IA Health Link and Hawki

Provider Manual

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Wellpoint

Hawki
Iowa HHS

Iowa Health Link
Iowa HHS

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CHAPTER 1: 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 Iowa Health Link or Hawki programs.

Iowa 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.

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. Select 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 a 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, and 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. 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 **provider.wellpoint.com/ia**. Throughout this manual, we often will refer you to items located on this resource page.

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.

Provider and Facility Digital Guidelines

Wellpoint understands that working together digitally streamlines processes and optimizes efficiency. We developed the Provider and Facility Digital Guidelines to outline our expectations and to fully inform providers and Facilities about our digital platforms.

Wellpoint expects providers and facilities will use digital tools, unless otherwise prohibited by law or other legal requirements.

The Digital Guidelines establish the standards for using secure digital provider platforms (websites) and applications when transacting business with Wellpoint. These platforms and applications are accessible to both participating and nonparticipating providers and facilities and encompass **Availity.com**, electronic data interchange (EDI), electronic medical records (EMR) connections and business-to-business (B2B) desktop integration.

Digital and/or electronic transaction applications are accessed through these platforms:

- Availity EDI Clearinghouse
- EMR connections
- B2B application programming interfaces (APIs)

Digital functionality available through Availity Essentials include:

- Eligibility and benefit inquiry and response
- Prior authorization submissions including updates, clinical attachments, authorization status, and clinical appeals
- Claim submission, including attachments, claim status
- Acceptance of digital ID cards
- Remittances and payments
- Provider Enrollment and Network Management
- Demographic updates

Additional digital applications available to providers and facilities include:

- Pharmacy prior authorization drug requests
- Services through Carelon Medical Benefits Management, Inc.
- Services through Carelon Behavioral Health, Inc.

Wellpoint expects providers and facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (for example, paper, mail, fax, call, chat). All channels are consistent with industry standards. All EDI transactions use version 5010.

Note, as a mandatory requirement, all trading partners must currently transmit directly to the Availity EDI gateway and have an active Availity Trading Partner Agreement in place. This includes providers using their practice management software and clearinghouse billing vendors.

Providers and facilities who do not transition to digital applications may experience delays when using non-digital methods such as mail, phone, and fax for transactions that can be conducted using digital applications.

Section 1: Accepting digital ID cards
As our members transition to digital member ID cards, providers and facilities may need to implement changes in their processes to accept this new format. Wellpoint expects that providers and facilities will accept the digital version of the member identification card in lieu of a physical card when presented. If providers and facilities require a copy of a physical ID card, members can email a copy of their digital card from their smartphone application, or providers and facilities may access it directly from Availity Essentials through the Eligibility and Benefits Inquiry application.

Section 2: Eligibility and benefits inquiry and response
Providers and facilities should leverage these Availity Clearinghouse hosted channels for electronic eligibility and benefit inquiry and response:

EDI transaction: X12 270/271 Eligibility Inquiry and Response	Availity Essentials	Provider Desktop Integration via B2B APIs
Wellpoint supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.	The Eligibility and Benefits Inquiry verification application allows a provider and facility to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.	Wellpoint has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity Client Services for available vendor integration opportunities.

Section 3: Prior authorization submission, attachment, status, and clinical appeals.
Providers and facilities should leverage these channels for prior authorization submission, status inquiries and submit electronic attachments related to prior authorization submissions:

Channels	Description
EDI Transaction: X12 278 – Prior authorization and referral	Wellpoint supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per HIPAA.
EDI transaction: X12 275 – Patient information, including HL7 payload for authorization attachments	Wellpoint supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
Availity Essentials	The Availity Essentials multi-payer Authorization application facilitates prior authorization submission, authorization status inquiry, and the ability to review previously submitted authorizations. Provider desktop integration via B2B APIs: • Wellpoint has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity Client Services for available vendor integration.

Section 4: Claims: submissions, claims payment disputes, attachments, and status
Claim submissions status and claims payment disputes
Providers and facilities should leverage these channels for electronic claim submission, attachments (for both pre- and post-payment) and status:

Channels	Description
EDI transaction: X12 837 – professional, institutional, and dental claim submission (v5010)	Wellpoint supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA. 837 claim batch upload through EDI allows a provider to upload a batch/file of claims (must be in X12 837 standard format).
EDI transaction: X12 276/277 – claim status inquiry and response	Wellpoint supports the industry standard X12 276/277 transaction set for claim status inquiry and response as mandated by HIPAA.
Availity Essentials – Claims & Payments application	The Claims & Payments application enables providers and facilities to enter a claim directly into an online claim form and upload supporting documentation for a defined claim. The Claim Status application enables a provider to access online claim status. Access the claim payment dispute tool from claim Status. Claims Status also enables online claim payment disputes in most markets and for most claims. It is the expectation of Wellpoint that electronic claim payment disputes are adopted when and where it is integrated.
Provider desktop integration via B2B APIs	Wellpoint has also enabled real-time access to claim status via APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity Client Services for available vendor integration.

Claim attachments

Providers and facilities should leverage these channels for electronic claim attachments from **Availity.com**:

EDI transaction: X12 275 – Patient information, including HL7 payload attachment	Availity Essentials – Claim Status application
• Wellpoint supports the industry standard X12 275 transaction for electronic transmission of supporting claim documentation including medical records via the HL7 payload.	• The Claim Status application enables providers and facilities to digitally submit supporting claims documentation, including medical records, directly to the claim. • Digital Request for Additional Information (Digital RFAI) – The Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation including medical records are needed to process a claim.

Section 5: Electronic remittance advice and electronic claims payment

Electronic remittance advice

Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your claims. Wellpoint supports the industry standard X12 835 transaction as mandated per HIPAA.

Providers and facilities can register, enroll and manage their ERA preference through **Availity.com**. Printing and mailing remittances will automatically stop thirty (30) days after the ERA enrollment date.

- Viewing an ERA on Availity Essentials is under *Claims & Payments*, *Remittance Viewer*. Features of remittance viewer, include the ability to search a two (2) year history of remittances and access the paper image.
- Viewing a portable document format (PDF) version of a remit is under Payer Spaces which provides a downloadable PDF of the remittance.

To stop receiving ERAs for your claims, contact Availity Client Services at **800-AVAILITY** (**282-4548**).
To re-enable receiving paper remittances, contact Provider Services.

Electronic claims payment

Electronic claims payment is a secure and fast way to receive payment, reducing administrative processes. There are several options to receive claims payments electronically.

Type	Description
Electronic Funds Transfer (EFT)	Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a provider's or facility's bank account at no charge for the deposit. Health plans can use a provider's or facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation. ○ **To enroll in EFT**: Providers and facilities can register, enroll, and manage account changes for EFT through EnrollSafe at **enrollsafe.payeehub.org**. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. For help with enrollment, use the **EnrollSafe User Reference Manual**.

Type	Description
	○ **To disenroll from EFT**: Providers and facilities are entitled to disenroll from EFT. Disenroll from EFT payments through EnrollSafe at **enrollsafe.payeehub.org**.
Virtual Credit Card (VCC)	For providers and facilities who do not enroll in EFT, and in lieu of paper checks, Wellpoint is shifting some reimbursements to virtual credit card (VCC). VCC allow providers and facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply. Note that Wellpoint may receive revenue for issuing a VCC. **Opting out of virtual credit card payment**. Providers and facilities are entitled to opt out of electronic payment. To opt out of virtual credit card payment, there are two (2) options: 1. Enrolling for EFT payments automatically opts you out of virtual credit card payments. To receive EFT payments instead of virtual credit cards payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**. 2. To opt out of virtual credit card payments, call **800-833-7130** and provide your taxpayer identification number.
Zelis Payment Network (ZPN) electronic payment and remittance combination	The Zelis Payment Network (ZPN) is an option for providers and facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to **Zelis.com**. Zelis may charge fees for their services. Note that Wellpoint may receive revenue for issuing ZPN. ERA through Availity Essentials is not available for providers and facilities using ZPN. **To disenroll from ZPN payment**, there are two (2) options: 1. Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**. 2. To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at **877-828-8770**.

Those not enrolled for EFT, VCC, or ZPN will receive paper checks by mail.

Providers and facilities can edit the downloaded roster and upload the updated version via Availity's Provider Data Management Upload Roster File screen to easily make changes to their data. Because the download is correctly formatted, it should enable automatic processing.

See Section 7: Demographic updates for more information about Provider Data Management.

Section 6: Provider enrollment and network management

Provider Enrollment

Simplified Enrollment Process	Real-Time Tracking
Providers and facilities can enroll as a new provider in our network for professional, ancillary, institutional, and facility provider types through Availity Essentials.	Providers and facilities can track the status of their requests in the My Dashboard section of the Provider Enrollment and Network Management application.

Contract Changes

Streamlined Contract Change Requests	Real-Time Tracking
Providers and facilities can easily submit certain requests for contract changes through Availity Essentials • Amendment requests to add a network or line of business • Change of Ownership notice • Contract, line of business, or Network Termination requests • TIN Change	Providers and facilities can track the status of their requests in the My Dashboard section of the Provider Enrollment and Network Management application.

Section 7: Demographic updates

Provider Data Management (PDM)

Availity Essentials Provider Data Management (PDM) is the digital intake application for providers and facilities to submit demographic change requests – it is also where providers can upload a roster with demographic changes. 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** and follow the prompts.

For provider and facilities using the **roster upload option**, additional resources are available:

Error Report	Results Report	Roster Submission Guide
Providers and facilities can use this Error Report to understand where errors occurred (specifically which sheet, tab, and row), the cause of the issue, and how to fix it. Providers and facilities are responsible for using the Error Report to identify errors in a roster, correct them, and resubmit the roster rows that contain errors. Rows in a roster that contain an error will not be processed and the addition, change, or termination will not be updated in our systems	When a roster has the status partially complete or complete a Results Report will be created for any rosters received on and after June 15, 2024. The Results Report is an Excel file that shows the adds and updates made to your provider group's demographic data based on the information contained in a specific roster.	For provider and facilities using the roster upload option, additional information about the Error Report and Results Report can be found in our Roster Submission Guide. Find it online at **Availity.com** > **Payer Spaces** > **Payer Tile** > **Resources** > **Roster Submission Guide using Provider Data Management**.

CHAPTER 2: 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.

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

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.

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: **provider.wellpoint.com/ia**
Carelon Behavioral Health, Inc. **National Provider Service Line**	**Carelon Behavioral Health, Inc.** **National Provider Service Line** Phone: **800-397-1630** Hours: Monday through Friday, 7 a.m. to 7 p.m. Central time
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 **Availity.com**
Integrated Case Management Referrals	**Wellpoint Case 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** Phone: **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

If you have questions about …	Contact
Claims: Medical Claim Refunds	Wellpoint P.O. Box 933657 Atlanta, GA 31193-3657
Credentialing and Recredentialing	Phone: **855-789-7989** Email: providersolutionsia@wellpoint.com Recredentialing Email: providersolutionsia@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**
Electronic Visit Verification (EVV)	CareBridge is Iowa's designated vendor for Electronic Visit Verification (EVV). If you have questions or need support using the EVV platform, use the following contacts: **CareBridge EVV Users**: Phone: **844-343-3653** Email: iaevv@carebridgehealth.com **Third-Party EVV users**: Phone: **844-920-0989** Email: evvintegrationsupport@carebridgehealth.com **Training and resources**: **carebridgehealth.com/trainingiaevv** **More EW information** available on the Iowa Health and Human Services (HHS) website: **hhs.iowa.gov/medicaid/about-medicaid/medicaid-projects/evv** **HHS EVV Frequently Asked Questions**: **hhs.iowa.gov/media/12270/download?inline**
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**

If you have questions about …	Contact
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: **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: **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** Mail: Central Appeals Processing Wellpoint P.O. Box 62429 Virginia Beach, VA 23466-2429

If you have questions about …	Contact
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: **Login** • 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: **provider.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: **provider.wellpoint.com/ia**
Pharmacy Questions and Prescriptions: Members	**Wellpoint Pharmacy** Phone: **833-205-6008** (TTY **711**) Hours: 24 hours a day, seven days a week Website: **wellpoint.com/ia/member**
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 **provider.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: **providerportal.com**
Prior Authorization: Pharmacy	**Wellpoint Pharmacy Department** Phone: **833-731-2143** Fax: **844-512-9004** ePrescribe: **covermymeds.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 Fax: **800-964-3627**

If you have questions about …	Contact
Transportation Services (Nonemergency medical transportation)	**MTM Health** **MTM Health for transportation Services:** • 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** Hours: Monday through Friday, 7 a.m. to 6 p.m. Central time
Transportation Services (for HCBS Waiver participants)	The Elderly Waiver, Intellectual Disability Waiver, Physical Disability Waiver and Brain Injury Waiver have transportation as a covered service. Schedule transportation services: **888-630-4822**. Review a previously requested reservation, call the Where's My Ride Line: **844-544-1390**. 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 MTM Health, based on the member's Wellpoint LTSS contract and in accordance with their person-centered plan. Transportation to medical, dental, and behavioral health services must be accessed through the State Plan Non-Emergency Medical Transportation (NEMT) benefit. HCBS waiver providers may not bill for or provide transportation to these services under the waiver, as this would duplicate the state plan benefit. HCBS waiver providers that wish to provide reimbursable NEMT services must be enrolled and contracted to do so with the designated NEMT vendor. Please see the NEMT section outlined in **Chapter 5** for more details. To contract, call **888-644-3547**.
Vision Services	**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: **superiorvision.com**

CHAPTER 4: COVERED AND NONCOVERED SERVICES

Overview

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 Services: Medicaid Services

Covered services: Medicaid Services	Coverage limits
1915(C) home- and community-based services	Covered
1915(I) habilitation services	Covered
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
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
Clinical trials	Covered, limitations may apply
Colorectal cancer screening	Covered
Community-based neurobehavioral rehabilitation services	Covered (may require prior authorization)

Covered services: Medicaid Services	Coverage limits
Congenital abnormalities correction	Covered as medically necessary
Contraceptive devices	Covered
Diabetes equipment and supplies	Covered
Diabetic self-management training	Covered
Diagnostic genetic testing	Covered
Dialysis	Covered

Durable medical equipment (DME) and supplies (DMS)
 	
DME and DMS *(continued)*
	Covered; Services may require PA This does not apply to DMS.
	Limits (may require prior authorization):
	• 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.
	  ○ 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 – 100 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
	• 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.

Early and periodic screening, diagnosis, and treatment (EPSDT)	Covered
Emergency medical transportation	Covered as medically necessary
Emergency room services	Covered $3 per visit for nonemergency medical services
Family planning-related services and supplies	Covered

Covered services: Medicaid Services	Coverage limits
Foot care (podiatry)	Covered Note: Routine foot care is not 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
Habilitation Services- State Plan HCBS (1915(i))	Covered with service plan authorization. Must meet medical necessity and not duplicate waiver or other State Plan Services. No fixed limits; based on member's assessed need.
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 and Community-Based Services (HCBS)-Waiver Services (1915 (c))	Covered, based on assessed need, for individuals meeting eligibility criteria for Iowa HHS 1915 (c)) waivers. Limits (Electronic visit verification required for personal care services)
Home health services (skilled nursing, home health aid, physical therapy, occupational therapy, and speech therapy)	Limits (Electronic visit verification required and may require prior authorization): • 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: • Routine care (If member is residing in a nursing facility, room-and-board charges covered at 95 percent) • 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
Inpatient hospital supplies	Covered

Covered services: Medicaid Services	Coverage limits
Inpatient physician services	Covered, includes anesthesia
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 inpatient treatment	Covered as medically necessary (may require prior authorization)
Mental health/behavioral health outpatient treatment	Covered as medically necessary (may require prior authorization)
Newborn child coverage	Covered
Non cosmetic reconstructive surgery	Covered as medically necessary (may require prior authorization)
Nonemergent transportation (NEMT)	Covered
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): • 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 pairs 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

Covered services: Medicaid Services	Coverage limits
Pharmacy	Limits (may require prior authorization): • Prior authorization is required as specified in the Preferred Drug List (PDL) at **iowamedicaidpdl.com**. Exclusions may apply. • 72-hour emergency supply; this does not apply to Repatha, Praluent, or Xofluza. • 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 include: ○ 31-day supply for most prescriptions, except contraceptives, which allows up to a 90-day supply. ○ Select maintenance medications require a 90-day supply. The first two fills of a medication may be filled at a 30-day supply, for a total of 60 days before the 90-day supply requirement. Please refer to the 90-day supply prescription list that is maintained on the State PDL website. ○ Initial 15-day supply limit for certain drugs ○ Quantity limits for certain drugs
Physician services (office visits, physician emergency room visits, inpatient hospital visits and consultations)	Covered
Physical therapy	Covered
Prescription and nonprescription drugs for smoking cessation	Covered
Prescription drug coverage - quantity	31-day supply for most prescriptions, except contraceptives, which allows up to a 90-day supply. Additionally, select maintenance medications require a 90-day supply as listed on the State PDL website.
Prescription drug generic copay	Covered
Prescription drug nonpreferred brand name copay	Covered
Prescription drug preferred brand name copay	Covered
Prescription oral contraceptives	Covered
Preventive care	Covered
Primary care physician services	Covered
Private duty nursing services	Covered up to age 21 under EPSDT
Prosthetics	Covered as medically necessary (may require prior authorization)
Prostate cancer screening	Covered as medically necessary
Psychiatric medical institutions for children (PMIC)	Covered (may require prior authorization)
Pulmonary rehabilitation	Covered, Prior authorization may be required

Covered services: Medicaid Services	Coverage limits
Radiation therapy	Covered as medically necessary (may require prior authorization)
Reconstructive surgery (Non cosmetic)	Covered as medically necessary
Routine check-ups	Covered
Screening mammography	Covered as medically necessary
Screening Pap test	Covered as medically necessary
Second surgical option	Covered
Sexually transmitted infection (STI) and sexually transmitted disease (STD) testing	Covered
Skilled nursing facility	Covered, limitations apply
Sleep apnea treatment	Covered (may require prior authorization)
Sleep study testing	Covered (may require prior authorization)
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

Covered services: Medicaid Services	Coverage limits
Transplant – organ and tissue	May require prior authorization. Limited to the following specified medical conditions and diagnoses: • 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: • 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

Covered services: Medicaid Services	Coverage limits
Vision frames and lenses	Frame services and single vision and multifocal lens services are covered: • 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: • 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: • For adults age 21 and older, once every 12 months • For children younger than age 21
Vision services	Limits: one per 12-month period
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 does not show all benefits. For more information, contact Provider Services at **833-731-2143**.

Noncovered Services: Medicaid Services

Noncovered Services: Medicaid Services	Details
Acupuncture	Not covered
Infertility diagnosis and treatment	Not covered
Pharmacy	Noncovered drug categories include: • 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 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 the 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.) • Covered Part D drugs for members enrolled in Medicare • Drugs prescribed with intention to alter primary or secondary sex characteristics related to a member's gender dysphoria

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

Covered Services: Hawki

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

Covered Services: Hawki	Details
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)
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 the 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

Covered Services: Hawki	Details
Hospital inpatient services	Covered services include: • Room and board (semi-private) Services that are covered as medically necessary include: • Supplies • Outpatient facility or surgi-center • Anesthesia • Surgery
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: hospital (inpatient or outpatient)	Covered, limitations may apply
Injections: physician's office	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: • Physician medical services • Hospital inpatient service for maternity • Room and board • Miscellaneous
Mental/behavioral health and substance use 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)
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: • Home visits or nursing facility visits • Allergy testing • Allergy injections Immunizations (cannot use Vaccines for Children [VFC])
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

Covered Services: Hawki	Details
Pharmacy	Covered as medically necessary; follow the Iowa Preferred Drug List (PDL)
Physician services	Covered services include: • Office visits • Physician emergency room visits Inpatient hospital visits and consultations
Physician surgical services	Covered services include: • Office • Inpatient • Outpatient
Podiatry	Covered
Prescription drug coverage - quantity	31-day supply for all prescriptions, except contraceptives, which allows up to a 90-day supply. Additionally, select maintenance medications require a 90-day supply as listed on the State PDL website.
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
Preventive care	Covered services include routine preventive physical exams, including well-childcare and gynecological exams
Primary care physician services	Covered
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 apnea treatment	Covered (may require prior authorization)
Sleep study testing	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)

Covered Services: Hawki	Details
Temporomandibular joints (TMJ) treatment	Services that are medically necessary; osteotomy not covered.
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: • Hospital (inpatient or outpatient) • Office As medically necessary: • Radiation therapy and chemotherapy

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

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
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
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
Nonemergency medical transportation	Not covered
Outpatient rehabilitative therapy (physical, occupational, speech, cardiac and pulmonary)	As medically necessary for physical and speech. Not covered for cardiac or pulmonary.

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

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

Covered Services: Iowa Health and Wellness Plan

Covered services: Iowa Health and Wellness Plan	Coverage limits
Affordable Care Act (ACA) preventive services	Covered
AIDS/HIV parity	Covered
Allergy testing and injections	Covered as medically necessary
Ambulance	Covered
Ambulatory surgical center	Covered, includes anesthesia
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	Covered, limitations may apply
Colorectal cancer screening	Covered
Congenital abnormalities correction	Covered as medically necessary
Contraceptive devices	Covered
Counseling and education services	Limits – noncovered services include: • 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.
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)

Covered services: Iowa Health and Wellness Plan	Coverage limits
Durable medical equipment (DME) and durable medical supplies (DMS)	Covered; a DME purchase less than $500 may not require prior authorization. This does not apply to DMS. Limits – noncovered services include: • Elastic stockings and bandages • Trusses • Lumbar braces • Garter belts • Similar items that can be purchased without a prescription
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
Emergency medical transportation	Covered as medically necessary
Emergency room services	Covered; nonemergency medical services are subject to a copay.
Eyeglasses	Covered for ages 19 to 20, limitations may apply Note: For members that qualify as medically exempt, eyeglasses are 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: • Routine care (If member is residing in a nursing facility, room-and-board charges covered at 95 percent) • Facility respite • Inpatient hospital continuous	• 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.
Inhalation therapy	Limit (may require prior authorization): 60 visits in a 12-month period
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: Iowa Health and Wellness Plan	Coverage limits
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: • Elastic stockings and bandages • Trusses • Lumbar braces • Garter belts • Similar items that can be purchased without a prescription
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.
Mental health/behavioral health outpatient treatment	Covered (may require prior authorization)
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: • 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

Covered services: Iowa Health and Wellness Plan	Coverage limits
Pharmacy **Pharmacy** *(continued)*	Covered (may require prior authorization) Limits: • Prior authorization is required as specified in the Preferred Drug List (PDL) at **iowamedicaidpdl.com**. Exclusions may apply. • 72-hour emergency supply; this does not apply to Repatha, Praluent, or Xofluza. • 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 include: ○ 31-day supply for most prescriptions, except contraceptives, which allows up to a 90-day supply. ○ Select maintenance medications require a 90-day supply. The first two fills of a medication may be filled at a 30-day supply, for a total of 60 days before the 90-day supply requirement. Please refer to the 90-day supply prescription list that is maintained on the State PDL website. ○ OTC drugs – minimum of 100 units per prescription, or currently available consumer package ○ Initial 15-day supply limit for certain drugs ○ Quantity limits for certain drugs • 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 the 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	Covered (may require prior authorization) **Limit**: 60 visits per year **Noncovered**: Inpatient physical therapy in the absence of a separate medical condition requiring hospitalization
Physician services (office visits, physician emergency room visits, inpatient hospital visits and consultations)	Covered
Preventive care	Covered
Primary care illness/injury physician services	Covered

Covered services: Iowa Health and Wellness Plan	Coverage limits
Prescription drug coverage - quantity	31-day supply for most prescriptions, except contraceptives, which allows up to a 90-day supply. Additionally, select maintenance medications require a 90-day supply as listed on the State PDL website.
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 oral contraceptives	Covered
Private duty nursing/personal cares per EPSDT authority	Covered up to age 21 under EPSDT
Prostate cancer screening	Limit: one per year for men ages 50-64
Prosthetics	As medically necessary (may require prior authorization)
Psychiatric Medical Institutions for Children (PMIC)	Covered for 19- to 20-year-olds. Limitations may apply. (may require prior authorization)
Pulmonary rehabilitation	Covered as medically necessary (may require prior authorization)
Pulmonary therapy – outpatient	Limit: 60 visits per year
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 mammography	Covered, limit: one screening per year
Screening Pap test	Covered as medically necessary
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): • Services must be for a diagnosis of sleep apnea • Treatment for snoring (without a diagnosis of sleep apnea) is not covered
Specialist office visit	Covered
Specialty physician services	Covered as medically necessary
Speech therapy - outpatient	Covered, limit: 60 visits per year

Covered services: Iowa Health and Wellness Plan	Coverage limits
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. (may require prior authorization) Residential treatment is not covered.
Temporomandibular joints (TMJ) treatment	Covered
Tobacco cessation	Covered
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 **Transplant – organ and tissue** *(continued)*	Covered, requires prior authorization Limited to the following specified medical conditions and diagnoses: • 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: • 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

Covered services: Iowa Health and Wellness Plan	Coverage limits
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 does not show all benefits. For more information, contact Provider Services at **833-731-2143**.

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

Noncovered services: Iowa Health and Wellness Plan	Details
Pharmacy	Noncovered drug categories include: • 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 the 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.) • Covered Part D drugs for members enrolled in Medicare • Drugs prescribed with intention to alter primary or secondary sex characteristics related to a member's gender dysphoria.
Psychiatric medical institutions for children (PMIC)	Not covered
Vision frames and lenses	Not covered

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

Covered Services: Substance Use Disorder Services

Covered services	Coverage limits
Clinically managed high intensity residential 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
Court-ordered evaluation for substance use	Covered as medically necessary
Evaluation, treatment planning and service coordination	Covered as medically necessary

Intake assessment and diagnosis services	Covered services include:
	• Appropriate physical exam
	• Urine screening
	• All needed medical testing to:
	  ○ Decide a substance use disorder diagnosis
	  ○ Identification of a medical or health problems
	Screen for contagious diseases

Intensive outpatient treatment	Covered as medically necessary
Medically monitored intensive inpatient treatment	Covered as medically necessary
Outpatient treatment	Covered as medically necessary
Partial hospitalization (day treatment)	Covered as medically necessary
Substance use counseling services through approved opioid treatment programs licensed under Iowa Code Chapter 125	Covered
Substance use 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

Covered services	Coverage limits
Substance use treatment services	Services vary based on the level of service and may include but are not limited to: • 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 use treatment • Diagnostic urine testing, specific to substance use treatment • Psychiatric, psychological, and medical lab testing, specific to substance use disorder treatment • Equipment and supplies Cost of prescription drugs

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

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 HHS's HCBS Provider Manual at **hhs.iowa.gov/media/4323** for required covered services and minimum coverage limits.
1915 (i) Habilitation services	Must meet Habilitation needs-based eligibility criteria. Providers may reference the HHS's Habilitation Provider Manual at **hhs.iowa.gov/media/4322/download** for required covered services and minimum coverage limits.

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

Chiropractic Services

For chiropractic services, Wellpoint will comply with the Iowa Department of Health and Human Services provider manual located at **hhs.iowa.gov/media/4314/download?inline**. Benefit limits are calculated using a rolling 12-month period rather than a calendar year. This means the applicable benefit limit is determined based on the prior 12 months from the date of service, not January 1 through December 31, for any chiropractic visit the member had in this time frame. The limits are defined based upon IA HHS categorization of diagnostic categories I, II, or III.

Covered Services: Value-Added Services

Wellpoint helps care for and address the specific needs of members by offering a suite of extra benefits and services, referred to as value-added services. These value-added services, which often come in the form of a gift card or shipped item, aim to promote healthier behaviors and outcomes, bridge resource gaps, empower independence, and prioritize member choice. We offer extra benefits to members who have completed annual wellness visits, are diagnosed with certain health conditions, and have specific social barriers that impact their access to care.

Each value-added service offered by Wellpoint has its own unique eligibility criteria and limitations. For eligibility details on Wellpoint's value-added services, members and providers may visit **wellpoint.com/ia/medicaid/member-materials** to review the Member Handbook.

Educational materials about our value-added services are also available upon request with your Wellpoint representative. **Note:** Value-added services and eligibility criteria are subject to change.

Members can also view what extra benefits they are eligible for by logging in to the secure member portal at **wellpoint.com/ia/medicaid** and navigating to the Benefit Reward Hub. Members may also call Member Services at **833-731-2140** (TTY **711**).

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?
   - Wellpoint confirms member enrollment and the member's information is passed 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.
   - 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).

- 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 month's 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, Wellpoint, 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
      a. NRT – 24 weeks combined therapy within a twelve-month period.
      b. Chantix – 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 ml
      b. Oral Smoking Cessation Therapy
         i. Bupropion (for smoking cessation) – 60 tablets per 30 days
         ii. Chantix – 556 tablets per 28 days
         iii. Chantix Starter Pak – 53 tablets per 28 days
   3. Age Edit – Payable for members 18 years of age and older. Prior authorization required for those <18.

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.

- 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 **covermymeds.com** or by fax to **844-512-9004**. Wellpoint's Pharmacy PA forms are located at **provider.wellpoint.com/iowa-provider/resources/forms**. This process allows the member to pick up the prescription at a retail pharmacy if the non-preferred PA is approved.

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-$50, which is loaded to a Healthy Rewards account and can be redeemed for gift cards from a variety of merchants and retailers.

Members can enroll in the program by calling **888-990-8681** (TTY **711**), Monday through Friday, 8 a.m. to 7 p.m. Central time, or by logging in to their secure member portal at **wellpoint.com/ia/medicaid** > **Benefit Reward Hub**. For more information on the Healthy Rewards program, members can visit **wellpoint.com/ia/medicaid/extras/healthy-rewards**. Incentives and retailers are subject to change.

[1] **https://hhs.iowa.gov/programs/welcome-iowa-medicaid/provider-services/medicaid-pharmacy**

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, controlling high blood pressure, health risk assessment completion, prenatal and postpartum exams, wellness visits, and vaccines. For a current list of all incentives, 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).

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 HHS Member Services Unit toll free at **800-338-8366**, Monday through Friday from 8 a.m.-5 p.m. Central time.

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.

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 their need for medication. If the contract is violated, the provider has the right to drop the member from their practice.

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 **provider.wellpoint.com/ia**.

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	MCNA Dental
800-544-0718 (toll-free) **515-261-5500** (local) **888-287-7312** (TDD)	**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
- 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

- 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
- 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

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.

Nonemergent Transportation Services

Nonemergent transportation is a benefit managed by MTM Health 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 MTM Health, 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 when authorized in the member's service plan. Waiver Transportation services are intended to support access to community-based activities such as employment, day programs, essential shopping, and other community integration needs. To schedule transportation services for waiver members that have transportation authorized in their service plan.

Transportation to medical, dental, and behavioral health services must be accessed through the State Plan Non-Emergency Medical Transportation (NEMT) benefit. For NEMT 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

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 Disabilities waiver
- Physical Disability waiver

The Habilitation Services program is also available under CMS waiver authority 1915(i); applicants must meet the needs-based eligibility criteria.

Below is more information on each program.

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 Choices Option (CCO)
- Attendant Care Services (AC)
- Counseling services
- Home-delivered meals
- Home health aide
- Homemaker Home Maintenance Support
- 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 positive behavioral support and consultation
- Consumer Choices Option (CCO)
- Attendant Care Services (AC)
- Enabling technology for remote supports
- Family counseling and training services
- Home and vehicle modification
- Interim medical monitoring and treatment
- Medical day care for children
- Personal emergency response
- Prevocational services
- Respite
- Specialized medical equipment
- Supported community living
- Supported employment
- Transportation

Children's Mental Health Waiver

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
- Medical day care for children
- 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
- Consumer Choices Option (CCO)
- Chore Assistance
- Attendant Care Services (AC)
- Home and vehicle modification
- Home-delivered meals
- Home health aide
- Homemaker-Home Maintenance Support
- 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
- Consumer Choices Option (CCO)
- Attendant Care Services (AC)
- Counseling
- Home-delivered meals
- Home health aide
- Homemaker Home Maintenance Support
- IMMT
- Home and vehicle modification
- Medical day care for children
- 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
- Consumer Choices Option (CCO)
- Attendant Care Services (AC)
- Prevocational services
- Day habilitation
- Enabling technology for remote supports
- Respite services
- Home and vehicle modification
- Medical day care for children
- 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 physical 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:

- Consumer Choices Option (CCO)
- Attendant Care Services (AC)
- Home and vehicle modification
- Personal emergency response
- Specialized medical equipment
- Transportation

Habilitation Services Program

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

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)
    - Note, rehabilitative services provided in a NF/SNF are the responsibility of the facility and not payable separately.
- 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 is 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)
    - Note: Rehabilitative services provided in a NF/SNF are the responsibility of the facility and not payable separately.

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.

In Lieu of Services (ILOS) for Members on HCBS Waiting Lists

Members on a waiting list for 1915(c) HCBS services may access additional supports and services to address health and safety needs while they are waiting for an HCBS waiver slot. Members must meet certain criteria which include being at imminent risk of hospitalization or nursing home placement. Members not eligible for ILOS are those currently enrolled in an HCBS waiver different than the one they are waiting for, members not eligible for the HCBS waiver waiting list, members who can meet the need through another resource, and members who are enrolled in Hawki or Iowa Health and Wellness Medicaid plans. To qualify, members must speak with a Wellpoint representative who will complete a telephonic needs-based assessment with the member and/or their guardian. Eligible members will be assigned a community-based case manager to ensure appropriate services and supports are requested and provided. All ILOS supports and services require prior authorization which are submitted by a community-based case manager. Information about ILOS is found on the Wellpoint Iowa provider website. Providers can email providersolutionsia@wellpoint.com for additional information or to make a referral.

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	Telephone
844-556-6121	Care Management at **833-731-2143**

Providers can obtain the status of a precertification request by visiting our provider website at **provider.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**.

Continuity of Care for Newly Enrolled Members
For members newly enrolled with Wellpoint, previously authorized services will be honored for up to 30 calendar days following the member's effective date of enrollment. This applies regardless of whether the prior authorization was issued to an in-network or out-of-network provider. Providers must submit authorization requests to Wellpoint for continued services beyond the 30-day transition period in accordance with precertification requirements.

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.

Person-Centered Case Management Model

Our approach uses 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.

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 their preferences and confirm the member's interest in LTSS.

During face-to-face assessments meetings, 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.

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.

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.

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 HHS 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 reviewing LTSS eligibility criteria for interested members using a state-approved tool, Wellpoint will refer all potentially eligible members to the state or its designee for completion of a state-approved tool 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.

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 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, they 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 initial face-to-face assessment meeting.

- 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 meeting 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 meeting 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 to 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 can 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 uses 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 can 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.

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 members' 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 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 complied through discussion with the SNF staff as well as a home visit, to identify member preferences and goals.
- Involve and collaborate with community originations 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.

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 a 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) is dependent on the member's need and preference.
- Follow all federal rules and regulations as applicable.
- Provide regular updates related to the care o service delivered
- Participate in discharge planning

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

Consumer Choices Option (CCO) is a Home and Community-Based Service (HCBS) option that allow individuals enrolled in most HCBS waivers more flexibility, choice, and control over how their services and supports are provided.

The Consumer Choices Option gives 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. Members may choose to develop and manage their CCO budget with assistance from their case manager or choose to work with an independent support broker (ISB) who can help to assist the CCO member to develop a CCO budget based on the monthly funds approved by their case manager.

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 Attendant Care Services 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 members' behalf.

To learn more about the CCO program, visit the Iowa Medicaid web site at **hhs.iowa.gov/programs/welcome-iowa-medicaid/cco**.

For more information on Veridian Fiscal Solutions, visit their website at **veridianfiscalsolutions.org/cco**.

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. Training information and resources are available online by accessing the CareBridge website at **carebridgehealth.com/trainingiaevv**

If you have questions or need support using the EVV platform, contact CareBridge at:

	CareBridge EVV Users	Third-Party EVV Users	HHS EVV Frequently Asked Questions
Phone	**844-343-3653**	**844-920-0989**	N/A
Email	iaevv@carebridgehealth.com	evvintegrationsupport@carebridgehealth.com	N/A
URL	N/A	N/A	**hhs.iowa.gov/media/12270/download?inline**

For more on EVV requirements, go to Iowa Medicaid web site at **hhs.iowa.gov/welcome-iowa-medicaid/evv**.

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 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. A 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.

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.

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 their representative specifically requests to transition.
- The member or their 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 use 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.

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:

- Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital.
- Results in the death of any person.
- Requires emergency mental health treatment for the member.
- Requires the intervention of law enforcement.
- 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.
- Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in 1, 2, or 3.
- 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 1, 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**.

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).

Nonemergency Medical Transportation (NEMT)

The following are required for billing NEMT services:

Transportation Companies only Performing NEMT

Transportation companies that only perform NEMT services are required to contract with MTM Health to bill MTM Health and receive payment for services provided. Providers may contact MTM Health at **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 MTM Health. Providers must use a service provider that is contracted with MTM Health, 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 MTM Health to be reimbursed for NEMT services. Providers may contact MTM Health at **888-644-3547** for contract information.

All non-medical HCBS Waiver services transportation provided should be billed directly to MTM Health 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 MTM Health 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 MTM Health 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 MTM Health. HCBS Waiver providers may contact MTM Health 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 MTM Health at **844-544-1389** Monday through Friday, 7:30 a.m. to 6:00 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 MTM Health's Where's My Ride line at **844-544-1390**.

CHAPTER 6: BEHAVIORAL HEALTH SERVICES

Overview

The mission of Behavioral Health at 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), 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.

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 with utilizing the most appropriate, least restrictive medical and behavioral health services 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 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.

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 support for meaningful and productive roles in society
- The elimination of stigma and discrimination

Principles

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

- Members are encouraged 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 (SMI) 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.

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 accreditatior standards.
- use 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 individualized and holistic support and care plan that allows the member to succeed at achieving their recovery and resiliency goals.
- Enhance provider satisfaction and provider success by working to develop collaborative and supportive provider relationships built or mutually agreed upon goals, outcomes, and incentives.
- Encourage 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 mental health and substance use disorder (SUD) services in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by Iowa HHS and Iowa Medicaid. 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.

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 disorders. 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:

Fundamentals of Recovery	Description
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 their own life goals and designs a unique path towards those goals.
Individualized and person-centered	There are multiple pathways to recovery based on an individual's unique strengths and resiliency, as well as their 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.
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 their own destiny and influences the organizational and societal structures in their life.
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), 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.
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.

Fundamentals of Recovery	Description
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.
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.
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.
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.
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.

General Provider Information

How to Become a Behavioral Health Provider in the Wellpoint Network

See our credentialing information in this Provider Manual. If you have questions about the Wellpoint credentialing process before joining our network, send an email to providernetworkia@wellpoint.com or call our Network Development team at **833-731-2143**. If you are being recredentialed, 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.

Services Requiring Precertification

Visit **provider.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.

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 their 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 substance use
  - **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, their 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.

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

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 **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 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 **provider.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.

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, or with referrals to network providers for your patients. If you are calling about precertification for a service that requires precertification, 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.

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 are licensed and meet experience requirements, which generally include at least four years of prior clinical experience.

Notification or Request Preauthorization

The quickest, most efficient way to request prior authorization is through Availity Essentials secure provider website at **Availity.com**. Through the secure provider website, you can access the Availity Essentials multi-payer Authorization and Referral application. This application offers a streamlined and efficient experience for providers requesting inpatient and outpatient behavioral health services for members. Providers can also use this tool to inquire about previously submitted requests regardless of how they were submitted (phone, fax, or other online tool).

- **Initiate preauthorization requests online**, eliminating the need to fax. The Availity Essentials multi-payer Authorization and Referral application allows detailed text, photo images and attachments to be submitted along with your request.
- **Review** requests previously submitted via phone, fax, or other online tool.
- **Instant accessibility** from almost anywhere, including after business hours.
- **Use 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 **Availity Essentials multi-payer Authorization and Referral application** under *Patient Registration* > *Authorizations and Referrals* via Availity Essentials.

For an optimal experience with the Availity Essentials multi-payer Authorization and Referral application, 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. Be prepared to provide clinical information in support of the request at the time of the call.

We do not accept outpatient preauthorization requests via phone. Please refer to the 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 **provider.wellpoint.com/ia**.

Note, all requests for precertification for psychological and neuropsychological testing beyond the four-hour initial limit should be submitted using our preferred electronic method via **Availity.com**.

Clinical Criteria

Wellpoint Clinical Criteria

- In addition to utilizing the "Iowa Definition of Medical Necessity" (see below), Wellpoint uses 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, visit **provider.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, contact Wellpoint Provider Services by email at providernetworkia@wellpoint.com or 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 Medical Necessity Adverse 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 a Wellpoint behavioral health medical director, or other appropriate practitioner.

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.

Reconsideration Process Following Adverse Medical Necessity Determination

Our intent is to ensure that providers have ample opportunity to present necessary clinical information when making service requests.

The Reconsideration process is available after an adverse determination (denial) has been rendered for a behavioral health prior authorization request for Wellpoint Iowa members. The Reconsideration process consists of two options available to providers:

Clinical Documentation Reconsideration
Documentation reconsideration is the process of giving a provider the opportunity to submit additional supporting clinical documentation relevant to a previously denied service request. The additional clinical information will be reviewed to substantiate medical necessity in reconsidering a previous adverse determination.

Peer-to-Peer (P2P) Reconsideration
P2P reconsideration is the process of giving a member's provider the opportunity to have a telephonic discussion of a medical necessity denial decision with a Wellpoint Iowa Behavioral Health medical director. Please note the following:

- Peer-to-peer discussions are not available in situations where an administrative denial decision has occurred.
- A vendor and/or provider who is not involved in the treatment of a member is not eligible to participate in a peer-to-peer discussion.

Time Frames
Time frames for provider request for reconsideration of denied services are as follows:

- Clinical documentation reconsideration request: within two business days of issuance of adverse determination
- Peer-to-Peer request: within two business days of issuance of adverse determination
- Note that requests for clinical documentation reconsideration or peer-to-peer reconsideration do not extend the mandatory 30-day timeframe for a Notice of Appeal Resolution. Reconsideration is not considered to be an appeal and does not limit any appeal rights.

A provider can initiate either of the above reconsideration options after an adverse determination has been rendered by Wellpoint Iowa. To initiate a Clinical Documentation Reconsideration, please fax additional clinical information to **844-442-8016** and identify "Documentation Reconsideration" on the fax cover sheet. To initiate a Peer-to-Peer Reconsideration, please contact the Wellpoint Utilization Management department that denied the initial request.

The reconsideration request will be reviewed to determine whether the initial decision will be overturned or upheld. All reconsiderations are conducted by the Wellpoint Iowa medical director making the initial determination, or an appropriate designee if the original Wellpoint Iowa medical director is not available. Once a decision is rendered on a documentation reconsideration or a peer-to-peer reconsideration, Wellpoint Iowa will notify the provider of the decision by mail. If an adverse determination is upheld, the provider will also be notified of the applicable appeal rights.

Our goal is to work collaboratively with our provider community on behalf of your patients and our Wellpoint members. If you need assistance with questions about any of our communications, our team is here to support you. You are welcome to reach out to your local Provider Relations manager, who is always ready to offer assistance. In addition, Provider Services may be reached via email at providernetworkia@wellpoint.com or by phone at **833-731-2143**.

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 a 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.

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.

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 contacting Provider Services at providernetworkia@wellpoint.com or calling **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 uses the following strategies:

Strategy	Description

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, the member's Health Home team and/or Wellpoint case managers/outreach care specialists 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 (for example, job, family, education, social activities, family background, prior service utilization)
	• 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	• An outreach care specialist 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.
	  ○ 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 they will make a successful transition back into the community.

Strategy	Description
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 use 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 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.

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. To contact Member Services electronically, members will need to log in to their account to then send a message or email.

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.

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 **provider.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 consumers of mental health services 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 **provider.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

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 **provider.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 contact Wellpoint Provider Services at providernetworkia@wellpoint.com or call **833-731-2143**.

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:

- Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital.
- Results in the death of any person.
- Requires emergency mental health treatment for the member.
- Requires the intervention of law enforcement.
- 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.
- Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in 1, 2 or 3.
- 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.

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**.

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).

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 are reasonably expected to improve their condition or prevent further regression, so the services will no longer be needed.

PMICs will provide or assist a member with access to:

PMIC Assistance	Description
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.
Individual plan of care	An individual plan of care is a written plan developed for each member to improve their 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.

PMIC Assistance	Description

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 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 may also be enrolled in an Integrated Health Home. Wellpoint is responsible for the following:

- Coordinating an assessment of needs-based on eligibility with the state's designated assessment vendor
- Service plan review and authorization
- Claims payment
- Provider recruitment
- Provider agreement execution
- Rate setting
- Providing training and technical assistance to providers
- Case management

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 may also be enrolled in an Integrated Health Home. Wellpoint is responsible for the following:

- Coordinating an assessment of needs-based eligibility with the state's designated assessment vendor
- Service plan review and authorization
- Claims payment
- Provider recruitment
- Provider agreement execution
- Rate setting
- Training and technical assistance for providers
- Case management

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

CHAPTER 7: 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 Iowa Health Link or Hawki are required to carry and present their Iowa Health Link or Hawki identification (ID) card when seeking services. The Iowa 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.

How to Verify Member Eligibility

To verify member eligibility, log on to Availity Essentials at **Availity.com**. From Availity Essentials homepage, select **Patient Registration** > **Eligibility & Benefits**.

Providers can also verify member eligibility as follows:

- Real-time member enrollment and eligibility verification for Iowa 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: **hhs.iowa.gov/Eligibility and Verification Information System**
- 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: **provider.wellpoint.com/ia**. Select **Login** or **Register** to access the secure site.

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**.

Identification Cards

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

The front includes the Wellpoint ID, the Iowa 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:

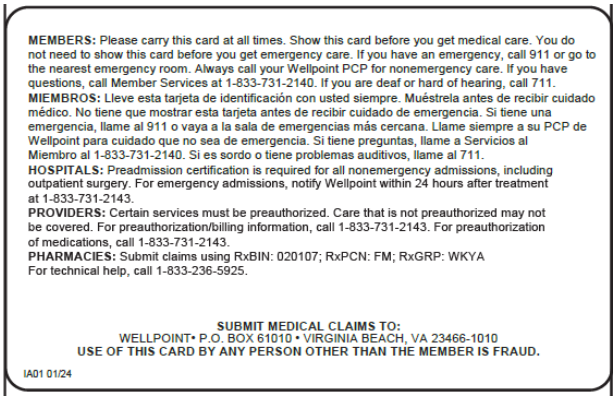
Iowa Health Link

Wellpoint Iowa 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**

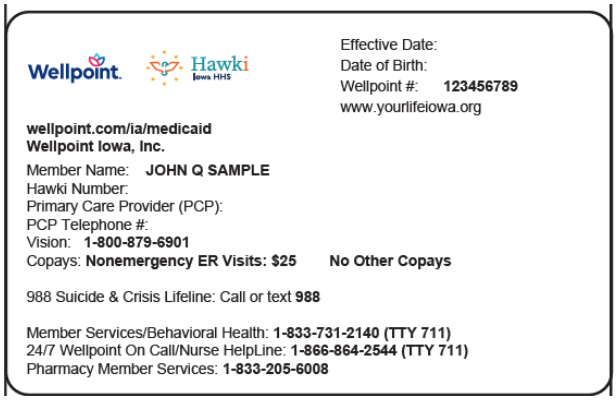


MEMBERS: Please carry this card at all times. Show this card before you get medical care. You do not need to show this card before you get emergency care. If you have an emergency, call 911 or go to the nearest emergency room. Always call your Wellpoint PCP for nonemergency care. If you have questions, 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



Wellpoint Hawki Iowa HHS

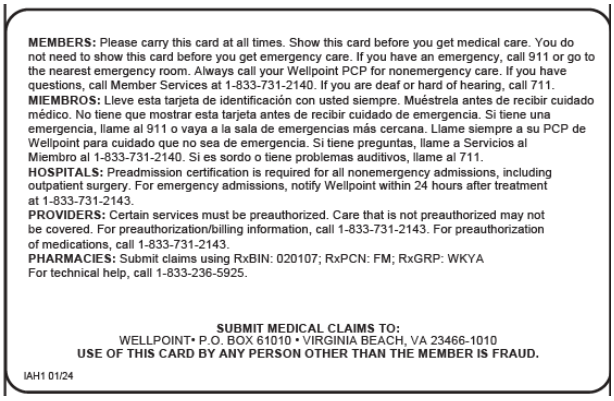
Effective Date:
Date of Birth:
Wellpoint #: **123456789**
www.yourlifeiowa.org

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**



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IAH1 01/24

CHAPTER 8: 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
- Wellpoint 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

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.

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 includes 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

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 **provider.wellpoint.com/ia** > **Precertification Lookup Tool**.

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

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.

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 Board of Pharmacy 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.
- 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 **provider.wellpoint.com/ia** > **Provider Resources & Documents** > **Quick Tools**.

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.

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.

Note, per Iowa Administrative Code (IAC), HHS must approve facility level of care prior to a facility being eligible for payment for long-term care services provided in a facility.

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 Iowa 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 Essentials 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.
    - Following childbirth, patients generally remain in the hospital for at least 48 hours after a vaginal delivery and 72 hours after a cesarean section. If you determine that both mother and baby are in good health, you may consider an earlier discharge. In such instances, it's advisable to arrange a follow-up visit, either in-office or through an in-home nurse, within 48 hours.
  - 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 MTM Health at **844-544-1389** for reservations.
- Physician referrals (in-network for consultations or a nonsurgical course of treatment).
- Standard X-rays or ultrasound.

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: **provider.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.

Information Needed for Medical Necessity Determination

Medical necessity determinations are made:

- Online through Availity Essentials multi-payer Authorization and Referral application at **Availity.com**, by following the prompts to provide all requested information.
- Via fax, by completing the Prior Authorization Request Form found at **provider.wellpoint.com/ia** > **Provider Resources & Documents** > **Forms**.
- By phone, by having the following information available as appropriate to the service request:
  - Member name and Iowa 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 **provider.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.

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.

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.

Routine Requests

For nonurgent requests, the Medical Management department will make a determination as quickly as possible, but always within 7 calendar days of a routine request.

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.

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 that ordinarily would require prior authorization, for example, acute inpatient admission, and acute psychiatric admission

The emergency department should send a copy of the emergency room record to the PCP's office within 24 hours. The PCP should: 1) review and file the chart in the member's permanent medical record, 2) contact the member, and 3) schedule a follow-up office visit or a specialist referral, if appropriate.

The Iowa Health Plan is responsible for coverage and payment of emergency services and post-stabilization care services. The health plan shall cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the health plan. Post-stabilization care services are covered and paid for in accordance with provisions set forth at 42 C.F.R. § 422.113(c).

The health plan may not deny payment for treatment obtained under either of the following circumstances:

- A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in (1), (2), and (3) of the definition of emergency medical condition in **42 CFR §438.114(a)**.
- A representative of the MCO instructs the member to seek emergency services.

The health plan shall cover post stabilization services. Post-stabilization services are covered related to emergency medical condition that are provided after a member is stabilize in order to maintain the stabilized condition, or to improve or resolve the member's condition. The requirements at 42 C.F.R. § 422.113(c) are applied to the health plan. This includes all medical and behavioral health services that may be necessary to assure, within reasonable medical probability, that no material deterioration of the member's condition is likely to result from, or occur during, discharge of the member or transfer of the member to another facility.

A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member. The attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in 42 CFR §438.114(b) as responsible for coverage and payment.

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 use

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.

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 use 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. It is 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.

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.

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:

- Decision
- Process for appeal
- Information on how to contact reviewing physician for peer-to-peer discussion of the case
- Process 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 review number at **844-227-8345** within two business days. A peer-to-peer review is not required to appeal an adverse decision.

Referrals to Specialists

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

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.

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

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

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

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 Iowa 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 perinatal members, 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.

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

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 Healthcare 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.

Preventive Care: Taking Care of Baby and Me®

Taking Care of Baby and Me is a proactive care management program for all perinatal members and their newborns. We use several resources to identify pregnancies as early as possible. Sources of identification may include state enrollment files, claims data, and hospital census reports 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 management services to mitigate risk.

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. They may also collaborate with community partners to facilitate connecting members to local and national agencies who can assist with services and support.

When it comes to pregnancy, we are committed to healthy outcomes for our members and their babies. 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 program which offers:

- Individualized, one-on-one complex care management support for 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 encourage members to keep up with checkups
- Proactive care coordination and complex care management support for parents of infants that are admitted to the neonatal intensive care unit (NICU)

As part of the Taking Care of Baby and Me program, perinatal members have access to a digital perinatal offering. This digital offering is available by smartphone app and provides pregnant and postpartum members with timely, proactive, and culturally appropriate education. 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 allow us to assess their pregnancy risk.

After risk assessment is complete, the app delivers gestational-age appropriate education directly to the member. This digital offering 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 Essentials or fax the forms to Wellpoint at **800-964-3627**.

We also ask that providers complete the Maternity Application in Availity Essentials during the initial Eligibility and Benefits (E&B) request performed on a pregnant member. The information obtained during this process supports our effort to identify pregnancies as early as possible so that we may notify eligible members of various perinatal resources, including the care management program. The steps to complete the Maternity Application are detailed below:

1. Perform an Eligibility and Benefits (E&B) request on the desired member.
2. Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.
3. If the appropriate conditions apply for payer, user, member and service type, the maternity question screen will display. Conditions include:
    - The member is female.
    - The member is 45 years of age or under.
    - The member is 15 years of age or over.
4. If the member is not pregnant, select **No** and **Submit** to continue to the E&B response screen.
5. If the member is pregnant, select **Yes** and **Submit**. You will be prompted to enter additional dates if known:
    - Estimated Due Date
    - First prenatal appointment date
6. When **Yes** is selected, the maternity data entered is saved for this member.
7. After submitting your response, the E&B response screen will display.

We encourage healthcare providers to share information about the Taking Care of Baby and Me program and the digital perinatal app 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 app, call Provider Services at **833-731-2143**, or refer to our website at **provider.wellpoint.com/iowa-provider/patient-care/maternal-child-services**.

Neonatal Intensive Care Unit (NICU) Care Management

If a baby is born premature or with a serious health condition, they may be admitted to the NICU. We believe the more parents know, the better they will be able to care for their infant. To support them, we have a NICU Case Management program.

We extend our support by helping parents to prepare themselves and their homes for when baby is released from the hospital. After baby is home, our case managers continue to provide education and assistance in improving baby's health, preventing unnecessary hospital readmissions, and guiding parents to community resources if needed.

The NICU can be a stressful place, bringing unique challenges and concerns that parents may have never imagined. The anxiety and stress related to having a baby in the NICU can potentially lead to symptoms of post-traumatic stress disorder (PTSD) in parents and caregivers. To reduce the impact of PTSD among our members, we assist by:

- Helping parents engage with hospital-based support programs
- Facilitating parent screenings for potential PTSD
- Connecting parents with behavioral health program resources and community support as needed
- Actively asking for their feedback on the provided resources and how an increased awareness of PTSD has helped

If you have a patient in your care that would benefit from our NICU Care Management program, reach out to Provider Services at **833-731-2143**, or refer to our website at **provider.wellpoint.com/iowa-provider/patient-care/maternal-child-services**.

Preventive Care: Long-acting Reversible Contraception

Iowa 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 **provider.wellpoint.com/ia**.

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 conditions are accredited by National Committee for Quality Assurance 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 **provider.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 programs and services provided, our staff, and our staff's qualifications and any contractual relationships.
- Decline to participate in or work with the Wellpoint programs and services for their 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
Call **888-830-4300** (TTY: **711**) to reach a case manager or contact us by email at condition-care-provider-referrals@wellpoint.com. Go to **provider.wellpoint.com/ia.** For additional information about Condition Care.

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 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.

Some examples:

- 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 **hhs.iowa.gov/programs/wic-Iowa**.

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 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 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, members 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?

1. 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.
2. 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 to Real Solutions Tobacco Cessation Program by Wellpoint c/o National Jewish Health, 1400 Jackson St., S117A Denver, CO 80206.
3. 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 two months' supply of patches, lozenges, or gum.

Provider Assessment of Smoking Use

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

- Assess the member's' smoking status and offer advice about quitting.
- Use the state's online Notification of Pregnancy form 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 advising the member to 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

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 **Availity.com** > **Claims & Payments** > **Claim Status**.

When viewing the status of a claim on Availity Essentials, 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

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:

1. CMS-1500 for professional services: **cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1188854**
2. CMS-1450 (UB-04) for institutional services: **cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1196256**

Using the wrong form or not correctly or completely filling out the form 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. 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 EDI submission Options

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, visit **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, partner with them to ensure you are receiving all reports. It is 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 Client Servies at **800-AVAILITY** (**800-282-4548**).

Availity EDI Payer ID
WLPNT

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

Electronic Remittance Advice (ERA)

The 835 eliminates the need for paper remittance reconciliation. Use Availity Essentials to register and manage ERA account changes with these three easy steps:

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

Note, if you use a clearinghouse or vendor, 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 (**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 **provider.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.

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.

National Provider Identifier (NPI)

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, **nppes.cms.hhs.gov**. Or request a paper application by calling NPPES at **800-465-3203.**

The following websites offer additional NPI information:

- CMS: **cms.gov**
- NPPES: **nppes.cms.hhs.gov**
- Workgroup for Electronic Data Interchange: **wedi.org**
- National Uniform Claims Committee: **nucc.org**

Atypical Providers
Atypical providers are businesses that are not healthcare providers and do not meet the definition of a healthcare provider according to the NPI rules. Atypical providers are required to use the state assigned atypical NPI number given to them by the state of Iowa to take the place of the NPI. Providers should report the full atypical provider identification number in addition to the outlining requirement for the G2 qualifier.

Below are the types of providers that 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 Attendant care services Agency
- Homemaker Home maintenance support services
- Companion services
- Home and vehicle modification/repair services
- Transportation services

Enrollment in Iowa Medicaid

To be reimbursed for services by Wellpoint, providers must successfully complete Iowa Medicaid's provider enrollment process. This includes billing, rendering, attending, operating and referring providers, though not all NPIs are required on all types of claims. All providers must bill with their NPI number in box 24J (b) (rendering provider) with the exception of FQHC, RHC, Indian Health, Chapter 24 providers or providers with an atypical NPI. Providers enroll by completing an online enrollment application at **hhs.iowa.gov/welcome-iowa-medicaid/provider-forms**.

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 two parts to ICD-10:

1. ICD-10-CM (Clinical Modification) used for diagnosis coding
2. 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.

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 180 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.

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.

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	Physician and other professional services. Specific ancillary services, including the following: • 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 Some ancillary providers may use a CMS-1450 form if they are ancillary institutional providers. Ancillary charges by a hospital are considered facility charges.	Submit within 180 days of service date.
CMS-1450 Claim Form	Hospitals, institutions, and home health services.	Submit within 180 days of service date.

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 the claim status at any time by calling Provider Services or accessing Availity Essentials platform, through our website at **provider.wellpoint.com/ia**. Refer to the Monitoring Submitted Claims 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 **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 obtaining an 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 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

Balance Billing

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

The provider should provide the member with the estimate cost before services are provided. The amount should not exceed fee schedule allowable.

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 their right to file a grievance if the member disagrees with the decision to deny authorization.
- Inform the member of their 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 a Wellpoint payment resulting from a denial of authorization.

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.

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 denied with a directive 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 a 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 Exception

Providers are not always required to coordinate first with the liable third party. When the claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program, we will first pay the provider and then coordinate with the liable third party.. Following reimbursement to the provider in this cost avoidance exception case, 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.

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 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 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.

Payment of Claims

After filing an electronic claim, you should generally 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.

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

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**.

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 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 **provider.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 **provider.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 newly 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.

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.

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 **provider.wellpoint.com/ia**. Select **Login** or **Register** to access the secure site.
- Contact Provider Services at **833-731-2143**.

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.

Note, many of the claims returned for further information are returned for common billing errors.

Reference: Covered Services

For a listing of covered services, see the **Covered and Noncovered Services** chapter.

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 possible inappropriate or fraudulent billing.
- Involves individuals under integrated case management or condition care.
- Involves termination of pregnancy: All termination of pregnancy claims requires 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.
- Is the subject of an internal or external audit, including high-dollar claims.
- 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.

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 Iowa 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.

Problem	Explanation	Resolution
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.
Unreasonable Numbers Submitted	Unreasonable numbers, such as "9999", may appear in the Service Units fields.	Check your claim for accuracy before submission.

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 payment must meet all aspects of criteria for reimbursement. 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 conditions of payments.

Schedules and Updates to Reimbursement Policies
Reimbursement policies undergo reviews for updates to state , federal or CMS contracts and/or requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to a Wellpoint business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will 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 (for example, CPT, HCPCS, ICD diagnosis/procedures, revenue codes).
- 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
- Home and Community-Based Services (HCBS)
- Independent Lab
- Independent Speech Pathologist
- Indian Health Services
- Lead Inspection Agencies
- Maternal Health Center
- Medical Supplies
- Nurse Practitioner
- Optician
- Optometrist
- Orthopedic Shoe Dealer
- Pharmacist
- Pharmacy
- Physical Therapist
- Physician
- Podiatrist
- Psychologist
- Psychiatric Medical Institute for Children
- Psychologist
- Public Health Agencies
- Rehabilitation Agency
- Screening Center
- Subacute Mental Health Services

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)
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.

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.

Behavioral Health Facility

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

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

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

- Bill with correct place of service (50 – FQHC; 72–RHC)
- Bill with appropriate encounter codes and CPT codes
- Bill with the group NPI in box 24J or leave the box blank

Intermediate Care Facility

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

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.

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.

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 claim denials.
- Occurrence codes: Claims will deny if the following elements are missing or not filled out appropriately:
    - Begin date of the applicable hospice election period is missing
    - Date of service billed is not within the election period
    - 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.

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. Our vendor-partner or our internal team may review these claims as part of our itemized bill review (IBR) program to ensure appropriate reimbursement. Upon completion of the review, documentation, including a summary of adjusted charges, will be provided for each claim. Disputes related to the review may be submitted according to the instructions in the Claims Payment Disputes section of this manual.

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, Blood Products, and Administration

Blood and blood products such as platelets or plasma are reimbursable. Administration of Blood or Blood Products by nursing/facility personnel are not separately reimbursable on inpatient claims. Administration of Blood or Blood Products by nursing/facility personnel billed on outpatient claims is separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage, transportation, processing, and preparation such as thawing, splitting, pooling, and irradiation are also not separately reimbursable. Lab tests such as typing, Rh, matching, are separately reimbursable charges.

Emergency Room Supplies and Services Charges

The Emergency Room level reimbursement includes all monitoring, equipment, supply, 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. See Facility Personnel Charges and Nursing Procedures sections for additional information.

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 or procedure charge. 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), therapeutic, prophylactic, or diagnostic intravenous (IV) injections or infusion or IV fluid administration/monitoring, call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services, and chemotherapy infusion/administration/monitoring. Charges for Outpatient Services for facility personnel are also not separately reimbursable and are included in the reimbursement 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, are not separately reimbursable and are included as part of the Operating Room (“OR”) time/procedure reimbursement. Charges for medications/drugs used for sedation and local anesthesia are separately reimbursable.

Lab Charges

The reimbursement of charges for specimen collection is 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, handling, 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 therapeutic, prophylactic, or diagnostic intravenous ("IV") injections or infusion or IV fluid administration/monitoring, intramuscular ("IM") injections, subcutaneous ("SQ") injections, nasogastric tube ("NGT") insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, pulse oximetry) and inpatient blood transfusion administration/monitoring and inpatient chemotherapy infusion/administration/monitoring (with the exception of OP blood administration, OP chemotherapy administration, or OP infusion administration which are submitted without a room charge, observation charges, treatment room charges, or procedure charges other than blood, chemotherapy, or infusion administration).

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 is defined as surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac cath labs, Hybrid Rooms, X-ray, pulmonary and cardiology procedural rooms. The operating room charge will reflect the cost of:

- Use of the operating room
- Services of qualified professional and technical personnel
- Any supplies, items, equipment, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services (Refer to Routine Supplies section of the manual).

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, eye lubricants, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste.

Pharmacy Charges

Pharmacy charges will be reimbursed to include only the cost of the drugs prescribed by the attending physician. Medications furnished to patients shall not include an additional separate charge for 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. 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 the 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. Reimbursement for the procedure includes all nursing care provided.

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 all used and/or available services, equipment, monitoring, and nursing care that is necessary for the patient's welfare and safety during their 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 or step-down recovery room, for example, arteriograms.

Respiratory Services

Mechanical ventilation/CPAP/BIPAP support and other respiratory and pulmonary function services provided at the bedside are considered facility personnel, equipment, and/or supply charges and not eligible for separate reimbursement.

Routine Supplies

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 supplies and not separately reimbursable in inpatient and outpatient environments. Reimbursement for routine services and supplies is included in the reimbursement for the room, procedure, or observation charges.

Special Procedure Room Charge

Charges for Special procedure room, billed in addition to the procedure itself, are included in the reimbursement for the procedure. If the procedure takes place outside of the OR (Refer to Operating Room Time and Procedure Charges for OR definition), then OR time will not be reimbursed to cover OR personnel/staff being present in the room, for example, procedures performed in the ICU, ER.

Stand-by Charges

Standby equipment and consumable items such as oxygen, which are on standby, are not reimbursable. Only actual use is covered. 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, isolation carts, mechanical ventilators, continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BIPAP) machines, and related supplies are not separately reimbursable. Oxygen charges, including but not limited to, oxygen therapy per minute/per hour when billed with room types ICU/CCU/NICU or any Specialty Care area are not separately reimbursable.

Tech Support Charges

Pharmacy Administrative Fees (including mixing medications), any portable fees for a procedure or service, patient transportation fees when taking a patient to an area for a procedure or test are not separately reimbursable. Transporting a patient back to their room following surgery, a procedure, or test, is 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

Calculation	Description
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 in 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.

Undocumented or Unsupported Charges

Charges that are not documented on medical records or supported with documentation are not reimbursed.

Video or Digital Equipment used in Procedures

Charges for video or digital equipment used for visual enhancement during a procedure are included in the reimbursement for the procedure and are not separately reimbursable. Examples include but are not limited to Ultrasound and Fluoroscopy guidance including but not limited to, for access and/or placement of medical devices, implants, or lines. Charges for items such as batteries, covers, film, anti-fogger solution, and tapes are also not separately reimbursable.

Additional Reimbursement Guidelines for Disallowed Charges

For any claims that are reimbursed at a percent of charge, only Charges for Covered Services are eligible for reimbursement. 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 the provider or facility agreement. Refer to the contractual fee schedule for payment determination.

The following tables illustrate examples of non-reimbursable items/services codes, including but not limited to:

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically billed under the identified revenue code(s) but not Limited to below list	**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 Procedures

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically billed under the identified revenue code(s) but not Limited to below list	**Description of Excluded Items**
0270, 0271, 0272	**Supplies and Equipment** Blood Pressure cuffs/Stethoscopes Thermometers, Temperature Probes, 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) 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 Supplies and Equipment (continued) 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) 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 and staple removers, sutures, scalpels, blades) IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, heparin, and saline flushes)

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically billed under the identified revenue code(s) but not Limited to below list	**Description of Excluded Items**
0220 – 0222, 0229, 0250	**Tech Support Charges** 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 and 99001 – Handling and/or conveyance of specimen from patient (charge for specimen handling
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** Medication prep Nonspecific descriptions Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges IV Solutions 250 cc or less, except for pediatric claims Miscellaneous Descriptions Compounding Fees
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	**Venipuncture** Specimen collection Draw fees Venipuncture Phlebotomy Heel stick Blood storage and processing blood administration Thawing/Pooling Fees

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically billed under the identified revenue code(s) but not Limited to below list	**Description of Excluded Items**
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time)
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 Heel/Elbow Protector Burrs Cardiac Monitor EKG Electrodes Vent Circuit Suction Supplies for Vent Patient Electrocautery Grounding Pad 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

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically billed under the identified revenue code(s) but not Limited to below list	**Description of Excluded Items**
0370 – 0379, 0410, 0460, 0480 – 0489	**Anesthesia (specifically, conscious/moderate sedation by same physician or procedure nurse)** Nursing care Monitoring Intervention Pre- or Post-evaluation and education IV sedation and local anesthesia if provided by same physician or procedure nurse Intubation/Extubation CPR
0410	**Nursing Respiratory Functions** Oximetry Vent management Medication Administration via Nebs, Metered dose (MDI) Postural Drainage Suctioning Procedure
0940 – 0945	Education/Training

CHAPTER 11: 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 Iowa 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.

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:

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

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)

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

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

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

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.

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.

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.

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
Z30.40	Encounter for surveillance of contraceptives, unspecified
Z30.41	Encounter for surveillance of contraceptive pills
Z30.431	Encounter for routine checking of intrauterine contraceptive device
Z30.42	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
Z31.42	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

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 as defined by **IA Health and Human Services** > **Vaccines for Children Program**. 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
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) absorbed, 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
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

HCPCS/CPT Code	Description
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

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.

Laboratory Services

We are bound by the Clinical Laboratory Improvement Amendments (CLIA) of 1988. The purpose of the CLIA program is to ensure laboratories testing specimens in interstate commerce consistently provide accurate procedures and services. As a result of CLIA, any laboratory soliciting or accepting specimens in interstate commerce for laboratory testing is required to hold a valid license or letter of exemption from licensure.

Claims that are submitted for laboratory services subject to the Clinical Laboratory Improvement Amendments of 1988 (CLIA) statute and regulations require additional information to be considered for payment.

To be considered for reimbursement of clinical laboratory services, a valid CLIA certificate identification number must be reported on a 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent for clinical laboratory services. The CLIA certificate identification number must be submitted in one of the following manners:

Claim format and elements	CLIA number location options	Referring provider name and NPI number location options	Servicing laboratory physical location
CMS-1500 (formerly HCFA-1500)	Must be represented in field 23	Submit the referring provider name and NPI number in fields 17 and 17b, respectively.	Submit the servicing provider name, full physical address and NPI number in fields 32 and 32A, respectively, if the servicing address is not equal to the billing provider address. The servicing provider address must match the address associated with the CLIA ID entered in field 23.
HIPAA 5010 837 Professional	Must be represented in the 2300 loop, REF02 element, with qualifier of X4 in REF01	Submit the referring provider name and NPI number in the 2310A loop, NM1 segment.	Physical address of servicing provider must be represented in the 2310C loop if not equal to the billing provider address and must match the address associated with the CLIA ID submitted in the 2300 loop, REF02.

To be considered for reimbursement of reference laboratory services, the referring laboratory must be an independent clinical laboratory. Modifier 90 must be submitted to denote the referred laboratory procedure. Per the Centers for Medicare and Medicaid (CMS), an independent clinical laboratory that submits claims in paper format may not combine non-referred or self-performed and referred services on the same CMS-1500 claim form. Thus, when the referring laboratory bills for both non-referred and referred tests, it must submit two separate paper claims: one claim for non-referred tests and the other for referred tests. If submitted electronically, the reference laboratory must be represented in the 2300 or 2400 loop, REF02 element, with qualifier of F4 in REF01.

Providers who have obtained a CLIA Waiver or Provider Performed Microscopy Procedure accreditation must include the QW modifier when any CLIA waived laboratory service is reported on a CMS-1500 claim form.

Laboratory procedures must be rendered by an appropriately licensed or certified laboratory having the appropriate level of CLIA accreditation for the particular test performed. Thus, any claim that does not contain the CLIA ID, has an invalid ID, has a lab accreditation level that does not support the billed service code, who render services outside of the effective dates of the CLIA certificate, does not have complete servicing provider demographic information and/or applicable reference laboratory provider demographic information, will be considered incomplete and rejected or denied.

Maternity Services

Effective October 1, 2025, Iowa Medicaid requires applicable maternity services to be billed using an unbundled reimbursement methodology when Iowa Medicaid is the member's primary payer and the member's first antepartum visit occurs on or after October 1, 2025.

Providers must bill applicable antepartum, delivery, postpartum, and other pregnancy-related services separately by date of service using the appropriate claim form, CPT/HCPCS codes, modifiers, and ICD-10 diagnosis codes, consistent with current Iowa Medicaid and Wellpoint requirements.

When Medicaid is secondary to commercial insurance or Medicare, providers must follow the primary payer's maternity billing requirements before submitting the claim to Wellpoint. Providers should refer to current Iowa Medicaid guidance and fee schedules for coding and billing updates.

Maternity billing requirements are as follows:

- Bill separately all laboratory tests, pregnancy tests and radiology services provided during pregnancy within the contract filing limit in accordance with HHS effective October 1, 2025. See Maternal Services: **provider.wellpoint.com/iowa-provider/patient-care/maternal-child-services**.
- 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.

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.

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

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
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

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 **hhs.iowa.gov/welcome-iowa-medicaid/provider-forms**.

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 their 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
- 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,

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.

either submitted with the claim or sent separately to the claims department.

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.

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 **hhs.iowa.gov/welcome-iowa-medicaid/provider-forms**. In the Search field, enter search criteria (for example, "abortion certification") and select **Search**.

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 Members for Services Not Medically Necessary

Providers may bill a Wellpoint member for a service that is not medically necessary if all of the following conditions are met:

- Member requests a specific service or item that, in your opinion, may not be reasonable or medically necessary.
- Member requests a specific service or item that, in our opinion, may not be reasonable or medically necessary.
- 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.
- Provider obtains a written acknowledgement verifying that you notified the Wellpoint member of financial responsibility for services rendered.

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 **providers.wellpoint.com/edi**.

CHAPTER 12: 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)

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.

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.

Note, system edits are in place for electronic claims. Claims submitted improperly cannot be processed easily and most likely will be returned.

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.

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.

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.

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.

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.

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 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 **hhs.iowa.gov/welcome-iowa-medicaid/provider-forms**. In the Search HHS Forms Library field, enter search criteria (for example, "abortion certification") and select **Search**.

Note, failure to submit the Certification Regarding Abortion Form correctly will result in denial of the claim.

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

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 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.

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

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
- Weekly summaries for each discipline
- A discharge plan and customized options, identified and implemented from the admission date
- Biweekly conference reports

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

Note, outpatient radiation therapy is excluded from this service category and should be billed under the requirements of the "Other Services" category.

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

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.

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
- Other services incidental to the outpatient infusion therapy visit

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, 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, 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.

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.

Note, because the member's benefits may not cover all of the services listed, confirm benefit coverage first.

Ambulance Services

CMS-1500 is required for all ambulance billing unless otherwise specified by contract or state HHS guidance.

Information for Ambulance Services	Details
Place of Service (POS)	• POS 41 — Ambulance is required on all ambulance claims.
Pick-Up and Drop-Off Information	• Pick-up and drop-off information is required. • Claims will reject if pick-up and drop-off locations are missing or incomplete. **Electronic Claims** (837P) • Pick-Up Location: Loop 2310E • Drop-Off Location: Loop 2310F • Both segments must include a **complete physical address**, including **street, city, state, and ZIP + 4**.
Origin and Destination Modifiers	• Origin and destination information is required • Origin and destination (O/D) modifiers are required for **all ambulance base rate and mileage codes**. • Claims submitted without valid modifiers **will deny**. **Exceptions** (Modifiers not required) • A0998 — Treatment without transport • A0999 — Unlisted ambulance service / GEMT
Prior Authorization/Notification Requirements	• **Emergency ambulance services** do **not** require prior authorization. • **Non-emergent transports** (for example, NEAT / NEMT) **may require authorization** or scheduling through contracted transportation vendors.

<table>
<tr><th>Information for Ambulance Services</th><th>Details</th></tr>
<tr><td>Same-day Repeat Trips (Same Member)</td><td>When multiple ambulance transports occur for the same member on the same date of service:
Each trip must be billed on a separate claim line or separate claim.
Origin and destination modifiers must be reported for each trip.
When O/D modifiers repeat (for example, RH → RH more than once), an additional modifier must be appended to distinguish each transport and prevent duplicate denials.
Acceptable Additional Modifiers (Wellpoint Iowa):<table><tr><th>Modifier</th><th>Description</th></tr><tr><td>GM</td><td>Multiple members or multiple transports on one trip/day</td></tr><tr><td>QL</td><td>Member died after ambulance was called (O/D not required)</td></tr><tr><td>QM</td><td>Provider arranged transport</td></tr><tr><td>QN</td><td>Provider furnished transport</td></tr><tr><td>TK</td><td>Multiple carry trips (used to distinguish repeat transports)</td></tr><tr><td>TQ</td><td>Volunteer ambulance provider</td></tr></table></td></tr>
</table>

Ambulatory Surgical Centers

Most outpatient surgery delivered in an ambulatory surgery center (ASC) requires precertification. Ambulatory surgical centers bill on the CMS-1500 form.

Wellpoint has edit criteria for Ambulatory Surgical Centers, where “logic” rules will fire when billed in Place of Service 24. This logic heavily depends upon the various NPI indications on the CMS-1500, including rendering (box 24j), billing (box 33), and 32 (servicing).

Since there are 2 claims submitted for the same member/procedure/date of service to ensure both entities are reimbursed for billed services, it is critical that the billed NPIs match the reimbursement expectations.

In the cases where there may be shared Tax ID between the ASC and servicing providers, it is especially critical.

Payment Directly to ASC

In the instances where the ASC/group wishes to be paid for the “facility” payment on the ASC claim, they must NOT indicate any practitioner information in Box 24J. 24J field should be left blank or with the facility/group NPI for the payment directly to the ASC.

Payment to the rendering physician

The claim that is billed and payable directly to the physician/rendering provider would need to have 24J filled out with the physician’s information.

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

Electronic Visit Verification (EVV) Vendors

CareBridge is the chosen EVV vendor for Iowa. Providers can use this EVV option directly or choose to use another 21st Century Cures Act compliant EVV vendor. If a third party EVV vendor is used, this vendor must work with CareBridge to aggregate data from the third party EVV vendor to CareBridge. All claims for EVV services must be generated by CareBridge to then be sent to Wellpoint. Any claims with dates of service on or after February 1, 2021, for EVV related services that do not come in via CareBridge will be denied. Home health is subject to the EVV requirement. To learn more about the EVV requirement, visit the Iowa Medicaid web site at **hhs.iowa.gov/welcome-iowa-medicaid/evv**.

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**.

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**.

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.

Note, catalogue pages are not acceptable as a manufacturer's invoice.

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.

Note, DME providers should use normal equipment collection guidelines. Wellpoint is not responsible for equipment not returned by members.

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.

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.

Dialysis

Dialysis centers and other entities performing dialysis should use the CMS-1450 claim form to bill for dialysis services.

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.

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.

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.

Home Healthcare

All home healthcare requires precertification from our Medical Management department before delivery of service. When billing for a home healthcare 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 **hhs.iowa.gov/welcome-iowa-medicaid/evv**.

Note, when billing for supplies and equipment used in a home healthcare visit, please refer to the **Durable Medical Equipment** section of this chapter for billing requirements.

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**.

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

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.

CMS-1450 Revenue Codes

CMS-1450 revenue codes are required for all 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.

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

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.

Recommended Fields for CMS-1450

For assistance in completing the CMS-1450 form, please review the Electronic Data Interchange (EDI) Companion guides at **providers.wellpoint.com/edi**.

UB-04 / 837I Claim Billing Requirements and Common Errors

Providers must submit institutional claims in accordance with **Iowa Medicaid requirements, NUBC UB-04 standards, and applicable CMS billing guidance**, as adopted by **Wellpoint Iowa**.

- **Interim / Continuing Claims -** The **Admission Date (Form Locator 12)** must reflect the member's **actual date of admission** and must remain **unchanged on all interim or continuing claims** unless the member is discharged and readmitted.
- **Statement Covers Period and Service Dates -** When the **Statement Covers Period (Form Locator 6)** spans multiple days or an entire month (for example, 06/01/2024–06/30/2024), claims **must not be submitted with only a single service date**. Service dates must align with the full statement period billed.

Claims submitted with inaccurate admission dates or inconsistent service dates **may be subject to denial or post-payment recoupment**.

For more information and billing guidance, see the Wellpoint Claims and Billing Guide **IA_WLP_CAID_Claims_Billing_Manual.pdf**.

For questions, call Provider Services at **833-731-2143**.

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 13: 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. Providers have the right to request that a member be reassigned to another PCP, under certain conditions and following specific guidelines.

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.

Wellpoint notifies PCPs of changes in member assignments through PCP Assignment Reports. These reports are available on Availity Essentials, our secure provider website, at **provider.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.

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 **provider.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.

PCP-Initiated Member Disenrollment

The disenrollment process for abusive behavior and failure to follow a prescribed treatment plan is as follows:

1. Complete the Provider Request for Member Deletion from PCP Assignment form located at **provider.wellpoint.com/ia** > **Medical** > **Forms**.
2. Mail or fax (preferred) the form to:
   Wellpoint
   P.O. Box 62429
   Virginia Beach, VA 23466-2429
   Fax: **800-964-3627**
3. 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 HHS requesting member reassignment to another healthcare plan.

State Agency-Initiated Member Disenrollment

HHS informs 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-Initiated PCP Reassignment

Members have the right to change their PCP at any time. When a member enrolls in Wellpoint, they may select a PCP or allow their PCP to be assigned. After that, if the member wants to make a change, they are 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 they are 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 **provider.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-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**).

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 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 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 Iowa 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

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 their special needs (except when their 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, they are 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

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 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 a 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 (1) 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 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.

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.

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. (8:00 am to 5:00 pm central standard time)
- **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 Iowa, Inc
  PO Box 62429
  Virginia Beach, VA 23466-2429

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 will 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 call the member and give the member written notice of the reason for the delay within two (2) calendar days.

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.

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.

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**).

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 use 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 a 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 **hhs.gov/ocr**
- 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 **hhs.gov/ocr**.

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:
  Grievances and Appeals Department
  Wellpoint Iowa, Inc
  PO Box 62429
  Virginia Beach, VA 23466-2429
- 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.

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 (3) 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 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.
- **Claim inquiry:** A question about a claim but not a request to change a claim payment
- **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, 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:

- A statement of the provider's reconsideration request.
- A statement of what action Wellpoint intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes, or provider manual references.
- 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.
- 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:

- A statement of the provider's claim payment appeal request.
- A statement of what action Wellpoint intends to take or has taken.
- The reason for the action.
- 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:

- **Online (for reconsiderations and claim payment appeals)**: Use the secure provider Availity Essentials Appeal application at **Availity.com**. Through Availity Essentials, 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.
- Verbal **(reconsideration only)**: Verbal submissions may be submitted by calling Provider Services at **833-731-2143**.
- 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

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.

Provider Services can help you with claim inquiries. Call **833-731-2143** and select the **claims** prompt within our IVR. They can provide services to support you:

- 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.

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.
EOP requests for supporting Documentation (Sterilization/Hysterectomy/Abortion Consent Forms, itemized bills, and invoices)	Submit a Claim Correspondence Form, a copy of your EOP and the supporting documentation at **Availity.com**.
EOP requests for medical records	Submit a Claim Correspondence Form, a copy of your EOP and the medical records at **Availity.com**.
Need to submit a corrected claim due to errors or changes on original submission	Corrected claims should be submitted **only when there are material changes** to the original claim (such as changes to services, charges, diagnosis codes, or provider information) and **not** as a means to simply adjust or resubmit a claim without substantive changes. To submit a corrected claim, complete a Claim Correspondence Form and submit it along with the corrected claim via **Availity.com**. Corrected claims must be clearly identified by using the appropriate frequency codes and referencing the claim ID being adjusted. Claims that are altered without material changes will be returned with an explanation of the reason for the return. Provided the original claim was timely received, corrected claims must be submitted within 365 days of the date of service, with a maximum limit of two years from the date of service. If a correction is required due to an adjustment to a primary insurance payment, and it is necessary to update other health insurance (OHI) payment information, the timely filing period begins with the date of the most recent OHI Explanation of Benefits (EOB). Corrected claims are not accepted in bulk submissions.
Submission of coordination of benefits (COB)/third-party liability (TPL) information	Submit a Claim Correspondence Form, a copy of your EOP and the COB/TPL information to at **Availity.com**.
Emergency room payment review	Submit a Claim Correspondence Form, a copy of your EOP and the medical records to at **Availity.com**.

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.

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 (1) 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.

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:

Online: Appeal online through the Department of Health and Human Services (HHS) website at **hhs.iowa.gov/appeals**

Phone, Email, Fax or Mail: Fill out the form offline or write us a letter and submit by:

- Phone: **888-723-9637**
- Email: appeals@hhs.iowa.gov
- Fax: (515) 564-4044
- Mail:
  Iowa Department of Health and Human Services
  Appeals Bureau
  321 E 12th Street, 4th Floor
  Des Moines, Iowa 50319

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 42 CFR § 438.408(b)(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 their right, under 42 CFR § 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 (3) business days of receipt. Appeals are divided into two (2) categories:

Type of Appeal	Description
Standard appeal	The appropriate process when a member, or their 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 a 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 their 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 Wellpoint and will identify further appeal rights, if applicable.

Providers cannot file an appeal on their own behalf.

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.

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, their 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.

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.

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 their 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 (2) 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 they disagree with that decision.
- Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

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.

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.

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.

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 (2) days of the expedited appeal decision.

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 **hhs.iowa.gov/appeals** or write a letter telling HHS why they disagree with our appeal resolution. If the member does not want to complete the form online, they may mail, fax, or take the appeal letter to:

Department of Health and Human Services
Appeals Bureau
321 E. 12th St, 4th Floor
Fax: **515-564-4044**
Email: appeals@hhs.iowa.gov

Members (or the member's representative) may also appeal by phone by calling the HHS Appeals Bureau at **888-723-9637**.

The process is as follows:

1. HHS sends a notice of the hearing request to Wellpoint.
2. Upon receipt of the request, we forward all documents related to the request to HHS.
3. HHS schedules a hearing, which is held by teleconference, unless the member requested an in-person hearing.
4. HHS 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.
5. An Administrative Law Judge renders a decision in the hearing.
6. 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.
7. If our position is overturned, we must adhere to the final decision and ensure the decision is carried out.

Note, if the member needs special arrangements to attend the hearing due to a disability or needs language translation services, call **888-723-9637**.

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.

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 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 they 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 (1) of the following happens:

- The member decides not to continue or withdraws the appeal or state fair hearing.
- The member does not request a state fair hearing within 10 days of the level 1 decision.
- A hearing decision is issued in the state fair hearing that is adverse to the member.

CHAPTER 15: CREDENTIALING AND RECREDENTIALING

Overview

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.

Note, prior to contracting and credentialing with Wellpoint you will need to become an Iowa Medicaid provider. Please visit **hhs.iowa.gov/medicaid/provider-services/provider-enrollment** and submit an enrollment application to the Iowa Medicaid Provider Enrollment Unit. You will **not** be paid for any services provided before your Iowa Medicaid application is approved.

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 use 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 **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 **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 email providerhelp@proview.CAQH.org.

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)
- 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

After completing the online credentialing application, you will be asked to:

- 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
- Authorize access to your information. Check the box next to Wellpoint or select the **Global Authorization** option.
- 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

The quickest, most efficient way of uploading these documents is directly to the CAQH portal at **proview.caqh.org/Login**.

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 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 **caqh.org/solutions/caqh-proview**.
2. **Select** the link titled **Providers**. Then, enter your username and password.
3. Select 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. Select **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

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)

Note, having a Wellpoint provider record ID does not automatically activate the Medicaid network for Wellpoint. 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 for Wellpoint.

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 for Wellpoint, 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 for Wellpoint, 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 **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.

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
   a) 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
3. Practitioners who provide care to members under Wellpoint's medical benefits
4. The criteria listed above apply to practitioners in the following settings
   4.1 Individual or group practices
   4.2 Facilities
   4.3 Rental networks
      a) That are part of Wellpoint's primary Network and include Wellpoint members who reside in the rental network area
      b) 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
   4.4 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:
  - 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)
  - Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)

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 a 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 a Wellpoint medical director designee and the vice-chair must be a lead medical officer or a 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 their judgment might otherwise be compromised. A committee member will also disclose if they have 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 used. To learn more about CAQH, visit their web site at **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. The 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 • 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
- Other internal Wellpoint 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)
- 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

Healthcare Practitioners

- **Initial** applicants must meet the following criteria in order to be considered for participation:
  - Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP
  - Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where they provide services to members
  - Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to their specialty in which they 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

- 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:
  - 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.
  - 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.
  - 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.
  - Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.
  - As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training, and certification requirement:
    - 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
    - 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
    - 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.
    - Practitioners meeting one of these three alternative criteria (1., 2., 3.) 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.

MDs and DOs

- The applicant must have unrestricted hospital privileges at 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.

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)

- Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
- Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
- Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
- No evidence of potential material omission(s) on application.
- Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to members.
- No current license action.
- No history of licensing board action in any state.
- No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
- Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to their specialty in which they 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.

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 they have applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:

- It can be verified that this application is pending.
- 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
- The applicant agrees to notify Wellpoint upon receipt of the required DEA/CDS registration.
- Wellpoint will verify the appropriate DEA/CDS registration via standard sources.
    - 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:

- It can be verified that the applicant's application is pending; and
- The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
- The applicant agrees to notify Wellpoint upon receipt of the required DEA registration; and
- Wellpoint will verify the appropriate DEA/CDS registration via standard sources; and
- 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:

- Controlled substances are not prescribed within their scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and
- They 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.
- DEA/CDS registration is or was not suspended, revoked, surrendered, or encumbered for reasons other than those aforementioned.
- 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.
- No history of or current use of illegal drugs or history of or current substance use disorder.
- No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
- 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.
- 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.
- A minimum of the past 10 years of malpractice claims history is reviewed.
- 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.
- No involuntary terminations from an HMO or PPO.

- No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
  - Investment or business interest in ancillary services, equipment or supplies.
  - Voluntary resignation from a hospital or organization related to practice relocation or facility utilization.
  - Voluntary surrender of state license related to relocation or nonuse of said license.
  - An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria.
  - 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).
  - 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.
  - Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion.
  - 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.

- **Licensed Clinical Social Workers (LCSW) or other master level social work license type**
  - Master or doctoral degree in social work.
  - 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.
  - Licensure to practice independently.
- **Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC) or other master level license type**
  - 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.
  - 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.
  - Practitioners with PhD training as a clinical psychologist can be reviewed.
  - Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
  - Licensure to practice independently or in states without licensure or certification:
    - Marriage and Family Therapists with a master's degree or higher:
      i. 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).
    - Mental Health Counselors with a master's degree or higher:
      i. 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).

- **Pastoral Counselors**
  - Master's or doctoral degree in a mental health discipline.
  - 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.
  - 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).

- **Clinical nurse specialist/psychiatric and mental health nurse practitioner**
  - Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
  - 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.
  - 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.
  - 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.
- **Clinical Psychologists**
  - Valid state clinical psychologist license.
  - Doctoral degree in clinical or counseling, psychology, or other applicable field of study.
  - 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.
- **Clinical Neuropsychologist**
  - 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)
  - 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
  - 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:
    - Transcript of applicable pre-doctoral training
    - Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate)
    - Letters from supervisors in clinical neuropsychology (including number of hours per week)
    - Minimum of five years' experience practicing neuropsychology at least ten hours per week
- **Licensed Psychoanalysts**
  - Applies only to practitioners in states that license psychoanalysts.

- 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).
- Practitioner must possess a valid psychoanalysis state license.
  - Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
  - Meet examination requirements for licensure as determined by the licensing state.

- **Requirements, and Verification – Nurse Practitioners**
  - 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.
  - 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.
  - 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.
  - 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.
  - All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
    - Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association
    - American Academy of Nurse Practitioners – Certification Program
    - National Certification Corporation
    - Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner)
    - Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY
    - 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 verify 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 submitted for individual review.

  - If the NP 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

nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.

- 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.
- 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.
- NPs will be clearly identified:
  - On the credentialing file
  - At presentation to the CC
  - Upon notification to network services and to the provider database

- **Process, Requirements and Verifications – Certified Nurse Midwives**
  - 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.
  - 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.
  - 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.
  - 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.
  - All CNM applicants will be certified by either
    - The National Certification Corporation for Ob/Gyn and neonatal nursing
    - The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes

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.

- 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.

- 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.
- 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.
- CNMs will be clearly identified:
  - On the credentialing file
  - At presentation to the CC
  - Upon notification to network services and to the provider database

- **Process, Requirements and Verifications – Physician's Assistants (PA)**
  - 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.
  - 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.
  - 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.
  - 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.
  - 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.
  - 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.
  - 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.

- 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.
- PA's will be clearly identified:
- On the credentialing file
  - At presentation to the CC
  - Upon notification to network services and to the provider database

- **Currently Participating Applicants (Re-credentialing)**
  - Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations
  - Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote
  - 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.
  - Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to members
  - No new history of licensing board reprimand since prior credentialing review
  - 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)
  - Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions
  - 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
  - No new (since previous credentialing review) history of or current use of illegal drugs or substance use disorder
  - No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field
  - No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest
  - 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.
  - No new (since previous credentialing review) involuntary terminations from an HMO or PPO
  - No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    - Voluntary resignation from a hospital or organization related to practice relocation or facility utilization
    - Voluntary surrender of state license related to relocation or nonuse of said license
    - An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria
    - 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)
    - 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
    - Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion
    - History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction
  - No quality improvement data or other performance data including complaints above the set threshold.
  - 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.

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.

General Criteria for HDOs:

- 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.
- Valid and current Medicare certification.
- 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.
- Liability insurance is acceptable to Wellpoint.
- 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.

Additional Participation Criteria for HDO by Provider Type covered in following section.

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 Healthcare 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

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 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 **provider.wellpoint.com/ia** under Provider Resources & Documents > Training. Or for additional information on cultural diversity and interpreter services, refer to **Chapter 24: Cultural Diversity and Linguistic Services** in this manual.

Wellpoint monitors provider compliance with access to care standards on a quarterly basis. Failure to comply may result in corrective action.

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, seven (7) days a week and without preauthorization
PCP urgent visits	Within 24 hours of request
PCP routine visits	Not to exceed four (4) to six (6) weeks from the date of a patient's request for a routine
Persistent symptoms	Within 48 hours of request
Specialist urgent visit	Within 24 hours of request
Specialist routine visit	Not to exceed thirty (30) days upon request for Routine Care
Initial visit for pregnant women	Within 14 calendar days of request
Behavioral health urgent, nonemergency	Seen or referred to appropriate provider within one (1) hour of presentation at a service delivery site or within 24 hours of telephone contact with provider or the contractor
Behavioral health emergency	Enrolled members with emergency needs shall be seen or referred to an appropriate provider, upon presentation at a service delivery site
Behavioral health mobile crisis	Within one (1) hour of presentation or request
Behavioral health persistent symptoms	Seen or referred to an appropriate provider within 48 hours of reporting symptoms
Behavioral health routine	Seen or referred to the appropriate provider within three (3) 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.
General Optometry Services	Usual and customary not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care.
Lab and X-Ray Services	Usual and customary not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care.

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:

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

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

Prenatal and Postpartum Visits

Nature of Visit	Appointment Standards
Prenatal	Within 14 days of request
Third trimester	Within five (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 7-84 days after delivery

Wait Times

When a provider's office receives a call from a 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.

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 Iowa Health Link. The statement must include the following:

- Waiting times for appointments
- Waiting times for care at facilities
- Languages spoken

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:

- **ada.gov**
- **ada.gov/medcare_mobility**

Interpreter Services

Wellpoint will ensure that members who need interpreter services have access to interpreters 24 hours a day, seven (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 may 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**)

Note, to schedule face-to-face interpreter services, please allow 72 hours. To cancel, please provide a 24-hour notice.

Missed Appointment Tracking

When members miss appointments, providers must do the following:

- Document the missed appointment in the member's medical record.
- Make at least three (3) attempts to contact the member to determine the reason for the missed appointment.
- Provide a reason in the member's medical record for any delays in performing an examination, including refusals by the member.

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, seven (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.
- Have the ability to contact a telephone interpreter for members with language barriers.
- 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.
- 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].

Note, Wellpoint prefers PCPs to 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.

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, seven (7) days a week, 365 days a year

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.

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

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.

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.**

Newly Enrolled

Our goal is to ensure 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 a 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.

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.

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 enroute 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.

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

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 Iowa 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

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.

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

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 website, at **provider.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 a Wellpoint member not assigned to you, obtain precertification first. Noncontracted providers must obtain precertification before treating Wellpoint members.

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.

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

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**

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, telehealth, telephonic and face-to-face interpreter services are available at no cost to you or the member. Request telehealth or 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**)

Note, to schedule face-to-face interpreter services, please allow 72 hours. To cancel, please provide a 24-hour notice.

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**.

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**.

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.

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 30 days 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.

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.

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.

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

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.

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 to 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).

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.

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.

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.

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 16: Access Standards and Access to Care**.

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 20: Quality Assessment and Performance**.

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.
- Notification that the provider is accepting new patients.
- 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.

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 use 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 **provider.amerigroup.com/ia**, > **For providers** > **Forms and Guides**. The **Roster Automation Rules of Engagement** and **Roster Automation Standard Template** appears 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.

***** If any roster data updates require credentialing, your submission will be routed appropriately for further action.

Accessing PDM Application:
Log onto **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** and follow the prompts.

Availity Essentials 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 include:

- 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

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.

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 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.

Professional and Respectful Communication Standards

Wellpoint maintains an ongoing commitment to fostering a respectful, collaborative, and professional environment, recognizing that effective communication is an integral component. Your Participating Provider Agreement (the "Agreement") with Wellpoint outlines your obligations as a participating provider with Wellpoint regarding conduct and professionalism. Providers, including those who represent them, such as office staff, billing entities, are expected to conduct themselves in a professional and respectful manner in all interactions with Wellpoint members, employees, and representatives. Professional and respectful communication is not just a courtesy, but a fundamental responsibility that supports collaboration, builds trust, and enhances the quality of service we offer to our members. By upholding these standards, providers contribute to a positive and inclusive atmosphere where every individual feels valued and respected.

In addition to the standard policies and guidelines outlined in this manual and your participating Provider Agreement, Wellpoint maintains a zero-tolerance policy for abusive or disruptive behavior, whether physical or verbal, from providers, or those representing providers during the course of business. Violent acts and/or continued abusive or disruptive behavior will result in the termination of your participation in Wellpoint's provider network.

Examples of behavior that will not be tolerated include, but are not limited to, any act of violence, threats, harassment, intimidation, and other disruptive behavior. Such behavior can include actual physical injury, direct or indirect verbal or written statements, disruptive behavior, suggestions of self-harm, threats of retaliation to others, or gestures that communicate a threat of physical harm.

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.

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 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-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 their 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.

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.

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.

Restrictions on AI Use in Performing a Health Plan Function

Providers who have been delegated to perform a health plan function (for example, Utilization Management, credentialing and/or claims payment) shall not use AI in the performance of any delegated health plan function without the advance written consent of the health plan. Providers shall request such approval in accordance with the notice provisions of the provider agreement and the health plan shall provide its' written response in accordance with the notice provisions of the provider agreement.

CHAPTER 18: CLINICAL PRACTICE AND PREVENTIVE HEALTHCARE 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 Healthcare 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 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 **provider.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) (September 2012)
  - 2020 Focused Updates to the Asthma Management Guidelines: A Report from the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group
  - Asthma Clinical Practice Guidelines (2024)
- Chlamydia: **2021 Sexually Transmitted Disease Treatment Guidelines (Chlamydial Infections)**
- Chronic Heart Failure (CHF) in the Adult: 2022 ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines
  - ACCF/AHA/HFSA Guideline for the Management of Heart Failure (Focused Update 2017)
- Chronic Obstructive Pulmonary Disease (COPD): **Global Initiative for Chronic Obstructive Lung Disease (GOLD)**
- Coronary Artery Disease (CAD): **Circulation–AHA/ACCF Guideline**
- Diabetes: **2025 Standards of Care**
- Heart and Vascular Resources: **National Heart, Lung and Blood Institute**
- High Blood Cholesterol: 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ ASPC, NLA/PCNA Guideline on the Management of Blood Cholesterol
- Human Papillomavirus (HPV): **2021 Sexually Transmitted Diseases Treatment Guidelines (Human Papillomavirus Infections)**
- Hypertension and High Blood Pressure: ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/ PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults (2025)
- Maternity and Perinatal: **Tailored Prenatal Care Delivery for Pregnant Individuals** (2025)

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.

Preventive Healthcare 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 Healthcare 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 **provider.wellpoint.com/ia** . To request a hard copy of the Preventive Health Guidelines please call Provider Services at **833-731-2143**.

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

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.

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 **provider.wellpoint.com/ia** > **Provider Resources & Documents** > **Training**.

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

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 **provider.wellpoint.com/ia**.

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.

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.
- Educate the member and provider(s) about care management, community resources, benefits, cost factors and all related topics so informed decisions may be made.
- Facilitate communication with the member and their family in the decision-making process.
- 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 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.

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.

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.

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

Health Home Services

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 use 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 **provider.wellpoint.com/ia**.

CHAPTER 20: 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 (for example, data submission for HEDIS measures).
- 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 Healthcare Effectiveness Data and Information Set (HEDIS) scores on 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 share 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.

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 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 about if a quality of care or grievance issue has been filed.
- Using preventive health and Clinical Practice Guidelines in member care.

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 or delegated vendor representative 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 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
- Coordination with other providers and agencies
- Focus studies
- Claims payments for covered services
- Investigation and resolution of member and provider complaints, and appeals within established time frames
- Retrospective reviews of services provided without authorization

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.

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

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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.

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.

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.

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.

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.

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.

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 Iowa 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.

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 use
    - 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 use 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

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.

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.

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.

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

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.

Marketing Policies

Wellpoint providers are prohibited from making marketing presentations and advising or recommending to an eligible individual that they 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 staff 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 they 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.
- Reproducing or signing an enrollment application for the member.
- 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.
- 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 Process

The HHS determines the eligibility and enrollment for individuals seeking to enroll in Iowa Health Link or Hawki, after which the process is as follows:

1. HHS presents Iowa 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 **provider.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

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.

Understanding Fraud, Abuse and Waste

Combating fraud, abuse and waste begins with knowledge and awareness.

Term	Description
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.

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

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 Iowa Health Link identification (ID) card
- Relocating to an out-of-service area and not notifying us
- Using someone else's Iowa Health Link ID

Reporting Provider or Recipient Fraud, Abuse or Waste

If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company) 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
Methods providers may report allegations of fraud, abuse, or waste:

- Visit our **fighthealthcarefraud.com** education site; at the top of the page select **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

Member Reporting
Methods for members to use to report to us if they suspect a doctor, dentist, pharmacist or other healthcare providers, or another person receiving benefits is doing something wrong:

- From our **fighthealthcarefraud.com** education site; at the top of the page, select **Report it** and complete the **Report Fraud, Waste 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 **provider.wellpoint.com/ia**. To locate this form, select **Waste, Fraud and 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 (for example, hospital, nursing home, home health agency)
- Medicaid number of the provider and facility, if available
- Type of provider (for example, doctor, dentist, therapist, pharmacist)
- 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

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

Note, the name of the person reporting the incident and their callback number will be kept in strict confidence by investigators to maintain that person's anonymity.

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, GA 30308
Attn: investigator name, #case number

Instructions for sending paper medical records and/or claims when working with the SIU is found in correspondence from the SIU. If you have questions, contact your investigator. Delays for claim and/or medical record review, and ultimately resolution of an investigation may be delayed if SIU-supplied instructions are not followed. An opportunity to submit claims and medical records electronically is an option if you register for an Availity Essentials 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 their 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 their 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.

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, they may be involuntarily disenrolled from our healthcare plan with state approval. Refer to the **Member Transfers and Disenrollment** chapter for more information.

Offsets

Wellpoint shall be entitled to offset claims and recoup an amount equal to any overpayments ("Overpayment Amount") or improper payments made by the health plan to provider or facility against any payments due and payable by the health plan to provider or facility with respect to any Health Benefit Plan under any contract with our company regardless of the cause. Provider or facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by the health plan that an Overpayment Amount is due from provider or facility, provider or facility must refund the Overpayment Amount within the timeframe specified in letter notifying the provider or facility of the Overpayment Amount. If the Overpayment Amount is not received within the timeframe specified in the notice letter, the health plan shall be entitled to offset the unpaid portion of the Overpayment Amount against other claims payments due and payable by Wellpoint to provider or facility under any Health Benefit Plan in accordance with Regulatory Requirements. Should provider or facility disagree with any determination, provider or facility shall have the right to appeal such determination under Wellpoint procedures set forth in this Provider Manual, on condition that such appeal shall not suspend Wellpoint's right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. Wellpoint reserves the right to employ a third-party collection agency in the event of non-payment.

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.

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

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

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.

The organization's member rights and responsibilities statement specifies that members have the right to:

- Receive information about the organization, its services, its practitioners, its providers, and member rights and responsibilities.
- Be treated with respect and recognition of their dignity and their right to privacy.
- Participate with practitioners in making decisions about their healthcare.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about the organization or the care it provides.
- 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 Iowa Health Link-covered service.
- Get the information given in the Member Handbook in another language or format.
- Get healthcare services as provided 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 a means of force, control, convenience, or retaliation.

Member Responsibilities

Wellpoint members have the responsibility to:

- Show their Iowa 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 Iowa 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
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Formulate culturally competent treatment plans.
- 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 use 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, and 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 and develop strategies for communicating to enhance patient understanding.
- **Reducing Healthcare 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 **provider.wellpoint.com/ia** > **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 **Contacts** 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 **Contacts** chapter.

All required information in this section is sent to current and potential members in an easily understood, readily accessible format.

Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan. Carelon Behavioral Health, Inc. is an independent company providing utilization management services on behalf of the health plan.

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