any of our members.

Access Standards and Access to Care

Provider Contract Termination

Wellpoint will arrange for continuity of care for members affected by a provider whose contract is terminated. A terminated provider actively treating members must continue to treat members until the date of termination. PCPs must give at least 180 days advance notice before terminating the Provider Agreement. HCBS providers must provide at least 30 days advance notice to Wellpoint when they are no longer willing or able to provide services to a member, and to cooperate with the member's care coordinator to facilitate a seamless transition to alternate providers.

After Wellpoint receives a provider's notice to terminate a contract, we notify all impacted members. We send a letter at least 15 days in advance to inform the affected members about the:

- Impending termination of their provider.
- Member's right to request continued access to care.
- Member Services phone number to make PCP changes and/or forward referrals to Medical Management for continued access to care consideration.

HCBS providers must continue to provide services to the member in accordance with the member's plan of care and as directed by Wellpoint, until the member has been transitioned to a new provider; this transition may exceed 30 days from the date of notice to us. Members should contact Member Services at **833-731-2140**.

Access Standards and Access to Care

Newly Enrolled

Our goal is to ensure that the healthcare of our newly enrolled members is not disrupted or interrupted. Wellpoint ensures continuity of care for our newly enrolled members when the member's health or behavioral health condition has been treated by specialists. We also ensure continuity of care when the member's health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted.

Wellpoint will pay a newly enrolled member's existing out-of-network provider for medically necessary covered services until that regimen of care is completed. The member's records, clinical information and care are transferred to an Wellpoint provider.

Payment to out-of-network providers is made within the same time period required for providers within the network. In addition, we comply with out-of-network provider reimbursement rules as adopted by the HHS. However, we are not obligated to reimburse the member's existing out-of-network providers for on-going care if the time elapsed has been greater than:

- 90 days after the member enrolls in Wellpoint.
- Nine months after the member enrolls in Wellpoint if the member was diagnosed with a terminal illness at the time of enrollment in our plan and has been receiving ongoing treatment for the illness.

All new enrollees receive evidence of coverage (EOC) membership information in their enrollment packets, which provides information regarding members' rights to request continuity of care.

Access Standards and Access to Care

Second Opinions

Wellpoint will help to ensure that members have access to a second opinion regarding any medically necessary covered service. When the request involves care from a specialist, a provider of the same specialty must give the second opinion. When no provider exists within the network who meets the

qualification, Wellpoint may authorize a second opinion by a qualified out-of-network provider. This service is provided at no cost to the member.

Access Standards and Access to Care

Emergency Transportation

Wellpoint covers emergency transportation services without precertification. When a member's condition is life-threatening and requires use of special equipment, life support systems and close monitoring by trained attendants while en route to the nearest appropriate facility, we will provide emergency transport by ambulance. Supporting medical documentation may be requested prior to reimbursement.

Examples of conditions considered for emergency transport include but are not limited to the following:

- Acute and severe illnesses
- Acute or severe injuries from auto accidents
- Extensive burns
- Loss of consciousness
- Semi-consciousness, seizure, or cardiopulmonary resuscitation (CPR) treatment during transport
- Untreated fractures

Emergency transportation is also available for facility-to-facility transfers when the required emergency treatment is not available at the first facility.

Access Standards and Access to Care

Emergency Dental Services for Adults and Children

When a member has a dental emergency resulting in swelling, fever, infection or injury to the jaw, natural teeth, mouth or face, Wellpoint covers the initial dental work and oral surgery, including anesthesia and drugs, for services provided in the following settings: outpatient, doctor's office, emergency care and urgent care.

The services are limited to the care needed to give proper treatment. Injury as a result of chewing or biting is not considered an accidental injury. Initial dental work refers to services provided within 48 hours of the injury, or as soon as possible. Covered services include all exams and treatment to complete the repair, such as:

- Anesthesia
- Lab tests
- Mandibular/maxillary reconstruction
- Oral exams
- Oral surgery
- Prosthetic services
- Restorations
- X-rays

Access Standards and Access to Care

Border City Providers

Some cities outside of the state of Iowa but within 50 miles of the Iowa border are designated as "Border Cities." Eligible providers practicing outside of Iowa but within a border city-designated area may enroll with Wellpoint for the provision of services to IA Health Link members. Such enrollment will not require Iowa licensure, but the provider must meet the licensing requirements of the state in which they are providing the services and obtain an Iowa Medicaid identification number.

CHAPTER 17: PROVIDER ROLES AND RESPONSIBILITIES

Provider Roles and Responsibilities

Overview

At Wellpoint, our goal is to provide quality healthcare to the right member, at the right time and in the appropriate setting. To achieve this goal, PCPs, specialists, and ancillary providers must fulfill their roles and responsibilities with the highest integrity. We rely on your extensive healthcare education, experience, and dedication to our members, who look to you to get well and stay well.

Wellpoint analyzes performance annually against the standards for the geographic distribution of each type of practitioner providing primary care.

Provider Roles and Responsibilities

Primary Care Physicians

PCPs are the principal point of contact for our members. The PCP's role is to provide members with a health "home," the member's first stop in the healthcare process and a centralized hub for a wide variety of ongoing healthcare needs. Wellpoint furnishes PCPs with a current list of assigned members. The PCP's role is to:

- Coordinate members' healthcare 24 hours a day, 7 days a week.
- Develop members' care and treatment plans, including preventive care.
- Maintain members' current medical records, including documentation of all services provided by the PCP, specialists, or referral services.
- Adhere to wait times, as outlined within the Provider Agreement and Provider Manual.
- Refer members to specialists.
- Coordinate with outpatient clinical services.
- Provide complete information about proposed treatments and prognosis for recovery to our members or their representatives.
- Facilitate interpreter services by presenting information in a language that our members or their representatives can understand.
- Ensure that members' medical and personal information is kept confidential as required by state and federal laws.

The PCP's scope of responsibilities includes providing or arranging for:

- Routine and preventive healthcare services.
- Emergency care services.
- Hospital services.
- Ancillary services.
- Interpreter services.
- Referrals to specialists.
- Coordination with outpatient clinical services, such as therapeutic, rehabilitative, or palliative services.

Please note: Services should always be provided without regard to race, religion, sex, color, national origin, age, or physical/behavioral health status.

Wellpoint members may select any contracted provider as their PCP if that provider is taking new patients. We keep providers up to date with detailed member information. We also furnish each provider with a current list of assigned members and provide medical information about the members' potential healthcare needs. Providers may use this information to coordinate treatment and services more effectively.

PCPs should provide services only to those Wellpoint members who have chosen you as their PCP. Verify that a member is assigned to you using any of the following methods:

- Call Provider Services at **833-731-2143**
 - Use the automated voice response (AVR) system to verify PCP assignment.
 - Speak to a Member Services representative.
- Log into Availity Essentials, the secure provider portal, at <https://providers.wellpoint.com/ia>. Select **Login** or **Register** to access the secure site.

You may experience delays in claims payments if you treat members who are not assigned to you on the date of service. If you must provide services to an Wellpoint member not assigned to you, obtain precertification first. Noncontracted providers must obtain precertification before treating Wellpoint members.

Provider Roles and Responsibilities

Referrals

PCPs coordinate and make referrals to specialists, ancillary providers, and community services. Providers should refer members to network facilities and providers. When this is not possible, providers should follow the appropriate process for requesting out-of-network referrals.

Please note: Specialty referrals to network providers do not require precertification.

All PCPs must perform the following regarding referrals:

- Help members schedule appointments with other healthcare providers, including specialists.
- Track and document appointments, clinical findings, treatment plans and care received by members referred to specialists or other healthcare providers.
- Refer members to health education programs and community resource agencies, when appropriate.
- Coordinate with the Women, Infants and Children (WIC) program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit, or hemoglobin.
- Coordinate with the local tuberculosis (TB) control program to ensure that all members with confirmed or suspected TB have a contact investigation and receive directly observed therapy (DOT).
- Report any member who is noncompliant, drug resistant or who is or may be posing a public health threat to the Iowa Department of Health and Human Services (Iowa HHS) or the local TB control program.
- Perform screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

Provider Roles and Responsibilities

Out-Of-Network Referrals

We recognize that an out-of-network referral may be justified at times. The Wellpoint Medical Management department will work with the PCP to determine medical necessity and will authorize out-of-network referrals on a limited basis. For assistance, contact the Medical Management department at:

- Phone: **833-731-2143**
- Fax: **800-964-3627**

Provider Roles and Responsibilities

Interpreter Services

Providers must notify members of the availability of interpreter services. Providers also must train their answering services and on-call personnel on how to access those services. Wellpoint providers should strongly discourage the use of minors, friends and family members acting as interpreters. Providers also must accommodate non-English speaking members by having multilingual messages on answering machines.

For those instances when you cannot communicate with a member due to language barriers, telephonic and face-to-face interpreter services are available at no cost to you or the member. Request telephonic interpreters for members needing language assistance as outlined below:

During business hours:

- Providers call Provider Services at **833-731-2143**
- Members call Member Services at **833-731-2140** (TTY: **711**)

After-hours, providers, and members call Wellpoint on Call at:

- **866-864-2544** (English)
- **866-864-2545** (Spanish)
- TTY: **711**

Request face-to-face interpreters for members needing language assistance, including American Sign Language, during business hours:

- Providers call Provider Services at **833-731-2143**
- Members call Member Services at **833-731-2140** (TTY: **711**)

Please note: To schedule face-to-face interpreter services, please allow 72 hours. To cancel, please provide a 24-hour notice.

Provider Roles and Responsibilities

Transitioning Members between Medical Facilities and Home

When medically indicated, the PCP initiates or assists with the discharge or transfer of members:

- From an inpatient facility to the appropriate skilled nursing or rehabilitation facility, or to the member's home.
- From an out-of-network hospital to an in-network hospital, or to the member's home with home healthcare assistance (within benefit limits).

The coordination of member transfers from noncontracted, out-of-network facilities to contracted, in-network facilities is a priority that may require the immediate attention of the PCP. Contact the Wellpoint Medical Management department to assist at **833-731-2143**.

Provider Roles and Responsibilities

Noncovered Services

All PCPs must inform members of the costs associated with noncovered services prior to rendering the noncovered services. For more information, call Provider Services at **833-731-2143**.

Provider Roles and Responsibilities

Specialists

Specialists, licensed with additional training and expertise in a specific field of medicine, supplement the care given by PCPs. Specialists are charged with the same responsibilities as PCPs, including the responsibility of ensuring that precertification has been obtained before rendering services.

Access to specialty care begins when the PCP refers a member to a specialist for medically necessary conditions beyond the PCP's scope of practice. Specialists diagnose and treat conditions specific to their area of expertise.

Please note: Specialty care is limited to Wellpoint benefits.

The following guidelines are in place for specialists:

- For urgent care, the specialist should see the member within 24 hours of receiving the request.
- For routine care, the specialist should see the member within two weeks of receiving the request.

In some cases, a member may self-refer to a specialist. These cases include but are not limited to:

- Family planning and evaluation.
- Diagnosis, treatment, and follow-up of sexually transmitted infections (STIs).

For some medical conditions, the specialist should be the PCP. Members may request that the specialist be assigned as their PCP if the member:

- Has a chronic illness.
- Has a disabling condition.
- Is a child with special healthcare needs.

Provider Roles and Responsibilities

Hospital Scope of Responsibilities

PCPs refer members to plan-contracted network hospitals for medically necessary conditions beyond the PCP's scope of practice. Hospital care is limited to Wellpoint benefits. Hospital professionals diagnose and treat conditions specific to their area of expertise. Hospital responsibilities include:

- Notification of admission and services
- Notification of observations
- Notification of precertification review decision

Refer to the following sections for specific information.

Notification of Admission and Services

The hospital must notify Wellpoint or the review organization of an admission or service at the time the member is admitted, or the service is rendered. If the member is admitted or a service is rendered on a day other than a business day, the hospital must notify Wellpoint of the admission or service the morning of the next business day.

Notification of Observations

If our member is admitted to the hospital or for observation, this will be flagged in our census, and we will deploy discharge planning and care coordination through our Utilization Management staff. If the member is released home and we are notified by the hospital, PCP or member, Integrated Case Management will conduct outreach to coordinate required follow-up care and outreach within a week.

Notification of Precertification Decisions

If the hospital has not received notice of precertification at the time of a scheduled admission or service, as required by the Utilization Management Guidelines and the Hospital Agreement, the hospital should contact Wellpoint and request the status of the decision.

Any admission or service requiring precertification that has not received the appropriate review may be subject to post-service review denial. Generally, providers are required to perform all precertification functions with Wellpoint. Before rendering services, the hospital must ensure that precertification has been granted or risk post-service denial.

Provider Roles and Responsibilities

Ancillary Scope of Responsibilities

PCPs and specialists refer members to plan-contracted network ancillary providers for medically necessary conditions beyond the PCP's or specialist's scope of practice. Ancillary providers diagnose and treat conditions specific to their area of expertise. Ancillary care is limited to Wellpoint benefits.

We have a wide network of participating healthcare professionals and facilities. All services provided by the healthcare professional, and for which the healthcare professional is responsible, are listed in the Ancillary Agreement.

Provider Roles and Responsibilities

Responsibilities Applicable to All Providers

The responsibilities applicable to all Wellpoint providers include the following:

- After-hours services
- Collaboration
- Confidentiality
- Continuity of care
- Disenrollees
- Eligibility verification
- Licenses and certifications
- Mandatory reporting of abuse
- Medical records standards and documentation
- Office hours
- Open clinical dialog/affirmative statement
- Oversight of nonphysician practitioners
- Precertification
- Prohibited activities
- Provider contract terminations
- Termination of ancillary provider/patient relationship
- Updating provider information

Provider Roles and Responsibilities

Office Hours

To maintain continuity of care, providers are required to be available for a minimum of 24 hours each week. Office hours must be clearly posted, and members must be informed about the provider's availability at each site. There are strict guidelines for providing access to healthcare 24 hours a day, 7 days a week:

- Providers must be available 24 hours a day by phone.
- An on-call provider must be available to take calls when a provider is not available.

Provider Roles and Responsibilities

After-Hours Services

All PCPs must have an after-hours system in place to ensure that our members can call with medical concerns or questions after normal office hours. The answering service or after-hours personnel must forward member calls directly to the PCP or on-call provider or instruct the member that the provider will be in contact within 30 minutes.

Emergencies

The answering service or after-hours personnel must ask the member if the call is an emergency. In the event of an emergency, the member must be directed to dial 911 or to proceed to the nearest hospital emergency room immediately.

If the PCP's staff or answering service is not available, an answering machine may be used. The answering machine message must instruct members with emergency healthcare needs to dial 911 or go directly to the nearest hospital emergency room. The message also must give members an alternative contact number to reach the PCP or on-call provider with medical concerns or questions.

Language-Appropriate Messages

Non-English-speaking members who call their PCP after-hours should expect to get language appropriate messages. In the event of an emergency, these messages should direct the member to dial 911 or proceed to the nearest hospital emergency room immediately. In a nonemergency situation, members should receive instructions on how to contact the on-call provider. If an answering service is used, the service should know where to contact a telephone Interpreter. All calls taken by an answering service must be returned.

Network On-Call Providers

Wellpoint prefers PCPs use network providers for on-call services. When that is not possible, the PCP must ensure that the covering on-call provider or other provider abides by the terms of the Provider Agreement. Wellpoint will monitor PCP compliance with after-hours access standards on a regular basis. Failure to comply may result in corrective action.

Wellpoint on Call

Members may call Wellpoint on Call 24 hours a day, 7 days a week to speak to a registered nurse. These nurses provide health information regarding illness, options for accessing care and availability of emergency services. Wellpoint on Call can be reached at **866-864-2544** (English; TTY: 711) or **866-864-2545** (Spanish).

Provider Roles and Responsibilities

Licenses and Certifications

Providers must maintain all licenses, certifications, permits, accreditations, or other prerequisites required by Wellpoint and federal, state, and local laws for providing medical services.

Provider Roles and Responsibilities

Eligibility Verification

All providers must verify member eligibility immediately before providing services, supplies or equipment. Because eligibility may change monthly, a member eligible on the last day of the month may not be eligible on the first day of the following month. Wellpoint is not responsible for charges incurred by ineligible patients. As part of the primary medical group (PMG) lock-in program, a member's PMG assignment also must be verified. Services are considered for payment if rendered by a provider affiliated with the assigned group.

Provider Roles and Responsibilities

Collaboration

Providers share the responsibility of giving respectful care, working collaboratively with Wellpoint specialists, hospitals, ancillary providers, and members and their families. Providers must allow Wellpoint to use performance data in cooperation with Quality Improvement programs and activities. Providers must permit members to participate actively in decisions regarding medical care, including, except as limited by law, their decision to refuse treatment.

Provider Roles and Responsibilities

Continuity of Care

PCPs maintain frequent communication with specialists, hospitals, and ancillary providers to ensure continuity of care. Wellpoint encourages providers to maintain open communication with their patients regarding appropriate treatment alternatives, regardless of their benefit coverage limitations. PCPs are responsible for being an ongoing source of primary care appropriate to the member's needs.

We established comprehensive mechanisms to ensure continued access to care for members when providers leave our healthcare program. Under certain circumstances, members may finish a course of treatment with the terminating provider. For more information, refer to [Chapter 14: Access Standards and Access to Care](#).

Provider Roles and Responsibilities

Medical Records Standards

Medical records must be maintained in a manner ensuring effective and confidential member care and quality review. At Wellpoint, we perform medical record reviews upon signing a provider contract. We then perform medical record reviews at least every three years to ensure that providers remain in compliance with these standards.

Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act. This act prohibits a provider of healthcare from disclosing any individually identifiable information regarding a patient's medical history, treatment, or behavioral and physical condition, without the patient's or legal representative's consent or specific legal authority.

Records required through a legal instrument may be released without patient or patient representative consent. Providers must be familiar with the security requirements of HIPAA and be in compliance. For more information on medical records standards, refer to [Chapter 18: Quality Assessment and Performance](#).

Provider Roles and Responsibilities

Updating Provider Information

Providers are required to inform Wellpoint of any material changes to their practice such as:

- Change in their professional business ownership.
- Change in their business address or the location where services are provided.
- Change in their federal 9-digit tax identification number (TIN).
- Change of their specialty.
- Services offered to children.
- Languages spoken.
- Change in demographic data.
- Legal or governmental action initiated against a healthcare professional. This type of action includes, but is not limited to, an action for professional negligence, for violation of the law or against any

license or accreditation which, if successful, would impair the ability of the healthcare professional to carry out the duties and obligations under the Provider Agreement.

- Other problems or situations that impair the ability of the healthcare professional to carry out the duties and obligations under the Provider Agreement's care review and grievance resolution procedures.
- Notification that the provider is accepting new patients.

To notify Wellpoint of changes, providers should call Provider Services at **833-731-2143**.

Submitting Provider Demographic Data Requests and Roster Submissions Through Roster Automation

Use the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all professional and facility care providers*. **Going forward, the PDM application is now the preferred intake tool for care providers to submit demographic change requests, including submitting roster uploads.** If preferred, Providers may continue to utilize the Provider Enrollment application in Availity Essentials to submit requests to add new practitioners under existing groups for available provider types.

Within the PDM application, Providers have the choice and flexibility to request data updates via the standard PDM experience or by submitting a spreadsheet via a roster upload.

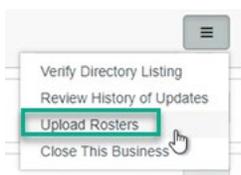
Roster Automation is our new technology solution designed to streamline and automate provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel document. Any provider, whether an individual provider/practitioner, group, or facility, can use Roster Automation today:**

The resources for this process are listed below and available on our website. Visit <https://provider.amerigroup.com/IA>, then under For Providers, select Forms and Guides. The **Roster Automation Rules of Engagement** and **Roster Automation Standard Template** appear under the Digital Tools category.

- **Roster Automation Rules of Engagement:** Is a reference document, available to ensure error-free submissions, driving accurate and more timely updates through automation.
- **Roster Automation Standard Template:** Use this template to submit your information. More detailed instructions on formatting and submission requirements can also be found on the first tab of the Roster Automation Standard Template (*User Reference Guide*).
- Upload your completed roster via the Availity PDM application.

Accessing PDM Application:

Log onto [availity.com](https://www.availity.com) and select **My Providers > Provider Data Management** to begin the attestation process. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select **Upload Rosters** (see screen shot below) and follow the prompts.



Availability Administrators will automatically be granted access to PDM. Additional staff may be given access to **Provider Data Management** by an administrator. To find your administrator, go to **My Account Dashboard > My Account > Organization(s) > Administrator Information**.

* Exclusions:

- Behavioral Health providers contracted with Carelon Behavioral Health who will continue to follow the process for demographic requests and/or roster submissions, as outlined by Carelon Behavioral Health.
- Any specific state mandates or requirements for provider demographic updates

** If any roster data updates require credentialing, your submission will be routed appropriately for further action.

Provider Roles and Responsibilities

Oversight of Nonphysician Practitioners

All providers using nonphysician practitioners must supervise and oversee nonphysician practitioners consistent with state and federal laws. The supervising provider and the nonphysician practitioner must have written guidelines for adequate supervision. All supervising providers must follow state licensing and certification requirements.

Provider Roles and Responsibilities

Open Clinical Dialogue/Affirmative Statement

Nothing within the Provider Agreement or this manual should be construed as encouraging providers to restrict medically necessary covered services or limit clinical dialog between providers and their patients. Providers may communicate freely with members regarding the available treatment options, including medications, regardless of benefit coverage limitations.

Provider Roles and Responsibilities

Provider Contract Termination

A terminated provider actively treating members must continue treatment until the termination date. The termination date is the end of the 90-day period following written notice of termination, or according to a timeline determined by the medical group contract.

After we receive a provider's notice to terminate a contract, we notify members impacted by the termination. Wellpoint sends a letter to inform affected members about the:

- Impending termination of their provider.
- Member's right to request continued access to care.
- Member Services phone number to request PCP changes.
- Referrals to Medical Management for continued access to care consideration.

Members under the care of specialists may also submit requests for continued access to care, including after the transition period, by calling Member Services at **833-731-2140** (TTY: **711**).

Wellpoint may terminate the Provider Agreement if we determine that the quality of care or services given by a healthcare provider is not satisfactory. We make this determination by reviewing member satisfaction surveys, integrated case management data, member complaints or grievances, other complaints or lawsuits alleging professional negligence and quality of care indicators.

Provider Roles and Responsibilities

Termination of the Ancillary Provider/Patient Relationship

Under certain circumstances, an ancillary provider may terminate the professional relationship with a member, as provided for and in accordance with the provisions of this manual. However, ancillary providers may not terminate the relationship because of the member's medical condition, or the amount, type or cost of covered services required by the member.

We'll notify members affected by the termination at least 30 calendar days prior to the effective termination date and help them select a new practitioner.

Provider Roles and Responsibilities

Disenrollees

When a member disenrolls and requests a transfer to another health plan, providers are expected to work with Wellpoint case managers responsible for helping the member make the transition. This transition must occur without disruption of any regimen of care that qualifies as a continuity of care condition. The case manager will coordinate with the member, the member's providers, and the case manager at the new health plan to ensure an orderly transition.

Provider Roles and Responsibilities

Provider Rights

Wellpoint providers, acting within the lawful scope of practice, shall not be prohibited from advising a member or advocating on behalf of a member for any of the following:

- The member's health status, medical care, or treatment options, including any alternative, self-administered treatment
- Any information the member needs to decide among all relevant treatment options
- The risks, benefits, and consequences of treatment or nontreatment
- The member's right to participate in decisions regarding their healthcare, including the right to refuse treatment and to express preferences about future treatment decisions
- To receive information on the Grievances and Appeals and state fair hearing procedures
- To have access to policies and procedures covering authorization of services
- To be notified of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested
- To challenge, on behalf of our members, the denial of coverage, or payment for, medical assistance
- To be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable law solely based on that license or certification

The Wellpoint provider selection policies and procedures do not discriminate against particular providers who serve high-risk populations or specialize in conditions requiring costly treatment.

Provider Roles and Responsibilities

Prohibited Activities

All providers are prohibited from:

- Billing eligible members for covered services.
- Segregating members in any way from other persons receiving similar services, supplies or equipment.
- Discriminating against Wellpoint members or Medicaid participants.

Provider Roles and Responsibilities

Misrouted Protected Health Information

You are not permitted to use or disclose Protected Health Information about individuals who you are not currently treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

CHAPTER 18: CLINICAL PRACTICE AND PREVENTIVE HEALTH CARE GUIDELINES

Clinical Practice and *Preventive Health Care Guidelines*

Overview

At Wellpoint, we believe that providing quality healthcare should not be limited to the treatment of injury or illness. We are committed to helping providers and members become more proactive in the quest for better overall health. To accomplish this goal, we offer providers tools to assist in finding the best, most cost-effective ways to:

- Provide member treatment.
- Empower members through education.
- Encourage member lifestyle changes, when possible.

We want providers to have access to the most up-to-date clinical practice and ***Preventive Health Care Guidelines***, offered by nationally recognized healthcare organizations and based on extensive research. These guidelines include the latest standards for treating the most common and serious illnesses, such as diabetes and hypertension. These guidelines also include recommendations for preventive screenings, immunizations and member counseling based on age and gender.

Clinical Practice and Preventive Health Care Guidelines

Clinical Practice Guidelines

Providers need the latest research on treating common conditions, such as asthma, diabetes, and hypertension. The *Clinical Practice Guidelines* follow nationally-recognized best practices for standards of treatment and give providers a powerful tool in educating our members. The *Clinical Practice Guidelines* are available on our website at <https://providers.wellpoint.com/ia> > The website offers the most up-to-date clinical resources and guidelines.

If you do not have Internet access, request a hard copy of the *Clinical Practice Guidelines* by calling Provider Services at **833-731-2143**.

The following *Clinical Practice Guidelines* are updated continually:

- Asthma: **Guidelines for the Diagnosis and Management of Asthma (EPR 3 Summary Report 2007)**
- Chlamydia: **2015 Sexually Transmitted Disease Treatment Guidelines (Chlamydial Infections)**
- Chronic Heart Failure (CHF) in the Adult: **2009 Focused Update Incorporated Into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults**
- Chronic Obstructive Pulmonary Disease (COPD): **Global Initiative for Chronic Obstructive Lung Disease (GOLD)**
- Coronary Artery Disease (CAD): **Circulation—AHA/ACCF Guideline**
- Diabetes:
 - **2013 Standards of Care**
 - **Evidence Table: Standards of Medical Care in Diabetes—2013**
- Heart and Vascular Resources: **National Heart, Lung and Blood Institute**
- High Blood Cholesterol: **Management of Blood Cholesterol in Adults: Systematic Evidence Review from the Cholesterol Expert Panel**
- Human Papillomavirus (HPV): **2015 Sexually Transmitted Diseases Treatment Guidelines (Human Papillomavirus Infections)**
- Hypertension and High Blood Pressure: **High Blood Pressure Guidelines (JNC 7)**
- Maternity and Perinatal: **Guidelines for Perinatal Care, 7th Edition**

Please note: Our recommendation of these guidelines is not an authorization, certification, explanation of benefits or a contract. Actual member benefits and eligibility for services are determined in accordance with the requirements set forth by the state.

Clinical Practice and Preventive Health Care Guidelines

Preventive Health Care Guidelines

Good health begins with good lifestyle habits and regular exams. We support providers in helping members to take control of their own health by identifying and reducing the risk of potentially serious conditions.

The *Preventive Health Care Guidelines*, offered by nationally-recognized health organizations as a provider resource, are an effective tool for improving the overall health of our members by emphasizing education and behavior change. The Preventive Health Guidelines are available on our website at

<https://providers.wellpoint.com/ia> . To request a hard copy of the Preventive Health Guidelines please call Provider Services at **833-731-2143**.

Please note: Our recommendation of these guidelines is not an authorization, certification, explanation of benefits or a contract. Actual member benefits and eligibility are determined in accordance with the requirements set forth by the state.

CHAPTER 19: INTEGRATED CASE MANAGEMENT

Integrated Case Management

Overview

Integrated Case management is a cooperative effort providing expert assistance to both providers and members in the coordination of complex healthcare. The program is designed to develop, implement, coordinate, and monitor healthcare plans to optimize our members' healthcare benefits.

A case manager, through discussions with providers and members, collects data and analyzes information about actual and potential care needs for the purpose of developing a healthcare plan. Members referred to integrated case management may be identified by disease or condition, or high utilization of services.

Examples of members appropriate for referral to integrated case management include those with:

- Unmanaged chronic conditions such as asthma, diabetes, and heart failure.
- Complex or multiple-care cases, including multiple trauma or cancer.
- Frequent hospitalizations or emergency room visits.
- Hemophilia, sickle cell anemia, cystic , or cerebral palsy.
- High-risk or teen pregnancies.
- Human immunodeficiency virus (HIV)/Acquired immune deficiency syndrome (AIDS).
- Potential transplants.
- Preterm births.

We make the following information available to contracted providers:

- Wellpoint criteria for determining which members might benefit from integrated case management.
- Provider's responsibility for identifying members who meet that criterion.
- Process for providers to follow when notifying Wellpoint about identified members.

Additionally, the Integrated Case Management department provides descriptions of the programs for the following conditions or needs:

- Asthma
- Cardiovascular disease, including hypertension, coronary artery disease (CAD) and chronic heart failure (CHF)
- Children with special healthcare needs
- Chronic kidney disease (CKD) and end-stage renal disease (ESRD)
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- Oncology
- Pregnancy, high-risk obstetrics, and teen pregnancy
- Special programs, including discharge transitions.

Please note: Our Integrated Case Management department is sensitive to the cultural and linguistic diversity of our members and its impact on their interaction within the healthcare system. We encourage providers to become familiar with our cultural and linguistic training materials, available on our website at <https://providers.wellpoint.com/ia> > Provider Resources & Documents > Training.

Integrated Case Management

Provider Responsibilities

PCPs have the responsibility of participating in the integrated case management process by sharing information and facilitating the process as follows:

- Referring members who could benefit from integrated case management.

- Sharing information as soon as the PCP identifies complex healthcare needs.
- Collaborating with Integrated Case Management staff on an ongoing basis
- Referring members to specialists, as required
- Providing medical information
- Monitoring and updating the care plan to promote healthcare goals.
- Coordinating county or state-linked services such as public health, behavioral health, schools, and waiver programs

Integrated Case Management

Referral Process

Providers, nurses, social workers and members or their representatives may refer members to Integrated Case Management as follows:

Phone: **844-986-4991**

Fax (using the Integrated Care Management Referral Form): **844-556-6122**

Email: iaicm@wellpoint.com

A case manager responds to a faxed request within three business days.

The Care Management Referral Form is on our provider website at <https://providers.wellpoint.com/ia>.

Integrated Case Management

Delegated Entities

In some cases, Wellpoint delegates management, condition care, utilization management and integrated case management activities to external entities. Wellpoint monitors these activities and performs oversight to ensure that those entities follow federal, state and accreditation standards.

Integrated Case Management

Role of the Integrated Case Manager

The case manager's role is to assess the member's healthcare status, develop a healthcare plan, and:

- Facilitate communication and coordination within the healthcare team.
- Facilitate communication with the member and his or her family in the decision-making process.
- Educate the member and provider(s) about care management, community resources, benefits, cost factors and all related topics so informed decisions may be made.
- Encourage appropriate use of medical facilities and services, with the goal of improving quality of care and maintaining cost-effectiveness on a case-by-case basis.

The Integrated Case Management department includes experienced and credentialed registered nurses, some of whom are certified case managers. The department also includes social workers, who add valuable skills allowing us to address our members' medical, psychological, social, and financial issues. Interpreter services are available to support the integrated case management process at no cost to the member.

Integrated Case Management

Integrated Case Management Procedure

When a member has been identified as having a condition that may require integrated case management, the case manager contacts the referring provider and member for an initial assessment. With the involvement of the member, the member's representative and the provider, the case manager develops an individualized care plan. That plan may involve coordinating services with public and behavioral health departments, schools, and other community health resources.

The integrated case manager periodically reassesses the care plan to monitor the following:

- Progress toward goals
- Necessary revisions
- New issues to be addressed to ensure the member receives the support necessary to achieve care plan goals.

After goals are met or Integrated Case Management can no longer impact the case, the integrated case manager closes the case.

Integrated Case Management

Transitioning Disenrollees

The case manager's responsibility is to assist when a member requests help to transition to another health plan. This must occur without disruption of any regimen of care that qualifies as a continuity of care condition. The case manager works with the member, the member's providers and the integrated case manager at the new health plan to ensure an orderly transition.

Integrated Case Management

Continued Access to Care

New Wellpoint members may receive services from out-of-network, Iowa Medicaid-certified providers if certain guidelines are met. First, the provider must contact us to discuss the scheduled health services in advance of the service date. Second, the case must meet a qualifying condition, as defined below, in which the member:

- Has been approved and scheduled to receive a cornea and/or kidney transplant or tissue replacement.
- Has been approved by the state of Iowa and scheduled to receive any other organ transplant or tissue replacement. Wellpoint will provide continuity of care for the preparation work for pre-surgery up until the member is transferred to fee-for-service Medicaid for the transplant or tissue replacement.
- Is in her second trimester of pregnancy and has an established relationship with an Iowa Medicaid-certified, out-of-network obstetrician and/or delivery hospital or has a prior relationship with a nonparticipating provider with previous pregnancies.
- Has been scheduled for inpatient/outpatient surgery that was approved prior to transitioning to Wellpoint.
- Has appointment(s) within the initial month of Wellpoint membership. These appointments must have been scheduled prior to the effective date of transition with Iowa Medicaid-certified, out-of-network specialists.
- Has received ongoing chemotherapy or radiation treatment.
- Has enrolled a newborn effective on the date of birth and within the first 100 days of life. The child must be born to a mother who was enrolled in the health plan at the time of the birth.
- Is undergoing screening for long-term care placement.
- Is transitioning through behavioral health services, especially if the member received precertification from the previous health plan or through fee-for-service coverage.

Integrated Case Management

Continuity of Care Process

Our integrated case management nurses review member and provider requests for continuity of care. These nurses facilitate continuation with the current provider until the regimen of care is complete or the member transitions to a new provider.

Only Wellpoint can make adverse determination decisions regarding continuity of care. Adverse determination decisions are sent in writing to the member and provider within two business days of the decision. Members, and providers with the member's written consent, may appeal the decision by following the procedures in the **Grievances and Appeals** chapter of this manual. Reasons for continuity of care denial include, but are not limited to:

- Course of treatment being complete
- Member being ineligible for coverage
- Condition is not a qualifying condition
- Request is for change of PCP and not for continued access to care
- Requested services are not covered benefits
- Services rendered are covered under a global fee
- Treating provider currently is contracted with Wellpoint

Case Management

Health Home Services

Overview

Iowa has two CMS-approved Health Home State Plan Amendments, Chronic Condition Health Home, and Integrated Health Home, for Medicaid members with chronic medical and behavioral health conditions.

An Integrated Health Home is a team of Healthcare Professionals, and the Chronic Condition Health Home is a Designated Provider that deliver personalized, coordinated care for individuals who meet program eligibility criteria. Services utilize a whole-person treatment approach coordinated between multiple delivery systems. Health Information Technology (HIT) assists in linking services, providing feedback, and facilitating communication among providers.

A Health Home facilitates access to a range of health and community services, simplifying the process for the member. Core Health Home services include the following:

- Comprehensive care management
- Care coordination
- Transitions in care
- Support to individual and family members
- The facilitation of referrals to community services and supports
- Health promotion and self-care

Eligibility Criteria

Chronic Condition Health Home eligibility criteria require members to have two chronic conditions, or one chronic condition and the risk of developing another from the following list:

- Mental health condition
- Substance use disorder
- Asthma
- Diabetes
- Heart disease
- BMI over 25
- Chronic Pain
- COPD
- Hypertension
- Child BMI > 85th percentile

An Integrated Health Home (IHH) is a team of professionals working together to provide person-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). Eligibility for IHH services includes either a diagnosis of Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) with severe functional impairment.

Eligibility criteria for either a Chronic Condition Health Home or Integrated Health Home include:

- Members who get full Medicaid benefits
- Members who get full Medicaid benefits and who also have Medicare
- Members enrolled in the Iowa Health and Wellness Plan and determined to be medically exempt

Wellpoint will identify eligible members, or a Health Home may refer a member to Wellpoint for eligibility determination. Members in the following programs are not eligible for the Health Home program:

- Iowa Health and Wellness Plan (unless determined to be medically exempt)
- Qualified Medicare Beneficiary
- Special Low-Income Medicare Beneficiary
- Program of All-Inclusive Care for the Elderly (PACE)
- Health Maintenance Organization members
- Presumptive Eligible*

**Temporary Medicaid coverage for women who are pregnant, or who need treatment for breast and cervical cancer, and children under the age of 19 who need temporary medical coverage.*

Case management activities for enrollees in the 1915I Children's Mental Health Waiver and 1915(i) Habilitation program will be provided through the Integrated Health Home. For more information, refer to the Health Homes Supplemental Provider Manual located at <https://providers.wellpoint.com/ia>.

CHAPTER 20: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Quality Assessment and Performance Improvement

Overview

Our goal is continuous, measurable improvement in our delivery of quality healthcare. Following federal and state guidelines, we have a Quality Assessment and Performance Improvement (QAPI) program in place to advance our levels of readiness, service, and care. The QAPI program, aligned with the State of Iowa's quality standards, includes focused studies measuring quality of care in the following clinical and service areas:

- Childhood immunization status
- Comprehensive diabetes care (HbA1C Testing and LDL-C Screening)
- Chronic obstructive pulmonary disease (COPD) and chronic heart failure (CHF) care
- Healthy birth outcomes
- Lead testing of 1- and 2-year-olds
- Smoking cessation
- Use of appropriate medication for asthmatics

All providers are expected to participate in these studies as part of our mutual goal of providing responsive, cost-effective healthcare that improves our members' lives. The studies include:

- Participation in multi-disciplinary teams for problem solving.
- Population studies.
- Random sample-based studies.
- Satisfaction surveys.

We share information from these studies with providers and encourage constructive feedback. Based on the results of the previous year's QAPI program, Wellpoint reviews and assesses the program's effectiveness and develops a new work plan for the next year's activities.

We also participate in national evaluations designed to gauge our performance and that of providers. An important measure of performance comes from the National Committee for Quality Assurance (NCQA), which annually reports HEDIS scores to healthcare plans throughout the country. This professional evaluation serves as a yearly report card and is a tool used by more than 90 percent of America's healthcare plans to rate performance across a wide spectrum of care and service areas, including:

- Member satisfaction with care access
- Member satisfaction with claims processing
- Customer service

Wellpoint uses the HEDIS data to identify areas for improvement and shares the results with providers. We submit the results of the HEDIS assessment and our own quality studies annually to the Iowa Department of Health and Human Services (HHS), which makes the results public. As a result, HEDIS summaries may be used by potential members to make comparisons before choosing a healthcare plan.

We also are committed to tracking preventable adverse medical events, also known as "never events," with the goal of eliminating these events.

Please note: If we determine the quality of care or services provided by a healthcare professional is not satisfactory, Wellpoint may terminate the Provider Agreement and related addendums. We make this determination by reviewing member satisfaction surveys, case management data, member complaints or grievances, other complaints or lawsuits alleging professional negligence, or quality of care indicators.

Quality Assessment and Performance Improvement

Quality Assessment and Performance Improvement Program

The QAPI program focuses on developing and implementing standards for clinical care and service, measuring conformity to those standards, and taking action to improve performance. The scope of the QAPI program includes, but is not limited to, the monitoring and evaluation of:

- Care and service provided in all health delivery settings.
- Internal organizational performance.
- Provider/member satisfaction.
- Provider promotion of preventive health programs and exams.
- Provider management of member health status.
- Provider site facilities and medical records.

Wellpoint develops an annual plan of quality improvement activities based on the results of the previous year's QAPI program evaluation. Then we review, evaluate, and revise the QAPI program's effectiveness. The evaluation is a written description of the ability of Wellpoint to implement the QAPI program, meet program objectives, and develop and implement plans to improve the quality of care and service to our members. The QAPI program requires the medical director's or designated physician's involvement in the QI program.

Providers support the activities of the QAPI program by:

- Completing corrective action plans, when applicable.
- Participating in the facility and medical record audit process.
- Providing access to medical records for quality improvement projects and studies.
- Responding in a timely manner to requests for written information and documentation if a quality of care or grievance issue has been filed.
- Using preventive health and *Clinical Practice Guidelines* in member care.

Quality Assessment and Performance Improvement

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS® is a national evaluation and core set of performance measurements gauging the effectiveness of Wellpoint and providers in delivering quality care. We are ready to help when providers and their office staff need training to participate in required HEDIS evaluations. Providers can request consultations and training in the following areas:

- Information about the year's selected HEDIS studies
- How data for those measures will be collected
- Codes associated with each measure
- Tips for smooth coordination of medical record data collection

Our Quality Improvement staff will contact the provider's office when we need to review or copy any medical records required for quality improvement studies. Office staff must provide access to medical records for review and copying.

Quality Assessment and Performance Improvement

Quality Management

Twice a year, and in accordance with NCQA standards, Wellpoint analyzes relevant utilization data against established thresholds for each plan to detect current utilization levels. If our findings fall outside specified target ranges and indicate potential underutilization or overutilization, further analysis will occur based on the recommendation of the Wellpoint Utilization Management committee.

The follow-up analysis may include gathering the following data from specific provider and practice sites:

- Case management services needed by members
- Claims payments for covered services
- Coordination with other providers and agencies
- Focus studies
- Investigation and resolution of member and provider complaints and appeals within established time frames
- Retrospective reviews of services provided without authorization

Quality Assessment and Performance Improvement

Best-Practice Methods

Best-practice methods are our most up-to-date compilation of effective strategies for quality healthcare delivery. We share best practice methods during site visits to provider offices. Member Services and Network Management departments offer policies, procedures, and educational toolkits to help guide improvements. Toolkits may include examples of best practices from other offices, including:

- Resources for improving compliance with preventive health services.
- Clinical practice guidelines.
- Care for members with special or chronic care needs.

Quality Assessment and Performance Improvement

Member Satisfaction Surveys

Member satisfaction with our healthcare services is measured every year by the NCQA. The NCQA conducts a survey called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The survey is designed to measure member satisfaction with our services, including:

- Access to care.
- Wellpoint customer service.
- Provider communications.
- Provider office staff performance.

We distribute the results of the CAHPS survey to both members and providers. Providers should review the results, share the results with office staff and incorporate appropriate changes in their offices.

Quality Assessment and Performance Improvement

Provider Satisfaction Surveys

Wellpoint may conduct provider surveys to monitor and measure provider satisfaction with our services and identify areas for improvement. Provider participation in these surveys is highly encouraged and your feedback is very important. We inform providers of the results and plans for improvement through provider bulletins, newsletters, meetings, or training sessions.

Quality Assessment and Performance Improvement

Medical Record and Facility Site Reviews

We may conduct medical record and facility site reviews to determine provider:

- Compliance with standards for providing healthcare.
- Compliance with standards for storing medical records.
- Compliance with processes that maintain safety standards and practices.
- Involvement in the continuity and coordination of member care.

The HHS and Wellpoint have the right to enter the premises of providers to inspect, monitor, audit or otherwise evaluate the work performed. We perform all inspections and evaluations in such a manner as to

not unduly delay work in accordance with the Provider Agreement. Wellpoint will conduct an office visit for those sites where a complaint is received within 60 calendar days of determining that the threshold was met.

If the threshold was not met, Wellpoint will implement corrective actions to improve offices that do not meet site criteria. The evaluation of the effectiveness of the corrective action will be performed at least every six months until deficient offices meet the site standards and threshold. Follow-up visits will be documented and presented to the QI committee.

Quality Assessment and Performance Improvement

Medical Record Documentation Standards

Wellpoint requires providers to maintain medical records in a manner that is current, organized, and permits effective and confidential member care and quality review. Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act, which requires the following:

- Providers of healthcare are prohibited from disclosing any individually identifiable information regarding a patient's medical history, mental condition, physical condition or treatment without the patient's or legal representative's consent or specific legal authority.
- Records required through a legal instrument may be released without patient or patient representative consent.
- Providers must be familiar and in compliance with the security requirements of HIPAA.

Quality Assessment and Performance Improvement

Medical Record Security

Medical records must be secure and inaccessible to unauthorized access to prevent loss, tampering, disclosure of information, alteration, or destruction of the records. Information must be accessible only to authorized personnel within the provider's office, Wellpoint, the Iowa HHS or to persons authorized through a legal instrument. Records must be made available to Wellpoint for purposes of quality review, HEDIS and other studies.

Quality Assessment and Performance Improvement

Storage and Maintenance

Active medical records should be stored in a central medical record area and must be inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed and organized, permitting effective patient care and quality review while maintaining confidentiality. Inactive records are to remain accessible for a period of time that meets state and federal guidelines.

Quality Assessment and Performance Improvement

Availability of Medical Records

The medical record system must allow for prompt retrieval of each record when the member comes in for a visit. Providers must maintain members' medical records in a detailed and comprehensive manner that accomplishes the following:

- Conforms to good professional medical practice
- Facilitates an accurate system for follow-up treatment
- Permits effective, professional medical review and medical audit processes

Medical records must be legible, signed and dated, and maintained for at least ten years or for the duration of contested case proceedings, whichever is longer, as required by state and federal regulations.

Providers must supply a copy of a member's medical record upon reasonable request by the member at no charge. The provider also must facilitate the transfer of the member's medical record to another provider at the member's request. Access to medical records and confidentiality must be provided in accordance with the standards mandated in HIPAA and all other state and federal requirements.

Providers must permit Wellpoint and IA Health Link representatives to review members' medical records for the purposes of monitoring the provider's compliance with the medical record standards, capturing information for clinical studies, monitoring quality or any other reason. Providers should have procedures in place to permit the timely access and submission of medical records to Wellpoint upon request. Wellpoint encourages providers to use technology, such as health information exchanges, to transmit and store medical record data.

Quality Assessment and Performance Improvement

Medical Record Requirements

At a minimum, every medical record must include the following:

- The patient's name or identification (ID) number on each page in the record
- Personal biographical data, including home address, employer, emergency contact name and phone number, home and work phone numbers and marital status
- Entries dated with month, day, and year
- Entries documented with the author's identification and title. For example, handwritten signature, unique electronic identifier, or initials
- Identification of all providers participating in the member's care
- Information on the services furnished by these providers
- List of problems, including significant illnesses, medical conditions, and psychological conditions
- Presenting complaints, diagnoses, and treatment plans, including the services to be delivered
- Physical findings relevant to the visit, including vital signs, normal and abnormal findings, and appropriate subjective and objective information
- Information on allergies and adverse reactions, or a notation that the patient has no known allergies or history of adverse reactions
- Information on advance directives
- Past medical history, including serious accidents, operations, and illnesses. In addition:
 - For patients 14 years old and older, the record must include information about substance abuse
 - For children and adolescents, the record must include past medical history as relates to prenatal care, birth, operations, and childhood illnesses
- Notations concerning the use of cigarettes, alcohol, and substance abuse for patients 14 years and older, including anticipatory guidance and health education
- Physical examinations, treatment necessary and possible risk factors relevant to the particular treatment
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Information about the individuals to be instructed in assisting the patient
- Medical records must be legible, dated and signed by the provider, physician assistant, nurse practitioner, or nurse midwife providing patient care
- Up-to-date immunization record for children, or an appropriate history for adults
- Documentation of attempts to provide immunizations. If the member refuses immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the member or guardian shall be documented in the member's medical record
- Evidence of preventive screening and services, in accordance with Wellpoint's preventive health practice guidelines

- Documentation of referrals, consultations, diagnostic test results, and inpatient records. Evidence of the provider's review may include the provider's initials or signature and notation in the patient's medical record. The provider may indicate review and patient contact, follow-up treatment, instructions, return office visits, referrals, and other patient information
- Notations of patient appointment cancellations or "no shows" and the attempts to contact the patient to reschedule
- No indication or implication that the patient was placed at inappropriate risk by a diagnostic test or therapeutic procedure
- Documentation on whether an interpreter was used in any initial or follow-up visit

Quality Assessment and Performance Improvement

Advance Directives

Recognizing a person's right to dignity and privacy, our members have the right to execute an advance directive, also known as a living will, to identify their wishes concerning healthcare services should they become incapacitated. Providers are expected to adhere to the following guidelines:

- Discuss the sensitive issues raised by advance directives with patients and their families.
- Advise members of their right to change or revoke their advance directive at any time.
- Advise members of their right to contact Member Services to request additional information about advance directives.
- Document in the member's medical record the discussion about advance directives.
- Document in the member's medical record whether or not an advance directive has been completed.
- Place a copy of a completed advance directive in the member's medical record.

Quality Assessment and Performance Improvement

Facility Site Review Process

An site inspection is required for all provider offices participating in Wellpoint, regardless of other accreditation or certification. In addition:

- A site review is required as part of the initial credentialing process for new providers if that site has not been reviewed and accepted as part of our credentialing process.
- OB-GYN specialist sites participating in our plan and not serving as PCPs also must undergo an initial site inspection.

A member of our department will call the provider's office to schedule an appointment date and time before the facility site review due date. The department will fax or mail a confirmation letter with an explanation of the audit process and required documentation. During the facility site review, the Quality Improvement associate will:

1. Lead a prereview conference with the provider or office manager to review and discuss the process of facility review and answer any questions.
2. Conduct a review of the facility.
3. Develop a corrective action plan, if applicable.

After the facility site review is completed, our associate will meet with the provider or office manager to:

1. Review and discuss the results of the facility site review and explain any required corrective actions.
2. Provide a copy of the facility site review results and the corrective action plan to the provider or office manager or mail a final copy within 10 days of the review.
3. Educate the provider and office staff about our standards and policies.
4. Schedule a follow-up review for any corrective actions identified.

Quality Assessment and Performance Improvement

Facility Site Review: Corrective Actions

If the facility site review results in a non-passing score, Wellpoint will notify providers immediately of the non-passing score, all cited deficiencies and corrective action requirements. The provider office will develop and submit corrective action plans and we will conduct follow-up visits every six months until the site complies with our standards.

The provider and office staff will:

1. Make an appointment time available for the review.
2. Be available to answer questions and participate in the exit interview.
3. Schedule follow-up reviews, if applicable.
4. Complete a corrective action plan.
5. Sign an attestation that corrective actions are complete.
6. Submit the completed corrective action plan, supporting documents and signed attestation to our quality improvement analyst.

Quality Assessment and Performance Improvement

Preventable Adverse Events

The breadth and complexity of today's healthcare system means there are inherent risks, many of which can be neither predicted nor prevented. However, preventable adverse events should be tracked and reduced, with the ultimate goal of eliminating these events.

Providers and healthcare systems, as advocates for our members, are responsible for the continuous monitoring, implementation, and enforcement of applicable healthcare standards. Focusing on patient safety, we work collaboratively with providers and hospitals to identify preventable adverse events and implement appropriate strategies and technologies to avoid these events. Our goal is to enhance the quality of care received not only by our members, but all patients receiving care in these facilities.

Prevention of adverse events may require the disclosure of protected health information (PHI). HIPAA specifies that PHI may be disclosed for the purpose of healthcare operations in relation to quality assessment and improvement activities. Moreover, the information you share with us is legally protected through the peer review process and will be maintained in a strictly confidential manner. If you receive a request for medical records, please provide the records within 10 days from the date of request.

We will continue to monitor activities related to the list of adverse events from federal, state, and private payers, including "never events":

Never events: As defined by the National Quality Forum (NQF), never events are adverse events that are serious, but largely preventable, and of concern to both the public and healthcare providers.

Preventable adverse events should not occur. When they do, we firmly support the concept that a health plan and its members should not pay for resultant services.

Medicaid is prohibited from paying for certain healthcare acquired conditions (HCAC), and this ruling applies to all hospitals.

CHAPTER 21: ENROLLMENT AND MARKETING RULES

Enrollment and Marketing Rules

Overview

The delivery of quality healthcare poses numerous challenges, not the least of which is the commitment shared by Wellpoint and providers to act in the best interest of our members. We want our members to make the best healthcare decisions possible. And when members ask for our assistance, we want to provide that assistance, so they make those decisions without undue influence.

We recognize that providers occupy a unique, trusted, and respected part of people's lives. Given the complexity of modern-day healthcare and the inherent difficulties communicating with some of the populations we serve, there are potentially serious pitfalls when providers try to assist in the decision-making process. Sometimes, even though the intent is to help make our members' lives better, we may overstep.

For that reason, we are committed to following strict enrollment and marketing guidelines created by Iowa HHS and to honoring the rules for all state healthcare programs.

Enrollment and Marketing Rules

Marketing Policies

Wellpoint providers are prohibited from making marketing presentations and advising or recommending to an eligible individual that he or she select membership in a particular plan. The HHS marketing practice policies prohibit network providers from making any of the following false or misleading claims:

- The provider's office staffs are employees or representatives of the state, county, or federal government.
- Wellpoint is recommended or endorsed by any state or county agency, or any other organization.
- The state or county recommends that a prospective member enroll with a specific healthcare plan.
- A prospective member or medical recipient loses Medicaid or other welfare benefits if the prospective member does not enroll with a specific healthcare plan.

These policies also prohibit network providers from taking the following actions:

- Making marketing presentations, advising, or recommending to an eligible individual that he or she select membership in a specific healthcare plan.
- Offering or giving away any form of compensation, reward, or loan to a prospective member to induce or procure member enrollment in a specific healthcare plan.
- Engaging in direct marketing to members designed to increase enrollment in a particular healthcare plan. The prohibition should not constrain providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.
- Using any list of members originally obtained for enrollment purposes from confidential state or county data sources, or from the data sources of other contractors.
- Employing marketing practices that discriminate against potential members other than persons specifically excluded from coverage under our contract. Providers may not discriminate based on marital status, age, religion, gender, gender identity, national origin, language, sexual orientation, ancestry, or pre-existing psychiatric problems or medical conditions, such as pregnancy, disability, or AIDS.
- Reproducing or signing an enrollment application for the member.
- Displaying materials only from the provider's contracted managed healthcare organizations and excluding others.

Providers are permitted to:

- Assist members in applying for benefits by calling for enrollment information:
 - Wellpoint Member Services: **833-731-2140** (TTY: 711)
 - Iowa Medicaid Member Services: **800-338-8366** or **515-256-4606** (when calling from within the Des Moines area); TTY: **800-735-2942**
- Distribute copies of Wellpoint applications to potential members.
- File a complaint with Wellpoint if a provider or member objects to any form of marketing, either by other providers or by Wellpoint representatives. Refer to **Chapter 14: Grievances and Appeals** for more information on the grievance process.

Enrollment and Marketing Rules

Enrollment Process

The HHS determines the eligibility and enrollment for individuals seeking to enroll in IA Health Link or Hawki, after which the process is as follows:

1. HHS presents IA Health Link or Hawki to eligible individuals and families.
2. HHS informs Wellpoint of new member enrollment.
3. Providers are given notice of new members assigned to their care through monthly eligibility reports. Providers access these reports by logging into Availity Essentials, and accessing the Provider Online Reporting application located on Payer Spaces, at <https://providers.wellpoint.com/ia>. Select **Login** or **Register** to access the secure site.
4. Wellpoint sends each new member a New Member Kit within five business days of receiving the HHS monthly membership file. This kit includes the Member Handbook, an information card with important phone numbers, and instructions for changing a PCP.
5. Members select a PCP. After 14 days, if the member has not selected a PCP, Wellpoint assigns a PCP to the member.

CHAPTER 22: FRAUD, ABUSE AND WASTE

Fraud, Abuse and Waste

Overview

We're committed to protecting the integrity of our healthcare program and the efficiency of our operations by preventing, detecting and investigating fraud, abuse and waste.

Fraud, Abuse and Waste

Understanding Fraud, Abuse and Waste

Combating fraud, abuse and waste begins with knowledge and awareness.

Fraud: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it -- or any other person. This includes any act that constitutes fraud under applicable Federal or State law.

Waste: Includes overusing services, or other practices that, directly or indirectly, result in excessive costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.

Abuse: behaviors that are inconsistent with sound financial, business, and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet professionally recognized standards for healthcare. This includes any member actions that result in unnecessary costs.

Fraud, Abuse and Waste

Examples of Provider Fraud, Abuse and Waste

The following are examples of provider fraud, abuse, and waste:

- Altering medical records
- Billing for services not provided
- Billing for medically unnecessary tests
- Billing professional services performed by untrained personnel
- Misrepresentation of diagnosis or services
- Overutilization
- Soliciting, offering, or receiving kickbacks or bribes
- Unbundling - when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding — when a Provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

Fraud, Abuse and Waste

Examples of Member Fraud, Abuse and Waste

The following are examples of member fraud, abuse, and waste:

- Forging, altering, or selling prescriptions
- Letting someone else use a member's IA Health Link identification (ID) card
- Relocating to an out-of-service area and not notifying us
- Using someone else's IA Health Link ID

Fraud, Abuse and Waste

Reporting Provider or Recipient Fraud, Abuse or Waste

If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste, or abuse, you

have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person and their information, if supplied, who reports the incident is kept in strict confidence by the Special Investigations Unit (SIU).

Provider Reporting

Providers may report allegations of fraud, abuse, or waste by :

- Visiting our <http://www.fighthealthcarefraud.com> education site; at the top of the page click “Report it” and complete the “Report Waste, Fraud and Abuse” form
- Call the SIU fraud hotline: **866-847-8247**
- Mail: Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
- Calling Provider Experience: **833-731-2143 if you are a network provider**

Member Reporting

Members should let us know if they suspect a doctor, dentist, pharmacist or other healthcare providers, or another person receiving benefits is doing something wrong by:

- Visiting our www.fighthealthcarefraud.com education site; at the top of the page click “Report it” and complete the “Report Waste, Fraud and Abuse” form
- Calling Member Services: **833-731-2140 (TTY: 711)**
- Calling the SIU fraud hotline: **866-847-8247**
- Mail: Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308

Both providers and members may report fraud, abuse and waste by completing our Waste, Fraud and Abuse Report Form online at our website at <https://providers.wellpoint.com/ia>. To locate this form, select **Waste, Fraud, & Abuse** at the bottom of the page.

When reporting about a provider, include the following:

- Name, address, and phone number of the provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if available
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

When reporting about a member who receives benefits, include the following:

- The person’s name
- The person’s date of birth, Member ID number or case number, if available
- The city where the person lives
- Specific details about the fraud, abuse, or waste

Fraud, Abuse and Waste

Anonymous Reporting of Suspected Fraud, Abuse and Waste

Any incident of fraud, abuse or waste may be reported to us anonymously. However, in certain instances, we may not be able to pursue an investigation without additional information. In such cases, we will need the following:

- The name of the person reporting and their relationship to the person suspected
- A call-back phone number for the person reporting the incident

Please note: The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators to maintain that person's anonymity.

Fraud, Abuse and Waste

Investigation Process

We do not tolerate acts that adversely affect providers or members. We investigate all reports of fraud, abuse, and waste. Allegations and the investigative findings are reported to HHS, regulatory agencies, and law enforcement agencies. In addition to reporting, we take corrective action(s) such as:

- *Written warning and/or education:* We send certified letters to the Provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries or may advise of further action.
- *Medical record review:* We review medical records in context to previously submitted claims and/or to substantiate allegations.
- *Prepayment Review:* A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- **Recoveries:** We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment of future claims and/or further legal action.

If you are working with the SIU, all checks and correspondence should be sent to:

- Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Paper medical records and claims are a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator. An opportunity to submit claims and medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at **800-AVAILITY (282-4548)** for more information.

About Prepayment Review

One method we use to detect FWA is through prepayment Claim review. Through a variety of means, certain Providers (Facilities or Professionals), or certain Claims submitted by Providers, may come to our attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider is an outlier compared to his/her/its peers.

Once a Claim, or a Provider, is identified as an outlier or has otherwise come to our attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination the Provider's action(s) may involve FWA, unless exigent circumstances exist, the Provider is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider is on prepayment review, the Provider will be required to submit medical records and any other supporting documentation with each Claim so the SIU can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation in accordance with this requirement will result in a denial of the Claim under review. The Provider will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, we may review coding, documentation, and other billing issues. In addition, one or more clinical utilization management guidelines may be used in the review of Claims submitted by the Provider, even if those guidelines are not used for all Providers delivering services to Plan Members.

The Provider will remain subject to the prepayment review process until the health plan is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider could face corrective measures, up to and including termination from the network at the direction of the State.

Providers are prohibited from billing a Member for services the health plan has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their Provider Agreement, proper billing procedures and state law. Providers also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Fraud, Abuse and Waste

Acting on Investigative Findings

If, after investigation, the SIU determines a provider appears to have committed fraud, waste, or abuse the provider:

- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination
- Will be referred to other authorities as applicable and/or designated by the State
- The SIU will refer all suspected criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

Failure to comply with program policy, procedures or any violation of the contract will result in termination from our plan.

If a member has committed fraud, exhibited abusive or threatening behavior, or has failed to correct issues, he or she may be involuntarily disenrolled from our healthcare plan with state approval. Refer to the **Member Transfers and Disenrollment** chapter for more information.

Fraud, Abuse and Waste

False Claims Act

We're committed to complying with all applicable federal and state laws, including the *federal False Claims Act (FCA)*. The *FCA* is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the *FCA*, anyone who knowingly submits, or causes another person or entity to submit, false claims for payment of government funds are liable for three times the damages, or loss, to the government, plus civil penalties of \$5,500 to \$11,000 per false claim.

The *FCA* also contains Qui Tam or “whistleblower” provisions. A “whistleblower” is an individual who reports in good faith an act of fraud or waste to the government, or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the *FCA* and may be entitled to a percentage of the funds recovered by the government

Fraud, Abuse and Waste

Employee Education about the *False Claims Act*

As a requirement of the Deficit Reduction Act of 2005, contracted providers who receive Medicaid payments of at least \$5 million dollars (cumulative from all sources), must comply with the following:

- Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
- Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, waste, and abuse.
- Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, abuse, and waste.

CHAPTER 23: MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights and Responsibilities

Overview

Members should be clearly informed about their rights and responsibilities so they can make the best healthcare decisions. Members also have the right to ask questions about the way we conduct business, as well as the responsibility to learn about their healthcare plan coverage.

The following member rights and responsibilities are defined by the state of Iowa and appear in the Member Handbook.

Member Rights and Responsibilities

Member Rights

Wellpoint honors civil rights and provides covered services to all eligible members regardless of the following:

- Age
- Color
- Disability
- Marital status
- National origin
- Race
- Religion
- Gender
- Gender identity
- Sexual orientation
- Taking part in the military
- Arrest or conviction record

All medically necessary covered services are offered to all members. All services are given in the same way to all members. All persons or groups who work with Wellpoint, or who refer or suggest services to members, shall do so in the same way for all members. Translation or interpretation services are offered free of charge for those members who need assistance.

Member Rights

The organization's member rights and responsibilities statement specifies that members have:

- A right to receive information about the organization, its services, its practitioners, its providers, and member rights and responsibilities.
- A right to be treated with respect and recognition of their dignity and their right to privacy.
- A right to participate with practitioners in making decisions about their healthcare.
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- A right to voice complaints or appeals about the organization or the care it provides.
- A right to make recommendations regarding the organization's member rights and responsibilities policy.
- Ask for an oral Interpreter and have an interpreter given to them during any IA Health Link-covered service.
- Get the information given in the Member Handbook in another language or format.
- Get healthcare services as given by federal and state law. All covered services must be offered and accessible. When medically needed, services must be offered 24 hours a day, 7 days a week.
- Get details about treatment options, such as the right to ask for a second opinion.

- Be free from any form of restraint or seclusion used as means of force, control, convenience, or retaliation.

Member Rights and Responsibilities

Member Responsibilities

Wellpoint members have the responsibility to:

- Show their IA Health Link ID card each time they receive medical care.
- Make or change appointments.
- Get to appointments on time.
- Call their PCP if they cannot make it to their appointment or if they will not be on time.
- Use the emergency room only for true emergencies.
- Pay for any services they ask for that are not covered by IA Health Link.
- Treat their PCP and other healthcare providers with respect.
- Tell us, their PCP, and their other healthcare providers what they need to know to treat them.
- Do the things that keep them from getting sick.
- Follow the treatment plans members, their PCP and their other healthcare providers agree on.
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Tell us and their County/Tribal Economic Support Caseworker if:
 - They move.
 - They change their phone number.
 - The number of people in their household changes.
 - They have other insurance.
 - They become pregnant.

CHAPTER 24: CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

Overview

Patient panels are increasingly diverse, and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. Wellpoint wants to help, as we all work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed, how symptoms are described,
- Expectations of care and treatment options,
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine.

Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values, and preferred means of having those needs met
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

Wellpoint ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. We encourage providers to access and utilize the following resources.

MyDiversePatients.com: The My Diverse Patient website offers resources, information, and techniques, to help provide the individualized care every patient deserves regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **My Inclusive Practice - Improving Care for LGBTQIA+ Patients:** Helps providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients, & develop strategies for providing effective healthcare to LGBTQIA+ patients.
- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a healthcare encounter.

- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations and learn techniques to improve patient-centered communication to support needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- **Reducing Health Care Stereotype Threat (HCST):** Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

Cultural Competency Training (Cultural Competency and Patient Engagement): A training resource to increase cultural and disability competency to help effectively support the health and healthcare needs of your diverse patients.

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients. See Chapter 13 Interpreter Services for guidance on interpreter support.

Wellpoint appreciates the shared commitment to ensuring members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

Interpreter Services

For those instances when you cannot communicate with a member due to language barriers, interpreter services are available at no cost to you or the member. Wellpoint provides over-the-phone and face-to-face interpreters. Providers must notify members of the availability of interpreter services and strongly discourage the use of friends and family, particularly minors, to act as interpreters. Face-to-face interpreters for members needing language assistance, including American Sign Language, are available by placing a request at least 72 hours in advance. A 24-hour cancellation notice is required.

During business hours, request telephone interpreter services by calling:

Providers: **833-731-2143**

Members: **833-731-2140** (TTY: 711)

After-hours, call Wellpoint on Call at:

English: **866-864-2544**

Spanish: **866-864-2545**

TTY: 711

For after-hours interpreter services, call Wellpoint on Call and take the following steps:

1. Give the member's identification (ID) number to Member Services.
2. Explain the need for an interpreter and state the language required.
3. Wait on the line while the connection is made.
4. Once connected to the interpreter, the associate or Wellpoint on Call nurse introduces the Wellpoint member, explains the reason for the call, and begins the dialogue.

Request face-to-face interpreter services by calling:

Providers: **833-731-2143**

Members: **833-731-2140** (TTY: 711)

Additional information on interpreter services is available on our website at

<https://providers.wellpoint.com/ia> under Provider Resources & Documents > Training Programs.

Services for Members with Hearing Loss, Visual and/or Speech Impairment

Members with hearing loss or speech impairment can call the designated TTY number — 711. The Iowa relay service is also available 24 hours a day by calling the numbers noted in the [Contact List](#) chapter. Members can also request face-to-face sign language interpreters at no cost. Members with visual impairments can request verbal assistance or alternative formats for assistance with printed materials at no cost.

Translation of Materials

Members can request translation of materials into non-English languages, at no cost, by contacting the appropriate Member Services number in the [Contact List](#) chapter.

All required information in this section is sent to current and potential members in an easily understood, readily accessible format.

APPENDIX A

Member Choice Value-added Services	
Fresh Food Connect	Wellpoint will ensure members have access to healthy and nutritious food options, they can select the option that will best suit their needs: <ul style="list-style-type: none"> • 10 Fresh, pre-measured ingredients and recipes, ready-to-cook family meals • 3 Farm fresh produce boxes • Annual (Sam’s Club or Costco) Membership • Annual Membership for free online grocery delivery
Baby Essentials	Wellpoint will offer Baby Essentials to help bridge resource gaps for new and expectant mothers by allowing them to select up to \$200 worth of essential items that help promote safety and member choice, help relieve stress, keep babies safe, and help parents manage better at home once their new family member arrives.
Asthma relief toolkit	Wellpoint’s Asthma Relief Toolkit VAS offers a range of solutions to enable members to select products that best suit their needs.
Personal care & hygiene supplies	Wellpoint will offer eligible members an allowance to purchase personal care and hygiene products from an online store.
Assistive devices and wheelchair accessories	Members can select one item from various assistive devices or wheelchair accessories that are intended to make everyday activities easier and safer

Access Value-Added Services	
Transportation Essentials	Eligible members will be able to receive up to 10 rounds trips to community locations such as self-help meetings, health education programs, fitness centers, job interviews, employment locations, and Medicaid redetermination appointments, and then be able to select from one of the following transportation options that best suit their needs: <ul style="list-style-type: none"> • Uber gift card • Gas card • Oil change • Car repairs • Bus pass
Digital mental health toolkit	Wellpoint’s Digital Mental Health Toolkit consists of a three-tiered approach to mental wellness. All members will receive unlimited access to our web-based online program built on the principals and tools of Cognitive Behavioral Therapy (CBT). For members who need a little more support, they will receive an annual subscription to Calm, a meditation and sleep app that helps calm the mind and body reducing anxiety and stress. Additionally, members with substance use disorders will receive access to our SUD Recovery Support Program which is a mobile platform that provides daily motivations/check in, peer support through discussion groups and peer to peer messages, counselor messaging, care plan reminders, goals, journals, high risk location alerts, and content to support ongoing recovery.
Smartphone Member Connect	The Federal Communications Commission (FCC) currently offers two smart phone programs, the Lifeline Program, and the new Affordable Connectivity Program (ACP) Program, that all Medicaid-eligible beneficiaries can use.
Digital library membership and e-reader	Wellpoint will offer eligible members will receive a Kindle and digital library membership
Self-Advocacy memberships	To help members develop skills for increased independence and support community living and/or community integration, Wellpoint will provide eligible members an annual stipend to attend a conference or event

Access Value-Added Services

sponsored by Iowans with Disabilities in Action, NAMI-Iowa, or Area Agencies on Aging.

Independent Living Skills Services

<p>Additional minutes through Safelink®</p>	<p>To help ensure our members always have a way to contact us, eligible Wellpoint members who have SafeLink get: 200 bonus minutes when they enroll with Wellpoint, 100 bonus minutes during their birth month. The bonus minutes are in addition to: 1000 monthly minutes, 1.5 GB of data*, Unlimited text messages, Free calls to Member Services. Member already has Lifeline? They may be able to switch from their current Lifeline carrier to SafeLink. If they keep their own smartphone, they will get 1.5 GB of data for the first three months, and 1 GB of data starting on the fourth month.</p>
<p>Personal Care and Hygiene Supplies</p>	<p>Maintaining good hygiene is essential for overall health and wellness. Benefits of maintaining good hygiene include but are not limited to: Disease and illness prevention, Social and professional acceptance, Higher confidence and self-esteem, Pain, and infection prevention. Eligibility: Transitional Aged members in foster care (17-21) and LTSS members</p>
<p>Community reintegration benefit</p>	<p>To help assist members reintegrate into their communities, Wellpoint will provide a community reintegration benefit for eligible members.</p>
<p>Home Essentials</p>	<p>Members in Foster Care and LTSS members who qualify for LTSS and are transitioning into a more independent living arrangement are eligible. Limit one option per member, per lifetime.</p>

Available to all members:

- Earn Healthy Rewards credit to redeem for gift cards for completing specific healthy activities with our Healthy Rewards program when they elect to sign up for the program.
- WW® (formerly Weight Watchers®) vouchers, personal exercise kits, and up to \$100 to help cover the cost of a gym membership.
- Dental hygiene kits every year.
- Help finding free and low-cost services nearby with our Community Resource Link.
- Help after leaving the hospital with a post-discharge stabilization kit and home-delivered meals for up to <14> days.
- A free cellphone with free data, talk, and texts if you qualify.
- Voucher to complete the high school equivalency test (HiSET).
- An allowance for asthma relief products and carpet cleaning to help mitigate asthma triggers.
- Access to our digital mental health toolkit, which includes: On-demand, interactive well-being resources, a meditation app subscription to help manage stress, and a robust substance use disorder recovery tool to help members track progress and receive support through their recovery journey.
- Job training resources and support in our Job Connections program
- To choose their favorite option that helps ensure access to healthy and nutritious food sources with our Fresh Food Connect benefit.
- Access to more than 1000 on-demand fitness and exercise resources through our ChooseHealthy program.
- Three months of fresh produce boxes delivered straight to their door.
- Healthy lifestyle aids, like digital scales, home blood pressure cuffs, and more, to help them achieve better health.
- Up to 10 additional round-trip community rides for Iowa Health Link members.
- To select a transportation benefit that best fits their needs to reduce transportation barriers.

For pregnant members:

- Nursing support package to encourage healthy breastfeeding
- Up to \$200 in baby essential items

Just for kids:

- Youth Club memberships, including Boys & Girls Club, Boy and Girl Scouts, 4H and more
- Access to hundreds of age-appropriate workout and fitness classes to promote physical activity
- A summer reading benefit of gift card or digital library membership and e-reader
- Up to <24> hours of no-cost virtual tutoring services

For members in certain waivers and other programs:

- Allowance for assistive devices and wheelchair accessories to help keep you safe and independent at home
- No-cost digital library membership and e-reader
- Up to \$2,500 to move back to your home from a nursing facility
- Options to support the purchase of home goods and other essentials
- Allowance for sensory products to help reduce anxiety, improve focus, and build fine motor skills
- Allowance for personal care and hygiene supplies

To learn more about any of these value-added services, call us at **833-731-2140 (TTY 711)**, visit our website at wellpoint.com/ia/medicaid or see the *Member Handbook*.

* Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.



<https://provider.wellpoint.com/ia/>

Services provided by Wellpoint Iowa, Inc.