Wellpoint • Texas | STAR+PLUS MMP (Medicare-Medicaid Plan)

Provider Manual

Wellpoint℠

TEXAS Medicare Medicaid PLAN
Your Health Plan ★ Your Choice

TEXAS Health and Human Services

855-878-1785
provider.wellpoint.com/tx

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Please note: Material in this provider manual is subject to change. Please visit **provider.wellpoint.com/tx** for the most up-to-date information.

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CHAPTER 1: INTRODUCTION

Welcome to Wellpoint

Welcome to the Wellpoint network of dedicated physicians and providers. We were selected by the State of Texas Health and Human Services Commission (HHSC) to integrate care for dual-eligible individuals, or those who are eligible for both Medicare and Medicaid. By consolidating the responsibility for all the covered services into a single plan, we see improved quality of care for the members; maximize the member's ability to remain safely in their homes and communities; and improve continuity of care across acute care, long-term care, behavioral health, and home- and community-based services using a patient-centered approach.

At Wellpoint, our goals are to assist you in providing quality care to your patients while making the practice of medicine more rewarding in terms of better patient outcomes, better practice economics and diminished practice difficulties. By furnishing the means to accomplish these ends and by helping you and your patients access them, we are confident you will be proud to have joined us.

Service Area

A service area is the geographic area approved by CMS and the State of Texas Health and Human Services Commission in which a person must live to become or remain a member of Wellpoint. Members who temporarily (as defined by CMS as six months or less) move outside of the service area are eligible to receive emergency and urgently-needed services outside the service area.

The service area for Wellpoint consists of the following counties:

- Bexar
- El Paso
- Harris
- Tarrant

Using This Manual

Designed for Wellpoint physicians, hospitals, long-term services and supports (LTSS) providers and ancillary providers who are participating in the Wellpoint network, this manual is a useful reference guide for you and your office staff. We recognize that managing our members' health can be a complex undertaking. It requires familiarity with the rules and requirements of a system that encompasses a wide array of healthcare services and responsibilities. We want to help you navigate our managed healthcare plan to find the most reliable, responsible, timely and cost-effective ways to deliver quality healthcare to our members.

This manual is available on our website at **provider.wellpoint.com/tx.** Providers may view it online, download it to their desktop or print it out from the site. If you have questions about the manual, please contact our Provider Services team at **855-878-1785**.

We understand some of the information in this manual may need to be revised or changed. To that end, Wellpoint may update or make changes to this manual periodically.

Provider Website

Wellpoint provides access to a website, **provider.wellpoint.com/tx**, which contains the full complement of online provider resources. The website features an online provider inquiry tool to reduce unnecessary telephone calls by enabling easy access at your convenience to the following resources:

- Online support services, such as:
  - Availity Essentials user registration and activation
- Interactive look-up tools and reference materials, such as:
  - Provider/referral directories.
  - Precertification lookup tool.
  - Reimbursement policies.

Provider manuals are available via the provider website or through your local provider relationship management representatives.

Legal and Administrative Requirements

Disclaimer

The information provided in this manual is intended to be informative and to assist providers in navigating the various aspects of participation with Wellpoint. Unless otherwise specified in the Provider Agreement, the information contained in this manual is not binding upon Wellpoint and is subject to change. Wellpoint will make reasonable efforts to notify providers of changes to the content of this manual.

This 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 this manual and the Provider Agreement between you or your facility and Wellpoint, the Agreement shall govern.

In the event of a material change to the Provider Manual, Wellpoint will make all reasonable efforts to notify you in advance of such changes through newsletter communications or website postings at **provider.wellpoint.com/tx**. In such cases, the most recently published information shall supersede all previous information and be considered the current directive.

The manual is not intended to be a complete statement of all Wellpoint program policies or procedures. Other policies and procedures not included in this manual may be posted on our website **provider.wellpoint.com/tx** or published in specially targeted communications. These communications include, but are not limited to letters, bulletins, and newsletters.

Throughout this manual, there are instances where information is provided as a sample or example. This information is meant for illustration purposes only and is not intended to be used or relied upon in any circumstance or instance.

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

Third-Party Websites
The Wellpoint website and this manual may contain links and references to internet sites owned and maintained by third-party entities. Neither Wellpoint nor its related affiliated companies operate or control in any respect any information, products, or services on these 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 their correctness, accuracy, timeliness, reliability or otherwise.

Privacy and Security Statements

Wellpoint privacy and security statements related to the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* can be found on the Wellpoint website at **provider.wellpoint.com/tx.**

Please be aware that when you travel from the Wellpoint website to another website, whether through links provided by Wellpoint or otherwise, you will be subject to the privacy policies (or lack thereof) of the other sites. We caution you to determine the privacy policy of such websites before providing any personal information.

Misrouted Protected Health Information
Providers and facilities are required to review all member information received from Wellpoint to ensure no misrouted protected health information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating or are not enrolled in the practice. PHI can be misrouted to providers and facilities by mail, fax, email, or electronic remittance advice. Providers and facilities are required to destroy immediately any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please contact Provider Services at **855-878-1785**.

Collection of Personal and Clinical Information
Wellpoint will collect and release all personal and clinical information related to members in keeping with Texas and federal laws, including *HIPAA*, court orders or subpoenas. Release of records according to valid court orders or subpoenas is subject to the provisions of that court order or subpoena.

The person or entity that is seeking to obtain medical information must obtain the authorization from the member and is to use that information only for the purpose it was requested and retain it only for the duration needed. The individual physician, provider, person, or entity may not intentionally share, sell, or otherwise use any medical information for any purpose deemed not necessary to provide healthcare services to the member.

Only necessary information shall be collected and maintained. Reasons for collecting medical information may include but are not limited to:

- Reviewing for medical necessity of care.
- Performing quality management, utilization management and credentialing/re-credentialing functions.
- Determining the appropriate payment under the benefit for covered services.
- Analyzing aggregate data for benefit rating, quality improvement and oversight activities.
- Complying with statutory and regulatory requirements.

Maintenance of Confidential Information

Wellpoint maintains confidential information as follows:

- Clinical information received verbally may be documented in the Wellpoint database. This database includes a secured system restricting access to only those with authorized entry. Computers, workstations, and laptops are protected by a password known only to the user assigned to that computer. Devices displaying member or provider information shall not be left on and unattended.
- Electronic, facsimile or written clinical information received is secured, with limited access to employees to facilitate appropriate participant care and reimbursement for such care. No confidential information or documents shall be unattended (i.e., open carts, bins, or trays at any time). Hard copies of all documents are not visible at any workstation during an employee's breaks, lunch or time spent away from desks.
- Written clinical information is stamped *Confidential* with a warning cautioning that its release is subject to state and federal law.
- Confidential information is stored in a secure area with access limited to specified employees, and clinical information is disposed of in a manner that maintains confidentiality (i.e., paper shredding and destroying of recycle bin materials).
- Any confidential information used in reporting to other departments or to conduct training activities, which may include unauthorized staff, will be "sanitized" (i.e., all identifying information blacked out), to prevent the disclosure of confidential information.

Any records related to Quality of Care, unexpected incidence investigations or other Peer Review matters are privileged communications. As such, these records are considered as confidential. Such records are labeled *Confidential* with a warning that its release is subject to State and Federal Law. Information is maintained in secure files.

Member Consent

Member authorization is not required for treatment, payment or healthcare operations. Direct treatment relationships (i.e., the provision and/or coordination of healthcare by providers) require member consent.

Member Access to Medical Records

Members may access their medical records upon proper request. Upon reviewed and approved requests to the Wellpoint compliance office, the member may provide a written amendment to their records if they believe that the records are incomplete or inaccurate.

No written request is required for information/documents to which a member would normally have access, such as copies of claims, etc. Wellpoint verifies the identity of the individual member (i.e., subscriber number, date of service, etc.) before releasing any information.

A written request signed by a member or the member's authorized representative is required to release medical records. An initial *consent to treat* may be signed at the point of entry into services prior to the provision of those services but does not allow records to be released for any reasons other than those delineated in that original consent (i.e., payment and specialty referral authorization processes).

Wellpoint will assist members who have difficulty obtaining requested medical records.

Release of Confidential Information
For members considered incompetent or lacking the legal capacity to give consent to medical treatment; incompetent members include:

- A member/conservatee who has been declared incompetent to consent to treatment by a court.
- A member/conservatee who has not been declared incompetent to consent to treatment, but whom the treating physician determines lacks the capacity to consent.
- A member who is not capable of understanding the nature and effect of the proposed treatment.

Wellpoint will consult with legal counsel as appropriate. The durable power of attorney or letters of conservatorship may need to be reviewed by legal counsel to determine who may consent to the release of member information.

Release to Providers
Provider requests may be honored if the request pertains to that provider's services. All other requests require the member's or member representative's signed release for the information. Electronic, facsimile or written clinical information sent is secured with limited access to those employees who are facilitating appropriate patient care and reimbursement for such care.

Release of Outpatient Psychotherapy Records
Anyone requesting member outpatient psychotherapy records must submit a written request except when the patient has signed a written letter or form waiving notification to the member and treating provider. The request must be sent to the member within 30 days of the receipt of the records except when the member has signed a written letter or form waiving notification.
The written request must be signed by the requestor and must identify:

- What information is requested.
- The purpose of the request.
- The length of time the information will be kept.

A person or entity may extend the time frame provided the person or entity notifies the practitioner of the extension. Any notification of the extension will include:

- The specific reason for the extension.

- The intended use or uses of the information during the extended time.
- The expected date of the destruction of the information.

The request must specifically include the following:
- Statement that the information will not be used for any purpose other than its intended use.
- Statement that the person or entity requesting the information will destroy the information when it is no longer needed.
- Specifics on how the information will be destroyed or specify that the person or entity will return the information and all copies of it before or immediately after the length of time indicated in the request.
- Specific criteria and process for confidentially faxing and copying outpatient psychotherapy records.

Release of Records Pursuant to a Subpoena
Member information will only be released in compliance with a *subpoena duces tecum* received by Wellpoint as follows:
- The subpoena is to be accepted, dated, and timed by the above person or designee.
- The subpoena should give Wellpoint at least 20 days from the date the subpoena is issued to allow a reasonable time for the member to object to the subpoena and/or preparation and travel to the designated stated location.
- All subpoenas must be accompanied by either a written authorization for the release of medical records or a "proof of service" demonstrating the member has been "served" with a copy of the subpoena.
- Alcohol or substance abuse records are protected by both Federal and State law (42 CFR § 2.1 *et seq.*) and may not be released unless there is also a court order for release which complies with the specific requirements.
- Only the requested information will be submitted (HIV and AIDS information is excluded). HIV and AIDS or AIDS-related information require a specific subpoena (Va. Code Ann. Section 32.1-127.1:03.D and Va. Code Ann Section 32.1-36.1)

Should a notice contesting the subpoena be received prior to the required date, records will not be released without a court order requiring so. If no notice is received, records will be released at the end of the 20-day period.

The record will be sent through the U.S. Postal Service by registered receipt or certified mail.

Archived Files/Medical Records
All medical records are retained by Wellpoint and/or the delegated/contracted medical groups as well as individual practitioner offices, according to the following criteria:
- Adult patient charts — 10 years
- X-rays — 10 years

Nondiscrimination Statement
Wellpoint does not engage in, aid, or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race,

color or national origin in providing aid, benefits or services to beneficiaries. Wellpoint does not utilize or administer criteria having the effect of discriminatory practices on the basis of 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 on the basis of gender or gender identity. In addition, in compliance with the *Age Act*, Wellpoint may not discriminate against any person on the basis of 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, physical or mental disability, or type of illness or condition.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when an Wellpoint representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so if the member requests assistance. We document, track, and trend all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201
- By phone at: **800-368-1019** (TTY/TTD: **800-537-7697**)

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

Wellpoint provides free tools and services to people with disabilities to communicate effectively with us. Wellpoint also provides free language services to people whose primary language isn't English (e.g., qualified interpreters and information written in other languages).

These services can be obtained by calling the Member Services 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, age, disability, gender, or gender identity, you can file a grievance with our member advocate via:

- Mail: 2505 N. Highway 360, Suite 300, Grand Prairie, TX 75050
- Phone: **855-878-1784** (TTY **711**), and ask for a member advocate
- Email: dl-txmemberadvocates@Wellpoint.com

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 consistently 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 (i.e., race, color, national origin, 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.

The Role of Our Providers

Role of Primary Care Providers (Medical Home)
The role of the primary care physician or primary care provider (PCP) is to provide a medical home for Wellpoint members. The PCP is also responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

Role of Specialty Care Providers
The role of the specialty care provider is to meet the medical specialty needs of Wellpoint members and provide all medically necessary covered services. Specialty care providers, including behavioral health providers, coordinate care with the member's medical home provider.

Role of Long-term Services and Supports Providers
Long-term services and supports (LTSS) providers are responsible for but not limited to:

- Verifying member eligibility.
- Obtaining prior authorization for services prior to provision of those services.
- Coordinating Medicaid and Medicare benefits.
- Notifying us of changes in members' physical condition or eligibility.
- Collaborating with the Wellpoint service coordinator in managing members' healthcare.
- Managing continuity of care for Wellpoint members.

Role of the Wellpoint Service Coordinator
Service coordination means specialized care management services performed by a licensed, certified and/or experienced person called a service coordinator. This includes but is not limited to:

- Identifying a member's needs through an assessment.
- Documenting how to meet the member's needs in a care plan.
- Arranging for delivery of the needed services.
- Establishing a relationship with the member and acting as an advocate for the member in coordinating care.
- Coordinating different types of services.
- Making sure the member has a PCP.

A service coordinator works as a team with the member and the PCP to arrange all services the member needs to receive, including services from specialists and behavioral health

providers (if needed). A service coordinator helps ensure that all of the member's healthcare needs are met.

Role of Pharmacy
Our pharmacy benefit provides coverage for medically necessary medications from licensed prescribers for: saving lives in emergency situations, treatment of short-term illness, sustaining life in chronic or long-term illness, or limiting the need for hospitalization. Members have access to most national pharmacy chains and many independent retail pharmacies.

Pharmacy providers are responsible for but not limited to:

- Filling prescriptions in accordance with the benefit design.
- Adhering to the Vendor Drug Program (VDP) formulary for over-the-counter drugs and *MMP Preferred Drug List (PDL)* for all other drugs.
- Coordinating with the prescribing physician.
- Ensuring members receive all medication for which they are eligible.
- Coordinating with Medicare Part D services available under the Wellpoint plan.
- Providing a 72-hour emergency supply of Medicaid only prescribed medication any time a prior authorization is not available, if the prescribing provider cannot be reached or is unable to request a prior authorization, and a prescription must be filled without delay for a medical condition.

Role of Main Dental Home
A main dental home serves as the member's main dentist for all aspects of oral healthcare. The main dental home has an ongoing relationship with that member to provide comprehensive, continuously accessible, coordinated and family-centered care. The main dental home provider also makes referrals to dental specialists when appropriate. Federally Qualified Health Centers (FQHCs) and individuals who are general dentists and pediatric dentists can serve as main dental homes.

Role of Nursing Facilities
The role of the nursing facility is to provide the necessary care and services for residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being, as defined by and in accordance with the comprehensive assessment and plan of care.

In addition, nursing facilities are responsible for but not limited to:

- Verifying member eligibility.
- Obtaining prior authorization for services prior to provision of those services.
- Coordinating Medicaid and Medicare benefits.
- Notifying us of changes in members' physical condition or eligibility within one business day of identification.
- Collaborating with the Wellpoint service coordinator in managing members' healthcare.
- Managing continuity of care for Wellpoint members.
- Allowing Wellpoint service coordinators and other key personnel access to Wellpoint members in the facility and to requested medical record information.

Nursing facility providers should refer to the separate *Nursing Facility Provider Manual* at **provider.wellpoint.com/tx** > Resources > Provider Manuals and Guides for information specific to nursing facilities.

Network Limitations

Providers with the following specialties can apply for enrollment with us as PCPs:

- General practice
- Family practice
- Internal medicine
- Pediatrics
- Obstetrics/gynecology (OB/GYN)
- Advanced practice registered nurses (APRNs) and physician assistants (PAs), when APRNs and PAs are practicing under the supervision of a physician specializing in family practice, internal medicine, pediatrics, or obstetrics/gynecology who also qualifies as a PCP
- Federally qualified health centers (FQHCs)
- Rural health clinics (RHCs) and similar community clinics
- Physicians serving members residing in nursing facilities

Wellpoint MMP providers must be enrolled with Texas Medicaid in one of the specialties listed above to serve as a PCP.

Specialist physicians may be willing to provide a medical home to selected members with special needs and conditions. Information regarding the circumstances in which specialists can be designated as PCPs is available under the **Specialist Acting as a PCP** section of this manual.

CHAPTER 2: CONTACTS

Overview

Quick Reference Information	
Provider Services	Contact Provider Services at **855-878-1785** for member eligibility, 24-Hour Nurse HelpLine and Pharmacy Services or any other issues.
Member Services	• Telephone: 855-878-1784
TTY	Members should call 711
Medical Notification/ Precertification	Precertification request: • Fax: 866-959-1537 • Phone: 855-878-1785 • To retrieve the status of the precertification request, visit **availity.com** or contact Provider Services at **855-878-1785**.
Claims Submission: Paper	Submit paper claims to: Claims Wellpoint P.O. Box 61010 Virginia Beach, VA 23466-1010
Claims Submission: Electronic	Electronic Data Interchange (EDI): Contact Availity Client Services with any questions at **800-Availity** (**282-4548**). Timely filing is governed by the terms of the *Provider Agreement*. • Wellpoint provides an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and precertification status at **availity.com**. • If you are unable to access the internet, you may receive claims, eligibility, and precertification status over the telephone at any time by calling our automated Provider Services number toll free at **855-878-1785**.
Dental Services	Liberty Dental: **888-700-0643**

Quick Reference Information	
National Provider Identifier (NPI)	**National Provider Identifier (NPI)** — The H*ealth Insurance Portability and Accountability Act (HIPAA)* requires the adoption of a standard unique Provider Identifier for health care providers. All Wellpoint participating providers must have an NPI number, with the exception of atypical providers. Atypical providers are those individuals or businesses that are not healthcare providers and do not meet the definition of healthcare providers according to the NPI rules. Therefore, these types of providers do not require an NPI number. 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 can apply for an NPI by completing an application: • Online at **https://nppes.cms.hhs.gov** (Estimated time to complete the NPI application is 20 minutes). • By downloading a paper copy at **https://nppes.cms.hhs.gov**. • By calling **800-465-3203** and requesting an application.
Participating Provider Appeals and Disputes	Appeals are determined by the liable party, not by the initiator. The time frame to review your request will commence once your appeal is routed to the appropriate department. Please refer to the denial letter or *Explanation of Payment (EOP)* issued to determine the correct appeals process. **Participating Provider Standard Appeals** A formal request for review of a previous Wellpoint decision where a determination was made with Provider liability assigned (see original decision letter). For contracted provider administrative appeals: ATTN: Provider Complaints Provider Complaints and Grievances Wellpoint Mailstop: OH0205-A5374 4361 Irwin Simpson Road Mason, OH 45040 Fax: **888-458-1406**

Quick Reference Information	
	For contracted provider medical necessity appeals: ATTN: Provider Complaints Provider Complaints and Grievances Wellpoint Mailstop: OH0205-A5374 4361 Irwin Simpson Road Mason, OH 45040 Fax: **888-458-1406** **Claims Payment Disputes** Payment disputes must be filed within 120 calendar days of the initial Wellpoint decision. Send payment disputes to: Provider Payment Disputes Wellpoint P.O. Box 61599 Virginia Beach, VA 23466-1599
Member Liability Appeals	Appeals are determined by the liable party, not by the initiator. Please refer to the denial letter or *EOP* issued to determine the correct appeals process to follow. In the event that failure to provide the service is life- or limb-threatening or that waiting the standard appeal time frame would be harmful to the member, an expedited or fast appeal can be initiated. Please indicate if your request is for an expedited appeal. All Wellpoint member liability appeals (expedited and standard) should be sent to: Medicare Complaints, Appeals and Grievances Department Wellpoint Mailstop: OH0205-A537 4361 Irwin Simpson Road Mason, OH 45040 Phone: **855-817-5787** Fax: **888-458-1406**
Nonemergent Medical Transportation	Access2Care Providers and members call **844-869-2767 (TTY 711)**

Quick Reference Information	
Provider Services	For more information, contact Provider Services at **855-878-1785** or your local provider relationship management representative.
Translation/ Interpreter Services	For assistance with translation services for your Wellpoint patients, contact Provider Services at **855-878-1785**.
Vision Services	Superior Vision of Texas Provider Services: **800-879-6901** Claims Submission: Claims Department Superior Vision of Texas 939 Elkridge Landing Road, Suite 200 Linthicum, MD 21090
Pharmacy Prior Authorization	Contact Provider Services at **855-878-1785** or fax **844-494-8342**.
Carelon Medical Benefits Management, Inc. (cardiology, oncology, radiation oncology, hi-tech radiology, sleep studies, physical therapy, occupational therapy, speech therapy, and musculoskeletal prior authorizations)	**833-305-1809** **providerportal.com**

Ongoing Provider Communications and Feedback

To ensure providers are up-to-date with information required to work effectively with Wellpoint and our members, we provide frequent communications to providers in the form of broadcast faxes, Provider Manual updates, newsletters, and information posted to the website. As per Wellpoint policy, we also provide orientation and training to providers, which will include the state-mandated minimum number of hours and topics of training to ensure awareness of the procedures as part of the Dual Demonstration program. The training will be consistent with the requirements contained in the contract between the health plan, state and CMS and provide resources and access information for the disability-competent care population.

CHAPTER 3: PARTICIPATING PROVIDER INFORMATION

The Wellpoint Provider Network

Wellpoint members obtain covered services by choosing a PCP who is part of the Wellpoint network to assist and coordinate their care. Members are encouraged to coordinate with their PCP before seeking care from a specialist, except in the case of specified services (such as women's routine and preventive care and behavioral healthcare).

Note: Some services provided by a specialist may require precertification or a referral.

When referring a member to a specialist, it's critical to select a participating provider within our network to maximize the member's benefit. If you need help finding a participating provider, call Provider Services at **855-878-1785**. We will provide members with timely and adequate access to out-of-network services if those services are necessary and covered but not available within the network.

The Primary Care Provider Role

The PCP is a network physician who has responsibility for the complete care of his or her members, whether providing it himself or herself or by referral to the appropriate provider of care within the network.

Members are asked to select a PCP when enrolling in Wellpoint and may change their selected PCP at any time. Wellpoint contracts with certain physicians that members may choose as their PCPs and may be individual practitioners associated with a contracted medical group or an independent practice association. The PCP is responsible for referring or obtaining precertification for covered services for members. Participating PCPs are generally physicians of internal medicine, family practitioners, general practitioners, pediatricians, obstetricians/gynecologists, or geriatricians. Advanced practice registered nurses (APRNs) and physician assistants (PAs), when APRNs and PAs are practicing under the supervision of a physician specializing in family practice, internal medicine, pediatrics, or obstetrics/gynecology who also qualifies as a PCP. Federally qualified health centers (FQHCs) and rural health clinics (RHCs) may be included as PCPs.

Each member has a service coordinator and a service coordination team (SCT) assigned to assist with developing care plans, collaborating with other team members and providing recommendations for the management of the member's care.

When coordinating member care, the PCP should refer the member to a participating provider within the Wellpoint network. To assist the specialty care provider, the PCP should provide the specialist with the following clinical information:

- Member name
- Referring PCP
- Reason for the consultation
- History of the present illness
- Diagnostic procedures and results

- Pertinent past medical history
- Current medications and treatments
- Problem list and diagnosis
- Specific request of the specialist

Any referral to a nonparticipating provider will require precertification from Wellpoint, or the services may not be covered. Contact Provider Services at **855-878-1785** for questions or more information.

Health Risk Assessments

Wellpoint believes that quality primary care and active care coordination are essential components to providing high-quality and cost-effective healthcare to our members. This philosophy supports the relationship between our contracted PCPs and other healthcare professionals who coordinate the medical needs of our members. The goal is to ensure each member receives appropriate care, and all of his or her providers are in communication with one another so that the member achieves healthier outcomes.

A health risk assessment (HRA) is a comprehensive questionnaire used by Wellpoint to obtain basic health information from members.

A physician health risk assessment (PHRA) is a questionnaire used to obtain basic health information from members that supplements the HRA performed by Wellpoint. PCPs complete the PHRA during a visit with an Wellpoint member and record the results on the form. The PHRA supplements the comprehensive HRA performed by Wellpoint.

To successfully complete the PHRA, the following fields must be legibly documented for processing and claims reimbursement:

- Patient name and Wellpoint ID number
- Physician name and NPI
- Date of assessment
- Physician signature included on each page

The PHRA will then be forwarded to the service coordination team to assist in the development and implementation of the member's plan of care (POC). To obtain a copy of the PHRA form, please access our website at **provider.wellpoint.com/tx**.

The Specialist's Role

A specialist is any licensed provider (as defined by Medicare) providing specialty medical services to members. A PCP may refer a member to a specialist when medically necessary. Specialists must obtain authorization from Wellpoint before performing certain procedures or when referring members to noncontracted providers. You can review precertification requirements online at **provider.wellpoint.com/tx** or call Provider Services at **855-878-1785**.

After performing the initial consultation with a member, a specialist should:

- Communicate the member's condition and recommendations for treatment or follow-up care with the PCP.
- Send the PCP the consultation report, including medical findings, test results, assessment, treatment plan and any other pertinent information.
- If the specialist needs to refer a member to another provider, the referral should be to another Wellpoint provider. Any referral to a nonparticipating provider will require precertification from Wellpoint.

Specialist Acting as a PCP

In some cases, a specialist other than the currently state-approved PCP listing (i.e., internal medicine, family practitioners, general practitioners, pediatricians, OB/GYNs, geriatricians, advanced practice registered nurses [APRNs] and physician assistants [PAs] — when APRNs/PAs are practicing under the supervision of a physician specializing in a listed area) also qualify as PCPs. Federally qualified health centers (FQHCs) and rural health clinics (RHCs) may be included as a PCP. If the specialist is not listed as a state-approved PCP, this must be authorized by our Case Management department. If you have any questions, contact Provider Services at **855-878-1785**. To download a copy of the *Specialist as a PCP* Form, visit **provider.wellpoint.com/tx.**

Participating Provider Responsibilities:

- Manage the medical and healthcare needs of members, including monitoring and following up on care provided by other providers, providing coordination necessary for services provided by specialists and ancillary providers (both in and out-of-network) and maintaining a medical record meeting Wellpoint standards.
- Provide coverage 24 hours a day, 7 days a week; regular hours of operation should be clearly defined and communicated to members.
- Provide all services ethically, legally and in a culturally competent manner and meet the unique needs of members with special healthcare needs.
- Participate in systems established by Wellpoint to facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements.
- Make provisions to communicate in the language or fashion primarily used by his or her assigned members.
- Provide hearing interpreter services upon request to members who are deaf or hard of hearing.
- Participate in and cooperate with Wellpoint in any reasonable internal and external quality assurance, utilization review, service coordination team meeting, continuing education, and other similar programs established by Wellpoint.
- Comply with Medicare, Texas State Health, and Human Services Commission (HHSC) laws, regulations, and CMS instructions; agree to audits and inspections by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records for a minimum of 10 years.
- Participate in and cooperate with the Wellpoint appeal and grievance procedures.
- Agree to not balance bill members for monies that are not their responsibility.

- Continue care in progress during and after termination of a provider's contract for up to 90 days, or such longer period of time (up to six months) as required by state laws and regulations, until a continuity of service plan is in place to transition the member to another network provider.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
- Develop and have an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens.
- Establish an appropriate mechanism to fulfill obligations under the *Americans with Disabilities Act of 1990 (ADA)*.
- Support, cooperate and comply with Wellpoint Quality Improvement program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner.
- Inform Wellpoint if a member objects to the provisions of any counseling, treatments, or referral services for religious reasons.
- Treat all members with respect and dignity, provide appropriate privacy, and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release
- Provide members complete information concerning their diagnosis, evaluation, treatment, and prognosis and give them the opportunity to participate in decisions involving their healthcare, except when contraindicated for medical reasons.
- Advise members about their health status, medical care, or treatment options, regardless of whether benefits for such care are provided under the program and advise them on treatments that may be self-administered.
- When clinically indicated, contact members as quickly as possible for follow up regarding significant problems and/or abnormal laboratory or radiological findings.
- Have a policy and procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies, and poison control centers to provide high-quality patient care.
- Agree any notation in a member's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research will be clearly contrasted with entries regarding the provision of non-research-related care.
- If a member self-refers or a provider is referring to another provider, that provider is responsible for checking the Wellpoint provider directory to ensure the specialist is in the network. Referrals to Wellpoint contracted specialists do not require precertification. Some procedures performed by specialist physicians may require precertification. Please refer to the Summary of Benefits document or Member Handbook for procedures that require precertification or call Provider Services at **855-878-1785**. If you cannot locate a provider in the Wellpoint network, you should contact Provider Services at **855-878-1785**. You must obtain authorization from Wellpoint before referring members to noncontracted providers. Additionally, certain services/procedures require precertification from Wellpoint.
- Agree to use any laboratory designated by Wellpoint for our members. Wellpoint will reimburse for a limited list of lab services when performed in provider's office.

- Notify Wellpoint and HHSC's administrative services contractor of any changes to the provider's address, telephone number, group affiliation, etc.
- Provider shall continue to provide services under the *Agreement* to members in the event of the health plan's insolvency, discontinuation of operations or termination of the CMS contract, throughout the period for which CMS payments have been made to Wellpoint, and, to the extent applicable, for members who are hospitalized, until such time as the member is appropriately discharged.

Note: Wellpoint does *not* cover the use of any experimental procedures or experimental medications, except under certain circumstances.

Update enrollment and demographic information with TMHP
Texas Medicaid & Healthcare Partnership (TMHP) is the provider enrollment administrator for HHSC and serves as the authoritative source for HHSC providers' enrollment and demographic information. Once you update your enrollment and demographic information with TMHP, your data will be reconciled with the demographic information on file with the managed care organizations (MCOs).

You can access current information at **tmhp.com** or contact TMHP directly at **800-925-9126** for assistance.

Reporting abuse, neglect, or exploitation (ANE)

Report suspected abuse, neglect, and exploitation:
MCOs and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO, and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO, and provider requirements continue to apply.

The provider must provide the MCO with a copy of the Abuse, Neglect and Exploitation report findings within one business day of receipt of the findings from the Department of Family and Protective Services (DFPS). In addition, the provider is responsible for reporting individual remediation on confirmed allegations to the MCO.

Report to the Health and Human Services Commission (HHSC) if the victim is an adult or child who resides in or receives services from:
- Nursing facilities.
- Assisted living facilities.
- Home and Community Support Services Agencies (HCSSAs) — Providers are required to report allegations of ANE to both DFPS and HHSC.
- Adult day care centers.
- Licensed adult foster care providers.

Contact HHSC at **800-458-9858**.

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:
An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:

- Local Intellectual and Developmental Disability Authority (LIDDA), Local Mental Health Authority (LMHA), community center, or mental health facility operated by the Department of State Health Services
- A person who contracts with a Medicaid managed care organization to provide behavioral health services
- A managed care organization
- An officer, employee, agent, contractor, or subcontractor of a person or entity listed above
- An adult with a disability receiving services through the Consumer Directed Services option

Contact DFPS at **800-252-5400** or, in nonemergency situations, online at **txabusehotline.org**.

Report to local law enforcement
If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Failure to report or false reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, HHSC or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
- It is a criminal offense to knowingly or intentionally report false information to DFPS, HHSC or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

Provider Responsibilities in the Management of Transitions in Care

A transition in care for a member is defined as a point at which the member's care is transferred from one provider to another or from a facility to another level of care. Examples of transitions in care include a referral from a PCP to a specialist, an admission to a hospital or a discharge from a hospital to home care or a skilled nursing facility.

When a member experiences a transition in care, it is the responsibility of the transferring provider to do the following:

- Notify the member in advance of a planned transition.
- Provide documentation of the care plan to the receiving institution or provider within 24 hours of the transition.
- Communicate with the member about the transition process.
- Communicate with the member about his or her health status and plan of care.
- Notify the member's usual practitioner of the transition within three business days after notification of the transition.
- Provide a treatment plan/discharge instructions to the member prior to discharge.

- Notify the member's service coordinator at Wellpoint.

The provider is an integral part of effectively managing transitions. Communication is the key with both the member and other treating providers. To prevent duplicate testing and provide critical information about the member, the following processes should be followed:

- The referring physician or provider should provide the relevant patient history to the receiving provider.
- Any pertinent diagnostic results should be forwarded to the receiving provider.
- The receiving provider should communicate a treatment plan back to the referring provider.
- Any diagnostic test results ordered by the receiving provider should be communicated to the referring provider.

Enrollment and Eligibility Verification

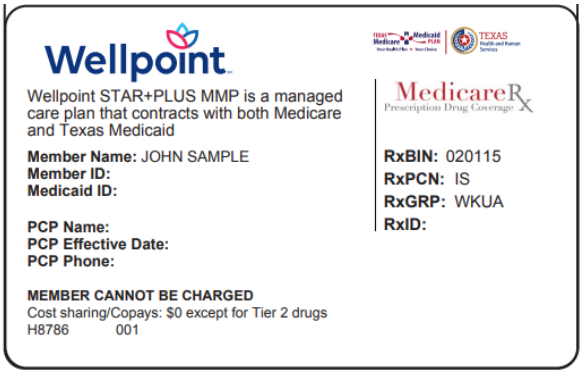
All healthcare providers are responsible for verifying enrollment and eligibility before services are rendered, except in the case of an emergency. In general, eligibility should be verified at the time of service and at least once monthly for ongoing services. In an emergency, eligibility should be determined as soon as possible after the member's condition is stabilized.

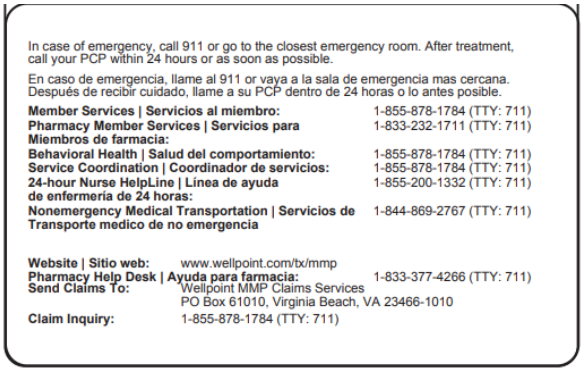
When a patient presents as a member, providers must verify eligibility, enrollment, and coverage by performing the following steps:

1. Request the member's Wellpoint card; if there are questions regarding the information, call Provider Services at **855-878-1785** or visit **availity.com** to verify eligibility and other benefit information.
2. Copy both sides of the member's Wellpoint card and place the copies in the member's medical record.
3. Copy the member's driver's license (if applicable) to ensure the member's information matches their Wellpoint card and place the copies in the member's medical record.
4. If you are a PCP, check your Wellpoint member panel listing to ensure you are the member's doctor.
5. If the patient does not have an identification card, visit **availity.com** to verify eligibility or call Provider Services at **855-878-1785**.

Identification Card for Wellpoint

The member will have a single ID card for Wellpoint.





Member Missed Appointments

Members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. Wellpoint requires providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling. The contact must be by telephone and should be designed to educate the member about the importance of keeping appointments and to encourage the member to reschedule the appointment.

Members who frequently cancel or fail to show up for appointments without rescheduling may need additional education in appropriate methods of accessing care. In these cases, please call Provider Services at **855-878-1785** to address the situation. Wellpoint staff will contact the member and provide more extensive education and/or case management as appropriate. Our goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP.

Noncompliant Wellpoint Members

Wellpoint recognizes providers may need help in managing nonadherent members. If you have an issue with a member regarding behavior, treatment cooperation, completion of treatment and/or making or appearing for appointments, call Provider Services at **855-878-1785**. A Member Services or Provider Services representative will contact the member by telephone, or a member advocate will visit the member to provide education and counseling to address the situation and will report the outcome of any counseling efforts to you.

Second Medical or Surgical Opinion

At the member's request, Wellpoint will provide a second opinion from a qualified healthcare professional within the Wellpoint network. If there's no provider in the Wellpoint network who can render a second opinion, Wellpoint will arrange for the member to obtain one outside the network at no cost to the member.

Access and Availability

Participating Wellpoint providers must:

- Offer hours of operation that are no less than the hours of operations offered to their other patients (e.g., commercial, or public fee for service insured).
- Provide coverage for members 24 hours a day, 7 days a week.
- Ensure another on-call Wellpoint provider is available to administer care when the PCP is not available.
- Not substitute hospital emergency rooms or urgent care centers for covering providers.
- See members within 30 minutes of a scheduled appointment or inform them of the reason for delay (e.g., emergency cases) and offer an alternative appointment.
- Provide an after-hours telephone service to ensure a response to emergency phone calls within 30 minutes and a response to urgent phone calls within one hour; individuals who

believe they have an emergency medical condition should be directed to immediately seek emergency services from the nearest emergency facility.

Access and Availability Standards Table

Type of Appointment (Medical)**	Availability Standard
Patient visit with new PCP	Within 30 calendar days
Routine follow-up or preventive care	As soon as possible but within 30 calendar days
Routine/symptomatic	Within 7 days
Non-urgent care	Within 7 days
Urgently needed services	Within 24 hours
Emergency	Immediately

** See the Behavioral Health Chapter for specific behavioral health access standards.

Wellpoint monitors adherence to appointment availability standards through office visits, long-term care visits, and tracking of complaints and grievances related to access and/or discrimination. Deviations from the policy are reviewed by the medical director for educational and/or counseling opportunities and tracked for provider recredentialing.

All providers and hospitals are expected to treat Wellpoint members with the same dignity and consideration as afforded to their non-Wellpoint patients.

Continuity of Care

Wellpoint will ensure newly enrolled members will continue to have access to medically necessary items, services, and prescription drugs as well as medical, behavioral health and LTSS providers for the transition period. Members will be allowed to maintain their current providers for 90 days from the date of enrollment. Members will be allowed to maintain their current LTSS providers for up to 6 months after initial enrollment or until the Comprehensive Health Risk Assessment has been completed and the Enrollee has signed the Integrated Plan of Care. Members who have a terminal illness at the time of enrollment have up to nine months. Members will also be allowed to maintain their preauthorized services for the duration of the prior authorization or six months from enrollment, whichever is sooner. Members who have a terminal illness will also be allowed to maintain their preauthorized services for the duration of the prior authorization or nine months from enrollment, whichever is sooner.

Wellpoint will also advise, in writing, both members and providers when members have received care that would not otherwise be covered at an in-network level. Wellpoint will contact noncontracted providers to inform them of the procedure for becoming an in-network provider.

Individuals residing in nursing facilities prior to their effective date with Wellpoint may remain in the facility as long as they continue to meet Texas State Health and Human Services Commission (HHSC) criteria for nursing home care, unless they or their families prefer to move to a different nursing facility or return to the community.

During the transition period referenced above, a change from the existing provider can only occur in the following circumstances:

- The member requests a change.
- The provider chooses to discontinue providing services to a member as currently allowed by Medicare or Medicaid.
- Wellpoint, CMS or HHSC identifies provider performance issues that affect a member's health and welfare.
- The provider is excluded under state or federal exclusion requirements.

Pregnant members past the 24th week of pregnancy are allowed to remain under the care of their current OB/GYNs through their postpartum checkup within six weeks of delivery. This applies even if the providers are out-of-network. If a member wants to change her OB/GYN to one who is in-network, she will be allowed to do so if the new provider agrees to accept her.

Member Moves Out of Service Area
We provide or pay out-of-network providers for medically necessary covered services to members who move out of the service area. Members are covered through the end of the period for which he or she is enrolled in Wellpoint.

Pre-Existing Condition not Imposed
We do not impose any pre-existing condition limitations or exclusions. We do not require evidence of insurability to provide coverage to any member.

Covering Physicians

During a provider's absence or unavailability, the provider must arrange for coverage for his or her members. The provider will either: 1) make arrangements with one or more Wellpoint network providers to provide care for his or her members, or 2) make arrangements with another similarly licensed and qualified provider who has appropriate medical staff privileges at the same network hospital or medical group, as applicable, to provide care to the members in question. In addition, the covering provider will agree to the terms and conditions of the network Provider Agreement, including any applicable limitations on compensation, billing, and participation. Providers will be solely responsible for a non-network provider's adherence to such provisions. Providers will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a member on the provider's behalf.

Provider demographic data changes and roster submissions

The Provider Data Management (PDM) application on Availity Essentials should be used to initiate and verify provider demographic change requests for all professional and facility providers. The PDM application is the required intake tool for providers to submit

demographic change requests, including submitting roster uploads. If preferred, providers may continue to utilize the Provider Enrollment application in Availity Essentials to submit requests to add new practitioners under existing groups for available provider types.

Within the PDM application, providers have the choice to request data updates via the standard PDM experience or by submitting a spreadsheet via a roster upload.

Roster Automation is 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 except for providers contracted with Carelon Behavioral Health.

The resources for this process are listed below and available on the provider website. Visit **provider.wellpoint.com/tx**, then under Resources, select Forms. Under Provider Demographics/Credentialing, these tools appear:

- **Roster Automation Rules of Engagement**: Is a reference document, available to help ensure 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 (*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 the PDM Application

Log on to **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, select **Upload Rosters** and follow the prompts.

Plan-Specific Termination Criteria

The occurrence of any of the following is grounds for termination of the Wellpoint provider's participation:

- Loss of reputation among peers due to unethical clinical practice or attitude
- The practice of fraud, waste and/or abuse
- Adverse publicity involving the provider due to acts of omission or commission
- Substance abuse
- Loss of professional office
- Inadequate record keeping
- Unsafe environment in the provider's office relative to inadequate access or other related issues that might cause a member injury
- An office that is improperly kept or unclean or does not present a proper appearance
- Failure to meet OSHA guidelines
- Failure to meet ADA guidelines

- Failure to meet Clinical Laboratory Improvement Amendments (CLIA) guidelines
- Member satisfaction ratings that drop below pre-established standards as determined by the medical advisory committee (MAC) (includes complaints relative to appearance, behavior, medical care, etc.)
- Repetitive complaints about office staff demeanor, presentation, and appearance
- Inclusion on the Debarred Providers Listing of the Office of the Inspector General of the Department of Health and Human Services (see "Sanctioned Providers" section below)
- Unfavorable inpatient- or outpatient-related indicators:
  - Severity-adjusted morbidity and mortality rates above established norms
  - Severity-adjusted length-of-stay above established norms
  - Unfavorable outpatient utilization results
  - Consistent inappropriate referrals to specialists
  - Improper maintenance of high-risk patients, such as those members with diabetes and hypertension
  - Underutilization relative to minimum standards of care established per medical management guidelines and/or accepted clinical practice in the community
  - Unfavorable malpractice-related issues
  - Frequent litigious activity above and beyond what would be expected for a provider in that particular specialty

Wellpoint providers have 30 calendar days to appeal a termination. The Wellpoint process is designed to comply with all state and federal regulations regarding the termination appeal process.

Incentives and Payment Arrangements

Financial arrangements concerning payment to providers for services to members are set forth in each Provider's Agreement. Wellpoint may also use financial incentives to reward providers for achieving certain quality indicator levels.

Wellpoint does not use or employ financial incentives that would directly or indirectly induce providers to limit or reduce medically necessary services furnished to individual enrollees. In cases where Wellpoint approves provider subcontracting arrangements, those subcontractors cannot employ any financial incentives inconsistent with this policy or CMS regulations.

Laws Regarding Federal Funds

Payments providers receive for furnishing services to members are derived in whole or in part from federal funds. Therefore, providers and any approved subcontractors must comply with certain laws applicable to individuals and entities receiving federal funds, including but not limited to Title VI of the *Civil Rights Act of 1964* as implemented by *45 CFR Part 84*; the *Age Discrimination Act of 1975* as implemented by *45 CFR Part 91*; the *Rehabilitation Act of 1973*; and the *Americans with Disabilities Act*.

Prohibition Against Discrimination

Neither Wellpoint nor its contracted providers may deny, limit, or condition the coverage or furnishing of services to members on the basis of any factor related to health status, including but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of healthcare
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability

Closing a Provider Panel

When closing a provider panel to new Wellpoint members or other new patients, providers must:

- Give Wellpoint prior written notice the provider panel is closing to new members as of a specific closing date.
- Keep the provider panel open to members who were patients of that practice before the panel closed or before they were enrolled with Wellpoint.
- Give Wellpoint prior written notice when reopening the provider panel, including a specific reopening date.

Transferring and Terminating Members from a Provider Panel

Wellpoint will determine reasonable cause for transferring a member based on written request and documentation submitted by the provider. Providers may not transfer a member to another provider due to the costs associated with the member's covered services.

A provider may request termination of a member due to fraud or disruption of medical services. In such cases, the provider should contact Provider Services at **855-878-1785**.

Reporting Obligations

Cooperation in Meeting CMS Requirements

Wellpoint is required to provide information to CMS necessary to administer and evaluate the Wellpoint program and to establish and facilitate a process for current and prospective members to exercise their choice in obtaining services.

Wellpoint provides the following information:

- Plan quality and performance indicators such as disenrollment rates (for beneficiaries enrolled in the plan the previous two years)
- Information on member satisfaction
- Information on health outcomes

Providers must cooperate with Wellpoint in its data reporting obligations by providing Wellpoint with any information required to meet these obligations in a timely fashion.

Certification of Diagnostic Data
Wellpoint is required to submit information to CMS necessary to characterize the context and purposes of each encounter between a member and provider, supplier, physician, or other practitioner (encounter data). Providers that furnish diagnostic data must certify (to the best of their knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.

Culturally and Linguistically Appropriate Services

Patient panels are increasingly diverse and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. Wellpoint wants to help, as we all work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed, how symptoms are described,
- Expectations of care and treatment options,
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine.

Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values, and preferred means of having those needs met
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

Wellpoint ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. We encourage providers to access and utilize the following resources.

MyDiversePatients.com: The My Diverse Patient website offers resources, information, and techniques, to help provide the individualized care every patient deserves regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **My Inclusive Practice -** Improving Care for LGBTQIA+ Patients: Helps providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients, & develop strategies for providing effective healthcare to LGBTQIA+ patients.
- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a healthcare encounter.
- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations and learn techniques to improve patient-centered communication to support needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- **Reducing Health Care Stereotype Threat (HCST):** Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

Cultural Competency Training (Cultural Competency and Patient Engagement): A training resource to increase cultural and disability competency to help effectively support the health and healthcare needs of your diverse patients.

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients. See Chapter 13 Interpreter Services for guidance on interpreter support.

Wellpoint appreciates the shared commitment to ensuring members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

Marketing

Providers may not develop or use any materials that market Wellpoint without our prior written approval. Under program rules, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Texas

STAR+PLUS Medicare-Medicaid plan unless the materials meet the CMS marketing guidelines and are first submitted to CMS for review and approval.

Additionally, providers can have plan marketing materials in their office as long as marketing materials for all plans the providers participate in are represented. Providers are allowed to have posters or notifications that show they participate in Wellpoint as long as the provider displays posters or notifications from all plans in which they participate.

Americans with Disabilities Act (ADA) Requirements

Wellpoint policies and procedures are designed to promote compliance with the ADA. Providers are required to take actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes the following:

- Access to an examination room that accommodates a wheelchair
- Access to a lavatory that accommodates a wheelchair
- Elevator or accessible ramp into facilities
- Handicap parking clearly marked unless there is street-side parking
- Street-level access
- Appropriate signage

For more information, please access the ADA website at **ada.gov.**

Reading/Grade Level Consideration

All Wellpoint member materials and website content are specially designed to take into consideration the Medicare-Medicaid Plan population's needs. Materials are intended to be user-friendly and concise. They are written at a reading level that is at or below 6th grade as measured by the Flesch Reading Ease Test. All member materials regarding advance directives are written at a 6th grade reading comprehension level, except where a provision is required by state or federal law and the provision cannot be reduced or modified to a 6th grade reading level because it is a reference to the law or is required to be included “as written” in the state or federal law.

CHAPTER 4: HEALTHCARE BENEFITS

Member Eligibility

To be eligible to participate in the Texas STAR+PLUS Medicare-Medicaid Plan (MMP) Demonstration, individuals must meet the following criteria:

- Age 21 and older
- Coverage with Medicare Part A, B and D
- Coverage with full Medicaid benefits through the Texas Medicaid STAR+PLUS program
- Reside in one of the Demonstration counties

Voluntary Enrollment

Other eligible individuals may choose to participate or opt to enroll but will not be passively enrolled. These include:

- Those in a Medicare Advantage Plan not operated by an MMP participating in the demonstration.
- Those participating in a Medicare Accountable Care Organization with fewer than 9,000 members.
- Those receiving services through the Program of All-Inclusive Care for the Elderly (PACE).

Individuals who meet at least one of the exclusion criteria listed below will be excluded from the Demonstration as appropriate:

- Dual-eligible children (age 20 and younger)
- Dual-eligible individuals not eligible for STAR+PLUS today, including those receiving services in a community-based intermediate care facility for individuals with intellectual disabilities or related conditions (ICF-IID) or receiving services in the following ICF-IID 1915 (c) waivers:
  - Home and Community-Based Services (HCS)
  - Community Living and Support Services (CLASS)
  - Texas Home Living (TxHmL)
  - Deaf-Blind Multiple Disabilities (DBMD)

The following individuals may receive Medicaid coverage for 1) Medicare monthly premiums for Part A, Part B, or both (carved-out payment); 2) coinsurance, copay, and deductible for Medicare-allowed services; and 3) Medicaid-covered services, including those that are not covered by Medicare:

- Individuals who are inpatients in state mental hospitals
- Individuals who are residents of state hospitals, ICF/MR facilities, residential treatment facilities or long-stay hospitals defined in Appendix 1
  - Dual-eligible individuals residing in nursing facilities will be enrolled in the Demonstration.
- Individuals who are participating in federal waiver programs for home- and community-based Medicaid coverage other than the EDCD Waiver (e.g., Individual and Family Developmental Disability Support, Intellectual Disabilities, Day Support, Technology-Assisted, and Alzheimer's Assisted Living Waivers)
- Individuals enrolled in a hospice program

  - Individuals receiving hospice services at the time of enrollment will be excluded from the Demonstration. If an individual enters a hospice program while enrolled in the Demonstration, he/she will be disenrolled from the Demonstration. However, plans shall refer these individuals to the EDCD Waiver preadmission screening team for additional LTSS.
- Individuals receiving the end-stage renal disease (ESRD) Medicare benefit at the time of enrollment into the Demonstration
  - However, an individual who develops ESRD while enrolled in the Demonstration will remain in the Demonstration unless he or she opts out. If he or she opts out, the individual cannot opt back into the Demonstration.
- Individuals with other comprehensive group or individual health insurance coverage other than full benefit Medicare, insurance provided to military dependents and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP)
- Individuals who have a Medicaid eligibility period that is less than three months
- Individuals who have a Medicaid eligibility period that is only retroactive
- Individuals enrolled in the Money Follows the Person (MFP) program
- Individuals residing outside of the Demonstration areas
- Individuals enrolled in a Program of All-Inclusive Care for the Elderly (PACE)
  - However, PACE participants may enroll in the Demonstration if they choose to disenroll from their PACE provider.
- Individuals participating in the CMS Independence at Home (IAH) demonstration
  - However, IAH participants may enroll in the Demonstration if they choose to disenroll from IAH.

Role of the Enrollment Broker/Maximus

To support enrollment decisions, the Texas State Health, and Human Services Commission (HHSC) will ensure that enrollees are educated on Texas STAR+PLUS Medicare-Medicaid Plan (MMP) benefits, Wellpoint networks, and the process for opting out of the Demonstration and for changing MCOs.

HHSC will focus on developing clear and accessible information (ensuring availability in alternative formats and languages) on available MCOs and consumer protections. To help facilitate enrollment choices, HHSC has contracted with Maximus to:

- Help educate enrollees.
- Assist with enrollment and MCO selection.
- Operate a toll-free enrollee helpline.

Summary of Benefits Tables

Notations regarding some benefit categories are listed below. Please note availability and limitations and refer to the appropriate Summary of Benefits for detailed information.

Precertification requirements are described in later sections and in detail on the provider website. All services from noncontracted providers, with the exceptions of urgent and emergent care and out-of-area dialysis, require precertification.

The medical benefits are further explained in the following sections.

Service	Coverage Description
Abdominal aortic aneurysm screening	Wellpoint will pay only once for an ultrasound screening for members at risk. A participant is at risk if he or she has a family history of abdominal aortic aneurysms, or he is a man 65 to 75 years of age and has smoked at least 100 cigarettes in his lifetime. Members must get a doctor's order for this screening at their "Welcome to Medicare" preventive visit.
Acupuncture	Acupuncture for chronic low back pain The plan will pay for up to 12 visits in 90 days for members with chronic low back pain: • Lasting 12 weeks or longer • Not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease) • Not associated with surgery; and • Not associated with pregnancy. The plan will pay for an additional 8 sessions if patient is improving. Plans will not pay for more than 20 acupuncture treatments each year. Acupuncture treatments must be stopped if patient doesn't get better or if you get worse.
Adult day healthcare	Wellpoint will pay for adult day healthcare for members who are functionally impaired, not homebound, and who require certain preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services. Adult day healthcare includes the following services: • Medical • Nursing • Food and nutrition • Social services • Rehabilitation therapy • Leisure time activities, which are a planned program of diverse meaningful activities • Dental • Pharmaceutical • Other ancillary services

Service	Coverage Description
AIDS adult day healthcare	Coverage includes AIDS adult day healthcare programs (ADHCP) for members with HIV; ADHCP includes the following services: • Individual and group counseling/education provided in a structured program setting • Nursing care (including triage/assessment of new symptoms) • Medication adherence support • Nutritional services (including breakfast and/or lunch) • Rehabilitative services • Substance abuse services • Mental health services • HIV risk reduction services
Alcohol misuse screening and counseling	Coverage includes one alcohol-misuse screening (SBIRT) for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. Members who screen positive for alcohol misuse can get up to four brief, face-to-face counseling sessions each year with a qualified primary care provider or practitioner in a primary care setting.
Ambulance services	Covered ambulance services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take member to the nearest place to provide care. The member's condition must be serious enough that other ways of getting to a place of care could risk the member's life or health. Ambulance services for other cases must be approved by the participant's ICT or Wellpoint. In cases that are *not* emergencies, the participant's ICT or Wellpoint may authorize the use of an ambulance. The participant's condition must be serious enough that other ways of getting to a place of care could risk member's life or health.
Ambulatory surgery center services	Wellpoint will pay for covered surgical procedures provided at ambulatory surgical centers.
Assertive community treatment (ACT)	Wellpoint will pay for ACT services. ACT is a mobile team-based approach to delivering comprehensive and flexible treatment, rehabilitation, case management and support services to individuals in their natural living setting.

Service	Coverage Description
Assisted living program	Wellpoint will pay for Assisted Living Program services provided in an adult home or enriched housing setting. Services include: • Personal care • Housekeeping • Supervision • Home health aides • Personal emergency response services • Nursing • Physical, occupational and/or speech therapy • Medical supplies and equipment • Adult day healthcare • A range of home health services • Case management services of a registered professional nurse
Assistive technology	Wellpoint will pay for physical adaptations to the private residence of the participant or the participant's family. The adaptations must be necessary to ensure the health, welfare, and safety of the participant or enable the participant to function with greater independence in the home. Covered adaptations include: • Installation of ramps and grab bars • Widening of doorways • Modifications of bathrooms • Installation of specialized electric and plumbing systems
Bone mass measurement	Coverage includes certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. Wellpoint will pay for the services once every 24 months or more often if they are medically necessary. Wellpoint will also pay for a provider to look at and comment on the results.
Breast cancer screening (mammograms)	Coverage includes the following services: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months

Service	Coverage Description
Cardiac (heart) rehabilitation services	Coverage includes cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's referral. Coverage also includes intensive cardiac rehabilitation programs.
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)	Coverage includes one visit a year with a PCP to help lower risk for heart disease. During this visit, providers may: • Discuss aspirin use. • Check blood pressure. • Provide information to make sure members are eating well.
Cardiovascular (heart) disease testing	Coverage includes blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.
Care management (service coordination)	Care management is an individually designed intervention that helps the participant get access to needed services. These care management interventions are designed to ensure the participant's health and welfare and increase the participant's independence and quality of life.
Cervical and vaginal cancer screening	Coverage includes the following: • For all women: Pap tests and pelvic exams once every 24 months • For women who are at high risk of cervical cancer: one Pap test every 12 months • For women who have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months
Chemotherapy	Wellpoint will pay for chemotherapy for cancer patients. Chemotherapy is covered when it is provided in an inpatient or outpatient unit of a hospital, a provider's office, or a freestanding clinic.
Chiropractic services	Coverage includes adjustments of the spine to correct alignment.

Service	Coverage Description
Colorectal cancer screening	Wellpoint will pay for the following: • **Barium enema**: Covered once every 48 months if participant is 50 or over and once every 24 months if participant is at high risk for colorectal cancer, when this test is used instead of a flexible sigmoidoscopy or colonoscopy • **Colonoscopy**: Covered once every 24 months if participant is at high risk for colorectal cancer. If participant is not at high risk for colorectal cancer, Medicare covers this test once every 120 months, or 48 months after a previous flexible sigmoidoscopy. • **Fecal occult blood test**: Covered once every 12 months if participant is 50 or older • **Flexible sigmoidoscopy**: Covered once every 48 months for most members 50 or older. If participant isn't at high risk, Medicare covers this test 120 months after a previous screening colonoscopy.
Community integration counseling	Wellpoint will pay for community integration counseling. This is a counseling service provided to members who are coping with altered abilities and skills, a revision of long-term expectations, or changes in roles in relation to significant others. This service is primarily provided in the provider's office or the participant's home. Community integration counseling services are usually provided in one-to-one counseling sessions. However, there are times when it is appropriate to provide this service to the participant in a family counseling or group counseling setting.
Community transitional services	Wellpoint will pay for Community Transitional Services (CTS). These services help a participant transition from living in a nursing facility to living in the community. CTS includes: • The cost of moving furniture and other belongings. • Buying certain essential items such as linen and dishes. • Security deposits, including broker's fees required to obtain a lease on an apartment or home. • Buying essential furnishings. • Set-up fees or deposits for utility or service access (for example, telephone, electricity, or heating). • Health and safety assurances such as pest removal, allergen control, or one time cleaning prior to occupancy. CTS cannot be used to purchase diversional or recreational items, such as televisions, VCRs/DVDs, or music systems.

Service	Coverage Description
Consumer-directed personal assistance services (CDPAS)	Wellpoint will pay for CDPAS, which provides services to chronically ill or physically disabled individuals who have a medical need for help with activities of daily living (ADLs) or skilled nursing services. Services can include any of the services provided by a personal care aide (home attendant), home health aide or nurse. Participants who choose CDPAS have flexibility and freedom to choose their caregivers. The participant or the person acting on the participant's behalf (such as the parent of a disabled or chronically ill child) is responsible for recruiting, hiring, training, supervising, and if necessary, terminating caregivers providing CDPAS services.
Continuing day treatment	Wellpoint will pay for continuing day treatment. This service helps members maintain or enhance current levels of functioning and skills, maintain community living, and develop self-awareness and self-esteem. Services include: • Assessment and treatment planning. • Discharge planning. • Medication therapy. • Medication education. • Case management. • Health screening and referral. • Rehabilitative readiness development. • Psychiatric rehabilitative readiness determination and referral. • Symptom management.
Day treatment	Wellpoint will pay for six months of day treatment. Day treatment is a combination of diagnostic, treatment and rehabilitative procedures that provide the services of the clinic treatment program as well as social training, task and skill training, and socialization activities.
Defibrillator (implantable automatic)	Wellpoint will pay for defibrillators for certain people diagnosed with heart failure, depending on whether the surgery takes place in a hospital inpatient or outpatient setting.

Service	Coverage Description
Dental services	Coverage includes the following: • Oral exams once every six months • Cleaning once every six months • Dental X-rays once every six months • Diagnostic services • Restorative services • Endodontics, periodontics, and extractions • Dental prosthetics and orthotic appliances required to alleviate a serious condition, including one that affects a participant's employability • Other oral surgery • Dental emergencies • Other necessary dental care • Supplemental comprehensive coverage is $1600/year, $400 every 3 months.
Depression screening	Wellpoint will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and recommendations for additional treatments.
Diabetes screening	Coverage includes screening (including fasting glucose tests) if the member has any of the following risk factors: • High blood pressure (hypertension) • History of abnormal cholesterol and triglyceride levels (dyslipidemia) • Obesity • History of high blood sugar (glucose) Tests may be covered in some other cases, such as if the member is overweight and has a family history of diabetes. Depending on the test results, members may qualify for up to two diabetes screenings every 12 months.

Service	Coverage Description
Diabetic self-management training, services, and supplies	Coverage includes the following services for all members who have diabetes (whether they use insulin or not): • Supplies to monitor blood glucose, including the following: – A blood glucose monitor – Blood glucose test strips – Lancet devices and lancets – Glucose-control solutions for checking the accuracy of test strips and monitors • For members with diabetes who have severe diabetic foot disease, Wellpoint covers one of the following: – One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year – One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) Coverage also includes fitting the therapeutic custom-molded shoes or depth shoes and training to help members manage their diabetes in some cases

Service	Coverage Description
Durable medical equipment and related supplies	The following items are covered: • Wheelchairs • Oxygen equipment • Crutches • IV infusion pumps • Hospital beds • Walkers • Nebulizers Other items *may* be covered. Please refer to the Wellpoint list of durable medical equipment to see which is covered. Generally, Wellpoint covers any durable medical equipment covered by Medicare and Medicaid from the brands and makers on this list. We will not cover other brands and makers unless the member's SCT or Wellpoint authorizes a doctor or other provider's request for the brand. However, if the member is new to Wellpoint and using a brand of durable medical equipment that is not on our list, we will continue to pay for this brand for up to 90 days. During this time, the member should talk with their service coordinator or SCT to decide what brand is medically right for the member after this 90-day period. If the member or their provider does not agree with the SCT or Wellpoint decision about paying for the equipment, the participant or their provider may file an appeal. The member can also file an appeal if they do not agree with their provider's decision about what product or brand is right for the member's medical condition.

Service	Coverage Description
Emergency care	*Emergency care* means services that are given by a provider trained to give emergency services and needed to treat a medical emergency or behavioral emergency. A *medical or behavioral emergency* is a condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in any of the following: • Placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy • Serious harm to bodily functions • Serious dysfunction of any bodily organ or part • In the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur: – There is not enough time to safely transfer the member to another hospital before delivery. – The transfer may pose a threat to the health or safety of the member or unborn child. ***Members may get covered emergency care whenever they need it, anywhere in the United States or its territories.***
Environmental modifications and adaptive devices	Wellpoint will pay for internal and external physical adaptations to the home that are necessary to ensure the health, welfare, and safety of the participant. Environmental modifications may include: • Installation of ramps and grab bars. • Widening of doorways. • Modifications of bathroom facilities. • Installation of specialized electrical or plumbing systems to accommodate necessary medical equipment. • Any other modification necessary to ensure the participant's health, welfare, or safety.

Service	Coverage Description
Family planning services	Participants may choose any provider for certain family planning services. This includes any doctor, clinic, hospital, pharmacy, or family-planning office. Coverage includes the following services: • Family planning exam and medical treatment • Family planning lab and diagnostic tests • Family planning methods (birth control pills, patch, ring, IUD, injections, implants) • Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • Counseling and diagnosis of infertility and related services • Counseling and testing for sexually transmitted infections (STIs), AIDS and other HIV-related conditions as part of a family planning visit • Treatment for sexually transmitted infections (STIs) • Voluntary sterilization (members must be age 21 or older and must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that the member signs the form and the date of surgery.) • Abortion
Freestanding birth center services	Wellpoint will cover all medically necessary services at freestanding birth centers.
Health and wellness education programs	Wellpoint will pay for health and wellness education for members and their caregivers, which includes: • Classes, support groups, and workshops. • Educational materials and resources. • Website, email, or mobile application communications. These services are provided on topics including but not limited to: heart attack and stroke prevention, asthma, living with chronic conditions, back care, stress management, healthy eating and weight management, oral hygiene, and osteoporosis. This benefit also includes annual preventive care reminders and caregiver resources.

Service	Coverage Description
Hearing services	Coverage includes hearing and balance tests conducted by the participant's provider. They are covered as outpatient care when a participant gets them from a physician, audiologist, or other qualified provider. Hearing services and products are covered when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include the following: • Hearing aid selecting, fitting, and dispensing • Hearing aid checks following dispensing • Conformity evaluations and hearing aid repairs • Audiology services, including examinations and testing • Hearing aid evaluations and hearing aid prescriptions • Hearing aid products, including hearing aids, ear molds, special fittings, and replacement parts when authorized by an audiologist
HIV screening	Coverage includes one HIV screening exam every 12 months for members who ask for an HIV screening test or are at increased risk for HIV infection. For women who are pregnant, coverage includes up to three HIV screening tests during a pregnancy.
Home- and community-support services (HCSS)	Wellpoint will pay for HCSS for members: • Who require assistance with personal care services tasks. • Whose health and welfare in the community is at risk because supervision of the participant is required when no personal care task is being performed.
Home-delivered and congregate meals	Wellpoint will pay for congregate and home-delivered meals. This is an individually designed service that provides meals to members who cannot prepare or obtain nutritionally adequate meals for themselves, or when providing such meals will decrease the need for more costly supported in-home meal preparation. This benefit includes three meals a day for 52 weeks a year.
Home health services	Before members can get home health services, a provider must inform Wellpoint of the participant's need for them, and they must be provided by a home health agency. Wellpoint will pay for the following services: • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies

Service	Coverage Description
Home health agency care	Coverage includes the following services: • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies
Home infusion	Wellpoint will pay for the administration of home infusion drugs and supplies.
Home maintenance services	Wellpoint will pay for home maintenance services. Home maintenance services include household chores and services that are required to maintain an individual's home environment in a sanitary, safe, and viable manner. Chore services are provided on two levels: • Light chores – Cleaning and/or washing of windows, walls, and ceilings; snow removal and/or yard work; tacking down loose rugs and/or securing tiles; and cleaning of tile work in bath and/or kitchen. Light chores are provided when needed. • Heavy-duty chores – Limited to one-time-only, intensive cleaning/chore efforts, except in extraordinary situations. Heavy-duty chore services may include (but are not limited to) tasks such as scraping and/or cleaning of floor areas.
Home visits by medical personnel	Wellpoint will cover home visits by medical personnel to provide diagnosis, treatment, and wellness monitoring. The purpose of these home visits is to preserve the participant's functional capacity to remain in the community. Wellness monitoring includes disease prevention, health education and identifying health risks that can be reduced.
Immunizations	Coverage includes the following services: • Pneumonia vaccine • Flu shots, once a year, in the fall or winter • Hepatitis B vaccine if you the member is at high or intermediate risk of getting hepatitis B • Other vaccines if the member is at risk and they meet Medicare Part B coverage rules Coverage also includes other vaccines that meet the Medicare Part D coverage rules.

Service	Coverage Description
Independent living skills and training	Independent living skills training and development (ILST) services are individually designed to improve or maintain the ability of the participant to live as independently as possible in the community. ILST may be provided in the participant's residence and in the community. Services may include assessment, training, and supervision of or assistance with the following: self-care; medication management; task completion; communication, interpersonal, sensory/motor, community transportation, problem solving, and prevocational skills; socialization; mobility; reduction/elimination of maladaptive behaviors; money management; and ability to maintain a household
Inpatient acute hospital care, including substance abuse and rehabilitative services	Coverage includes the following services: • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units, such as intensive/coronary care units • Drugs and medications • Lab tests, X-rays, and other radiology services • Needed surgical and medical supplies • Appliances, such as wheelchairs • Operating and recovery room services • Physical, occupational and speech therapy • Inpatient substance abuse services • Blood, including storage and administration • Physician services • In some cases, the following transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell and intestinal/multi-visceral If a member needs a transplant, a Medicare-approved transplant center will review their case and decide whether they are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, the member can get their transplant services locally or at a distant location outside the service area. If Wellpoint provides transplant services at a distant location outside the service area and the member chooses to get their transplant there, Wellpoint will arrange or pay for lodging and travel costs for the member and one other person.

Service	Coverage Description
Inpatient mental healthcare	Coverage includes mental healthcare services that require a hospital stay, including days in excess of the Medicare 190-day lifetime maximum.
Inpatient services covered during a non-covered inpatient stay	Inpatient stays that are not reasonable and needed will be denied. However, in some cases Wellpoint will pay for services members get while they are in the hospital or a skilled nursing facility (SNF) even if the hospital stay is not covered: • Provider services • Diagnostic tests, like lab tests • X-ray, radium, and isotope therapy, including technician materials and services • Surgical dressings • Splints, casts, and other devices used for fractures and dislocations • Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices; these are devices that: – Replace all or part of an internal body organ (including contiguous tissue) – Replace all or part of the function of an inoperative or malfunctioning internal body organ • Leg, arm, back and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs and replacements needed because of breakage, wear, loss, or a change in the patient's condition • Physical therapy, speech therapy and occupational therapy
Intensive psychiatric rehabilitation treatment programs	Wellpoint will pay for time-limited, active psychiatric rehabilitation designed to: • Help a participant form and achieve mutually agreed upon goals in living, learning, working and social environments. • Intervene with psychiatric rehabilitative technologies to help a participant overcome functional disabilities.

Service	Coverage Description
Kidney disease services and supplies	Coverage includes the following services: • Kidney disease education services to teach kidney care and help members make good decisions about their care. Members must have stage IV chronic kidney disease, must refer be referred by their physician. Coverage includes up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area • Inpatient dialysis treatments if the participant is admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for the participant and anyone helping the participant with home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on home dialysis, to help in emergencies, and to check dialysis equipment and water supply.
Medical nutrition therapy	This is covered for members with diabetes or kidney disease without dialysis. It is also covered after a kidney transplant when referred by the member's provider. Coverage includes three hours of one-on-one counseling services during the first year the member receives medical nutrition therapy services under Medicare; this includes our plan, any other Medicare Advantage plan or Medicare. Coverage includes up to two hours of one-on-one counseling services each year after that. If the member's condition, treatment or diagnosis changes, the member may be able to get more hours of treatment with a provider's request and approval by the SCT or Wellpoint. A provider must prescribe these services and renew the request to the SCT or to Wellpoint each year if your treatment is needed in the next calendar year.
Medical social services	Wellpoint will pay for medical social services, which includes the assessment of social and environmental factors related to the participant's illness and need for care. Services include: • Home visits to the individual, family, or both. • Visits to prepare to transfer the participant to the community. • Patient and family counseling, including personal, financial, and other forms of counseling services.

Service	Coverage Description
Medicare Part B prescription drugs	These drugs are covered under Part B of Medicare. Wellpoint will pay for the following drugs: • Injected or infused while provided by a physician, hospital outpatient, or ambulatory surgery center services • Drugs taken using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors – self-injection for members with hemophilia • Immunosuppressive drugs, if member is enrolled in Medicare Part A at the time of the organ transplant • Osteoporosis drugs that are injected. These drugs are paid for if member is homebound, has a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug themselves • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics and erythropoiesis-stimulating agents (such as Procrit®, Aranesp®) • IV immune globulin for the home treatment of primary immune deficiency diseases
Medication therapy management (MTM) services	Wellpoint provides medication therapy management (MTM) services for members who take medications for different medical conditions. MTM programs help members, and their providers make sure members' medications are working to improve their health.
Mobile mental health treatment	Wellpoint will pay for mobile mental health treatment, which includes individual therapy provided in the home. This service is available to members who have a medical condition or disability that limits their ability to come into an office for regular outpatient therapy sessions.

Service	Coverage Description
Moving assistance	Wellpoint will pay for moving assistance services. These are individually designed services intended to move a participant's possessions and furnishings when the participant must be moved from inadequate or unsafe housing to an environment which more adequately meets the participant's health and welfare needs and reduces the risk of unwanted nursing facility placement. Moving assistance does not include items such as security deposits, including broker's fees required to obtain a lease on an apartment or home; set-up fees or deposits for utility or service access (for example, telephone, electricity, heating); and health and safety assurances such as pest removal, allergen control or cleaning prior to occupancy.
24-Hour Nurse Help Line	Wellpoint has a nurse help line, which is a toll-free phone service that members can call 24 hours a day, 7 days a week. Members can call the nurse help line for answers to general health-related questions and for assistance in accessing services through Wellpoint.
Nursing facility care	Wellpoint will pay for nursing facilities for members who need 24-hour nursing care and supervision outside of a hospital.
Nutrition (includes nutritional counseling and educational services)	Wellpoint will pay for nutrition services provided by a qualified nutritionist. Services include: • Assessment of nutritional needs and food patterns. • Planning for providing food and drink appropriate for the individual's physical and medical needs and environmental conditions.
Obesity screening and therapy to keep weight down	Coverage is available for members with a body mass index of 30 or more and includes counseling to help the member lose weight. Members must get the counseling in a primary care setting and be managed within the member's full prevention plan.
Other supportive services the SCT determines are necessary	Wellpoint will pay for additional supportive services or items determined by the participant's SCT to be necessary for the participant. This is meant to cover items or services that are not traditionally included in the Medicare or Medicaid programs but that are necessary and appropriate for the participant. One example is Wellpoint paying for a blender to puree foods for a participant who cannot chew.

Service	Coverage Description
Outpatient blood services	Blood, including storage and administration, beginning with the first pint you need
Outpatient diagnostic tests and therapeutic services and supplies	Coverage includes the following services: • CT scans, MRIs, EKGs, and X-rays when a provider orders them as part of treatment for a medical problem • Radiation (radium and isotope) therapy, including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used for fractures and dislocations • Medically necessary clinical lab services and tests ordered by a provider to help diagnose or rule out a suspected illness or condition • Blood, including storage and administration • Other outpatient diagnostic tests
Outpatient hospital services	Coverage is available for medically needed services available in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Coverage includes the following services: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Labs and diagnostic tests billed by the hospital • Mental healthcare, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Some screenings and preventive services • Some drugs that members can't give themselves

Service	Coverage Description
Outpatient mental healthcare	Coverage includes mental health services provided by the following: • A state-licensed psychiatrist or doctor • A clinical psychologist • A clinical social worker • A clinical nurse specialist • A nurse practitioner • A physician assistant • Any other Medicare-qualified mental healthcare professional as allowed under applicable state laws Coverage includes the following services: • Group therapy sessions • Clinic services • Day treatment • Psychosocial rehab services Participants may directly access one assessment from a network provider in a 12-month period without getting prior authorization.
Outpatient rehabilitation services	Coverage includes physical therapy (PT), occupational therapy (OT) and speech therapy (ST). Members can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs) and other facilities. OT, PT and ST services are limited to twenty visits per therapy per calendar year, except for individuals with intellectual disabilities, individuals with traumatic brain injury and individuals under age 21.
Outpatient surgery	Coverage is available for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.
Palliative care	Wellpoint covers interdisciplinary end-of-life care and consultation with the participant and his/her family members. These services help to prevent or relieve pain and suffering and to enhance the participant's quality of life. Services include the following: • Family palliative care education • Pain and symptom management • Bereavement services • Massage therapy • Expressive therapies

Service	Coverage Description
Partial hospitalization services	Partial hospitalization is a structured program of active psychiatric treatment. It is offered in a hospital outpatient setting or by a community mental health center. It is more intense than the care a member gets in their doctor's or therapist's office. It can help keep members from having to stay in the hospital. Wellpoint will pay for partial hospitalization to serve as an alternative to inpatient hospitalization or to reduce the length of a hospital stay within a medically supervised program. Services include the following: • Assessment and treatment planning • Health screening and referral • Symptom management • Medication therapy • Medication education • Verbal therapy • Case management • Psychiatric rehabilitative readiness determination • Referral and crisis intervention
Peer-delivered services	Wellpoint will pay for peer support services provided by a peer support provider. This is a person who assists individuals with their recovery from mental illness and substance abuse disorders.
Peer mentoring	Wellpoint will pay for peer mentoring for members who have recently transitioned into the community from a nursing facility or during times of crisis. This is an individually designed service intended to improve the participant's self-sufficiency, self-reliance, and ability to access needed services, goods, and opportunities in the community. This will be accomplished through education, teaching, instruction, information-sharing and self-advocacy training.
Personal care services (PCS)	Wellpoint will pay for PCS to assist members with activities such as personal hygiene, dressing, feeding and nutritional and environmental support function tasks (meal preparation and housekeeping). PCS must be medically necessary, ordered by the participant's physician, and provided by a qualified person according to a plan of care.
Personal emergency response services (PERS)	Wellpoint will pay for PERS, which is an electronic device that enables certain high-risk members to reach out for help during an emergency.

Service	Coverage Description
Personalized recovery-oriented services (PROS)	Wellpoint will pay for PROS to assist individuals in recovery from the disabling effects of mental illness. This includes the coordinated delivery of a customized array of rehabilitation, treatment, and support services in traditional settings and in off-site locations.
Pharmacy benefits (outpatient)	Wellpoint will pay for certain generic, brand, and OTC drugs to treat a participant's illness or condition.
Physician/provider services, including doctor's office visits	Coverage includes the following services: • Medically necessary healthcare or surgery services given in places such as: – Physician's office. – Certified ambulatory surgical center. – Hospital outpatient department. • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams given by a primary care provider ***or*** specialist • Second opinion before a medical procedure
Podiatry services	Coverage includes the following services: • Care for medical conditions affecting lower limbs, including diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • Routine foot care for members with conditions affecting the legs, such as diabetes. Wellpoint will pay for four routine foot care visits every year for all members.
Positive behavioral interventions and support (PBIS)	Wellpoint will pay for PBIS for members who have significant behavioral difficulties that jeopardize their ability to remain in the community. The primary focus of this service is to decrease the intensity and/or frequency of the targeted behaviors and to teach safer or more socially appropriate behaviors. Examples of PBIS include: • Comprehensive assessment of the participant. • Development and implementation of a holistic structured behavioral treatment plan. • Training of family, natural supports, and other providers. • Regular reassessment of the effectiveness of the participant's behavioral treatment plan.

Service	Coverage Description
Prescription drug coverage	Wellpoint follows this Formulary Tier Structure: • Tier 1 – Medicare Part D preferred brand/generic drugs with $0 copay • Tier 2 – Medicare Part D preferred and nonpreferred brand/generic drugs – low-income subsidies (LIS) copay applies • Tier 3 – state Medicaid Rx generic drugs and brand name drugs with $0 copay • Tier 4 – state Medicaid over-the-counter (OTC) with $0 copay
Prescription drugs	Prescription drugs are only available by prescription, are used or sold in the United States and must be used for medically accepted indications. Prescription drugs covered by Wellpoint are listed in the Wellpoint formulary. The formulary includes all generic drugs covered under the program as well as many brand-name drugs, nonpreferred brands and specialty drugs. One can view a copy of the formulary on the Wellpoint website at **provider.wellpoint.com/tx** or request a copy from the Provider Relations department. Some of these drugs have precertification or step-therapy requirements or quantity limits. Providers may request authorization for a drug or coverage of a drug not on the formulary by contacting the Pharmacy department **855-878-1785** or via fax at **844-494-8342**. Wellpoint members should obtain covered drugs from a network pharmacy pursuant to a physician's prescription. Pharmacy claims are processed by CarelonRx, the Wellpoint pharmacy benefit management vendor. CarelonRx services also include home infusion, specialty pharmacy and mail-order pharmacy. More information on these services can be obtained by contacting the Pharmacy department at the number listed above.

Service	Coverage Description
Prescription drugs by mail order	Members can use the mail-order service to fill prescriptions for maintenance drugs (i.e., drugs taken on a regular basis for a chronic or long-term medical condition). For mail-order prescriptions, the physician must write on the maintenance drug prescription whether it is for a 31-, 62- or 93-day supply. When mailing in a prescription to the mail-order service for the first time, the member should allow up to two weeks for the prescription to be filled. For refills of the same prescription, members should allow up to two weeks for mailing and processing. If a member runs out of a medication before receiving a new supply from the mail-order pharmacy, call Pharmacy at **833-203-1738** They will assist with obtaining an emergency supply of the participant's medication until he or she receives the new mail-order supply. Participants are not required to use mail-order prescription drug services to obtain an extended supply of maintenance medications. Members also have the option of using a retail pharmacy in the Wellpoint network to obtain their maintenance medications. Some retail pharmacies may agree to accept the mail-order reimbursement rate for an extended supply of medication, which may result in no out-of-pocket payment difference to the participant.
Preventive services	Wellpoint will pay for all preventive tests and screenings covered by Medicare and Medicaid to help prevent, find, or manage a medical problem. This includes but is not limited to all the preventive services listed in this table.
Private duty nursing services	Wellpoint will pay for private duty nursing services covered for continuous or intermittent skilled nursing services. These services are provided in the member's home and are beyond what a certified home health agency can provide.
Prostate cancer screening exams	Coverage is for men age 50 and older and includes the following services once every 12 months: • A digital rectal exam • A prostate specific antigen (PSA) test

Service	Coverage Description
Prosthetic devices and related supplies	Coverage includes the following prosthetic devices: • Colostomy bags and supplies related to colostomy care • Pacemakers • Braces • Prosthetic shoes • Artificial arms and legs • Breast prostheses (including a surgical brassiere after a mastectomy) • Orthotic appliance and devices • Support stockings • Orthopedic footwear Coverage also includes some supplies related to prosthetic devices, including repair or replacement of prosthetic devices.
Pulmonary rehabilitation services	Wellpoint will pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). The participant must have an order approved by the ICT or Wellpoint for pulmonary rehabilitation from the provider treating the COPD. This service is initially limited to 36 visits over a 12- to 18-week period but can be renewed. No prior authorization is required for the first course of treatment. Physician authorization is required for additional courses of treatment.
Respiratory care services	Wellpoint will pay for respiratory therapy, which is an individually designed service provided in the home. Respiratory therapy includes preventive, maintenance and rehabilitative airway-related techniques and procedures.
Respite care services	Wellpoint will pay for respite care services to provide scheduled relief to nonpaid supports who provide primary care and support to a participant. The service may be provided in a 24-hour block of time as required. The primary location for this service is in the participant's home, but respite services may also be provided in another community dwelling or facility acceptable to the participant.

Service	Coverage Description
Sexually transmitted infections (STIs) screening and counseling	Wellpoint will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A PCP or other primary care practitioner must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. Wellpoint will also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20-30 minutes long. Wellpoint will pay for these counseling sessions as a preventive service only if they are given by a PCP. The sessions must be in a primary care setting, such as a doctor's office.
Skilled nursing facility care	Wellpoint covers an unlimited number of days of skilled nursing facility care, and there is no prior hospital stay required. Coverage includes the following services: • A semi-private room or a private room if it is medically needed • Meals, including special diets • Nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs that're part of the member's plan of care, including substances that are naturally in the body, such as blood-clotting factors • Blood, including storage and administration • Medical and surgical supplies given by nursing facilities • Lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • Appliances, such as wheelchairs, usually given by nursing facilities • Physician/provider services Members will usually get care from network facilities. However, members may be able to get care from a facility not in our network. Members can get care from the following places if they accept our plan's amounts for payment: • A nursing home or continuing care retirement community where a member lived before they went to the hospital (as long as it provides nursing facility care) • A nursing facility where the member's spouse lives at the time the member leaves the hospital

Service	Coverage Description
Silver Sneakers Fitness Membership	Wellpoint provides the Silver Sneakers program as a supplemental benefit. Members are instructed on the use of the contracted fitness center's equipment and home self-paced exercise programs through an orientation of the program.
Smoking and tobacco cessation (counseling to stop smoking or tobacco use)	If a member uses tobacco but does not have signs or symptoms of tobacco-related disease; uses tobacco and has been diagnosed with a tobacco-related disease; or is taking medicine that may be affected by tobacco: • Wellpoint will pay for two counseling quit attempts in a 12-month period as a preventive service. This service is free for the member. Each counseling attempt includes up to four face-to-face visits. • Wellpoint will pay for smoking cessation counseling for pregnant women and women up to six months after birth. This smoking cessation counseling is in addition to benefits for prescriptions and over-the-counter smoking cessation products.
Social and environmental supports	Wellpoint will pay for services and items to support a member's medical needs. Services may include: • Home maintenance tasks. • Homemaker/chore services. • Housing improvement. • Respite care.
Social day care	Wellpoint will pay for social day care for functionally impaired members for less than 24 hours per day. The services included in this benefit provide members with socialization, supervision, and monitoring, personal care, and nutrition in a protective setting.
Social day care transportation	Wellpoint will pay for transportation between a member's home and the social day care facilities.

Service	Coverage Description
Structured day program	Wellpoint will pay for structured day program services provided in an outpatient congregate setting or in the community. Services are designed to improve or maintain the participant's skills and ability to live as independently as possible in the community. Services may include the following: • Assessment • Training and supervision to an individual with self-care • Task completion • Communication skills • Interpersonal skills • Problem-solving skills • Socialization • Sensory/motor skills • Mobility • Community skills • Reduction/elimination of maladaptive behaviors • Money management skills • Ability to maintain a household
Substance abuse services: Opioid treatment services	Wellpoint will pay for opioid treatment services to help members manage addiction to opiates such as heroin. Opioid treatment programs administer medication, generally methadone by prescription, along with a variety of other clinical services. These programs help members control the physical problems associated with opiate dependence and provide the opportunity for members to make major lifestyle changes over time. This service does not include methadone maintenance, which is available through Medicaid but not through Wellpoint.
Substance abuse services: Outpatient medically supervised withdrawal	Wellpoint will pay for medical supervision of members that are: • Undergoing mild to moderate withdrawal. • At risk of mild to moderate withdrawal. • Experiencing nonacute physical or psychiatric complications associated with their chemical dependence. Services must be provided under the supervision and direction of a licensed physician.

Service	Coverage Description
Substance abuse services: outpatient substance abuse services	Wellpoint will pay for outpatient substance abuse services including individual and group visits. Participants may directly access one assessment from a network provider in a 12-month period without getting prior authorization.
Substance abuse services: substance abuse program	Wellpoint will pay for substance abuse program services to provide individually designed interventions to reduce/eliminate the use of alcohol and/or other substances by the participant, which, if not effectively dealt with, will interfere with the individual's ability to remain in the community.
Telehealth/telemonitoring and web-phone based technology services	Wellpoint will pay for telehealth services for members with conditions that require frequent monitoring and/or the need for frequent physician, skilled nursing, or acute care services to reduce the need for in-office visits. Participants eligible for this service include those with the following conditions: congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, mental or behavioral problems limiting self-management, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition, or enteral feeding.
Transportation services (emergency and nonemergency)	Wellpoint will pay for emergency and nonemergency transportation. Transportation is provided for medical appointments and services. Transportation is also available for nonmedical events or services — such as religious services, community activities or supermarkets — through transportation modes including but not limited to the following: • Taxi • Bus • Subway • Van • Medical transport • Ambulance • Fixed-wing or airplane transport • Invalid coach • Livery • Other means

Service	Coverage Description
Urgent care	Urgent care is care given to treat: • A nonemergency. • A sudden medical illness. • An injury. • A condition that needs care right away. Members requiring urgent care should first try to get it from a network provider. However, they can use out-of-network providers when they cannot get to a network provider. Urgent care does not include primary care services or services provided to treat an emergency medical condition. Members may get covered emergency care whenever they need it, anywhere in the United States or its territories.
Vision care	Wellpoint will pay for the diagnosis and treatment of visual defects, eye disease and eye injury. This includes treatment for age-related macular degeneration. Examinations for refraction are limited to one exam every two years unless medically necessary. For people at high risk of glaucoma, Wellpoint will pay for one glaucoma screening each year. People at high risk of glaucoma include: • Participants with a family history of glaucoma • Participants with diabetes • African-Americans who are age 50 and older

Service	Coverage Description
Vision care: eyeglasses (lenses and frames) and contact lenses	Wellpoint will pay for eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services, when authorized by an optometrist or ophthalmologist. Coverage also includes the repair or replacement of parts. Eyeglasses (lenses and frames) and contact lenses are provided once every two years unless it is medically necessary to have them more frequently or unless the glasses or contact lenses are lost, damaged, or destroyed. Wellpoint will pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If the member has two separate cataract surgeries, he or she must get one pair of glasses after each surgery. The member cannot get two pairs of glasses after the second surgery, even if he or she did not get a pair of glasses after the first surgery. Wellpoint will also pay for corrective lenses, frames and replacements if needed after a cataract removal without a lens implant. In addition to the covered services, the plan will provide up to $300 extra for one pair of eyeglasses or contact lenses every year.
"Welcome to Medicare" preventive visit	Coverage includes the one-time "Welcome to Medicare" preventive visit. The visit includes: • A review of the member's health. • Education and counseling about the preventive services a member needs (including screenings and shots). • Referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months the member has Medicare Part B.

Service	Coverage Description
Wellness counseling	Wellpoint will pay for wellness counseling to help medically stable members maintain their optimal health status. A registered professional nurse (RN) works with the member to reinforce or teach healthy habits such as the need for daily exercise, weight control or avoidance of smoking. The RN is also able to offer support for control of diseases or disorders such as high blood pressure, diabetes, morbid obesity, asthma, or high cholesterol. The RN can help the member identify signs and symptoms that may require intervention to prevent further complications from the disease or disorder.

Medicaid Covered Services for Wellpoint members

Our coverage of Medicaid members includes medically necessary services as outlined for the Medicaid FFS program in the *Texas Medicaid Provider Procedures Manual (TMPPM)*, enhanced pharmacy and inpatient coverage, and extra benefits.

Covered services are subject to change in accordance with Texas Medicaid requirements. Modifications to covered services are communicated through provider mailings, faxes, newsletters and/or provider contractual amendments. Medicaid members do not have deductibles or copays for Medicaid covered services, and providers are prohibited from balance billing for Medicaid covered services.

Medicare has a certain amount of allowable inpatient days. Medicaid does as well. If the Medicare allowable days are exhausted, the reimbursement to hospitals for inpatient services is limited to the Medicaid spell of illness. The spell of illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days. The spell of illness days will be counted concurrently with the Medicare allowable days. This means the Medicare and Medicaid days may both be exhausted.

Exceptions to the spell of illness are as follows:

- A prior-approved solid organ transplant. The 30-day spell of illness for transplants begins on the date of the transplant, allowing additional time for the inpatient stay.

Wellpoint will provide Medicaid wrap-around services for outpatient drugs, biological products, certain limited home health supplies (LHHS), and vitamins and minerals as identified on the HHSC drug exception file to Wellpoint members under a non-risk, cost settlement basis. Wrap-Around Services means services for dual-eligible members that are covered by Medicaid: (1) when the dual eligible member has exceeded the Medicare coverage limit; or (2) that are not covered by Medicare.

Supplemental Benefits/Value-Added Services

We cover extra healthcare benefits for our members. These extra benefits are also called supplemental benefits. You can find a list of these benefits in our member handbooks at **provider.wellpoint.com/tx**. If you have problems accessing the information, call Provider Services at **855-878-1785**.

Benefit Name	Benefit Description	Note
Acupuncture	6 visits/year	+ Medicare
Cardiac Rehab Services	12 cardiac rehab services/year	+ Medicaid, + Medicare
Dental Comprehensive	$1,600 annual max, earned $400/ quarter	Limited to non-STAR+PLUS Waiver (SPW) (SPW, $5,000 / year.)
Dental Preventative	1 exam, cleaning/6 months; 1 set of X-rays/year	No other benefit
Eye Exam	1 routine eye exam/year	+ Medicaid's 1 exam/2 years
Eyewear	$300/year for 1 pair of contact lenses or eyeglasses	+ Medicaid's 1 set of eyeglasses / 2 years
Fitness Club	Silver Sneakers membership	No other benefit
Hearing Aids	$2,000/year (both ears combined)	+ Medicaid benefit (1, Left or Right, every 5 years)
Meals	2/day, 5-day max, post discharge	+ Limited to non-SPW (covered benefit, SPW)
OTC Catalog	$51 per quarter for approved Walmart OTC Card/Catalog	+ Medicaid (unlimited formulary OTC w/scrip)
Emergency Response	Personal Emergency Response Service	Limited to OCC (covered benefit SPW, CFC)
Pest Control	Home services, 1/quarter	Limited to Non-Nursing Facility members
Podiatry	1 routine visit/quarter	+ MCR, + MCD
Respite care	8 hours of Respite Services/ year	Limited to OCC, Non-NF members

Coordination with Non-Medicaid Managed Care Covered Services

In addition to Medicare and Medicaid services, Wellpoint members are eligible for the services described below. Wellpoint and our network providers are expected to refer to and coordinate with these programs. These services are described in the *Texas Medicaid Provider Procedures Manual (TMPPM)*.

- Health and Human Services Commission (HHSC) hospice services
- Preadmission screening and resident review (PASRR) screenings, evaluations, and specialized services

Nonemergency Medical Transportation (NEMT) Services

What are NEMT services?

NEMT services provide transportation to covered health-care services for Medicaid members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. NEMT services do ***not*** include ambulance trips.

What services are part of NEMT services?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb service transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health-care service. The ITP can be the member, the member's family member, friend, or neighbor.

If you have a member needing assistance while traveling to and from his or her appointment with you, NEMT services will cover the costs of an attendant. You may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered health-care services are being provided but may remain in the waiting room during the member's appointment.

If you have a member, you think would benefit from receiving NEMT services, please refer him or her to Wellpoint at **844-869-2767 (TTY 711)** for more information.

Ambulance Transportation Services (Emergent)

Ambulance transportation service is a benefit when the member has an emergency medical condition. See the "**Emergency Services**" section in this manual for the definition of emergency medical condition.

Facility-to-facility transport may be considered an emergency if emergency treatment is not available at the first facility and the member still requires emergency care. The transport must be to an appropriate facility, meaning the nearest medical facility equipped in terms of equipment, personnel, and the capacity to provide medical care for the illness or injury of the member.

Transports to out-of-locality providers (one-way transfers of 50 or more miles from the point of pickup to the point of destination) are covered if a local facility is not adequately equipped to treat the condition. Transports may be cut back to the closest appropriate facility.

Ambulance Transportation Services (Nonemergent)

Nonemergency ambulance transport is a benefit when provided for a member to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the member's home after discharge from a hospital if the member has a medical condition such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contraindicated). In this circumstance, contraindicated

means that the member cannot be transported by any other means from the origin to the destination without endangering the individual's health.

A physician, nursing facility, healthcare provider or other responsible party is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency. Requests can be faxed, submitted via the provider website at **availity.com**, or called into Wellpoint via the contact numbers shown in the table below. All requests require clinical information to support the need for the member to be transported by nonemergent ambulance transportation. The ambulance provider may not submit an authorization request.

Transports must be limited to those situations where the transportation of the client is less costly than bringing the service to the client.

Some requests for nonemergent ambulance transportation will occur after business hours. Authorizations that meet medical necessity will be authorized retrospectively if the request is received the next business day. The request can be called in or faxed the next business day to the numbers listed in the table below.

Request type	**Behavioral health facilities/ behavioral health provider and IDD members**	**All other members for discharge from facility to home or from home to a provider/facility**
Urgent same day	**855-878-1785**	**855-878-1785**
Non-urgent requests	Fax request to **844-430-6804**	Fax request to **866-959-1537**

Durable Medical Equipment and Other Products Normally Found in a Pharmacy

Wellpoint reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy. For all qualified members, this includes medically necessary items such as nebulizers, ostomy supplies or bedpans, and other supplies and equipment.

To be reimbursed for DME or other products normally found in a pharmacy, a pharmacy must be in the CarelonRx pharmacy network or enrolled with us as a DME provider. Pharmacies that want to join the CarelonRx network should call Network Enrollment at **866-488-4708**.

Pharmacies may obtain information about becoming a DME provider with us by sending an email to TXCredentialing@Wellpoint.com.

CarelonRx network pharmacies that are not Wellpoint DME providers should submit claims to CarelonRx. Refer to the CarelonRx provider manual for information on the claim submission process.

Pharmacies enrolled with us as a DME provider should submit medical (CMS 1500) claims.

Pharmacies enrolled in both the CarelonRx and the Wellpoint networks have the option to bill these specific DME supplies through either CarelonRx or Wellpoint, but not both. Claims for these supplies may be subject to post payment desk reviews to ensure claims from DME providers and pharmacies do not result in a member exceeding the maximum quantity or a duplicate payment for the same member and supply.

Emergency Dental Services

Wellpoint is responsible for emergency dental services provided to members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth and removal of cysts
- Treatment of oral abscess of tooth or gum origin

Nonemergency Dental Services

Wellpoint is not responsible for paying for routine dental services provided to members except as allowed for HCBS STAR+PLUS Waiver members or supplemental benefits.

Vision Services

Coverage for Wellpoint members may be obtained by calling Superior Vision of Texas at **866-819-4298**. Services are available for member self-referral to a network vision provider for basic vision benefits. Members can call **800-428-8789**.

Pharmacy

Members have access to most national pharmacy chains and many independent retail pharmacies that are contracted with us. Members may obtain their medications at any network pharmacy.

We have contracted with CarelonRx to process prescription drug claims using a computerized point-of-sale (POS) system. This system gives participating pharmacies online real-time access to beneficiary eligibility, drug coverage (to include prior authorization requirements), prescription limitations, pricing and payment information, and prospective drug utilization review.

Formulary Exceptions

If a prescription drug is not listed in the Wellpoint formulary, check the updated formulary on the Wellpoint member website at **provider.wellpoint.com/tx.** The website formulary is updated frequently with any changes. In addition, providers may contact the Wellpoint Pharmacy department to be sure a drug is covered. If the Pharmacy department confirms the drug is not on the formulary, there are two options:

- The prescribing physician can prescribe another drug that is covered on the formulary.
- The patient or prescribing physician may ask Wellpoint to make an exception (a type of coverage determination) to cover the nonformulary drug. If the member pays out-of-pocket for a nonformulary drug and requests an exception Wellpoint approves, Wellpoint will reimburse the member. If the exception is not approved, the member may appeal our

denial. See the “Participant Liability Appeals” section for more information on requesting exceptions and appeals.

In some cases, Wellpoint will contact a member who is taking a drug that is not on the formulary. Wellpoint will give the member the names of covered drugs used to treat his or her condition and encourage the member to ask his or her physician if any of those drugs would be appropriate options for treatment. Also, members who recently joined Wellpoint may be able to get a temporary supply of a drug they are taking if the drug is not on the Wellpoint formulary.

Pharmacy Transition Policy

New Wellpoint members may be taking drugs that are not on the formulary or that are subject to certain restrictions, such as precertification or step therapy. Current members may also be affected by changes in the formulary from one year to the next. Members are encouraged to talk to their providers to decide if they should switch to a different drug Wellpoint covers or request a formulary exception to get coverage for the drug (as described above).

During the period of time members are talking to their providers to determine the right course of action, Wellpoint may provide a temporary supply of the nonformulary drug if those members need a refill for the drug during the first 90 days of new participation in Wellpoint. For current members affected by a formulary change from one year to the next, Wellpoint will provide a temporary supply of the nonformulary drug for members needing a refill for the drug during the first 90 days of the new plan year.

When a member goes to an Wellpoint network pharmacy and we provide a temporary supply of a drug that is not on the formulary or that has coverage restrictions or limits, Wellpoint will cover at least a one-time, 31-day supply (unless the prescription is written for fewer days). If necessary, Wellpoint will cover more than one refill of these drugs during the first 90 days a member is enrolled in our plan. Wellpoint will provide the member with a written notice after it covers a temporary supply. The notice will explain the steps the member can take to request an exception and the way to work with the prescribing physician to decide if switching to an appropriate formulary drug is feasible.

If a new member is a resident of a long-term care facility (like a nursing home), Wellpoint will cover a temporary, 31-day transition supply (34-day transition supply for LTC) (unless the prescription is written for fewer days). If necessary, Wellpoint will cover more than one refill of these drugs during the first 90 days a member is enrolled in our plan. If the member has been enrolled in the plan for more than 90 days and needs a drug that is not on the formulary or is subject to other restrictions such as step therapy or dosage limits, Wellpoint will cover a temporary 31-day emergency (34-day transition supply for LTC) supply of that drug (unless the prescription is for fewer days) while the new member requests a formulary exception.

This policy also applies to current members who experience a change in the level of their care. For example, if a member leaves the hospital and enters a long-term care facility or leaves hospice status and reverts back to standard care, the member may receive a temporary

transition supply of the non-formulary drug for up to 31 days unless the prescription is written for fewer days.

Emergency Prescription Supply

A 72-hour emergency supply of prescribed Medicaid-only drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (PA).

The 72-hour emergency supply should be dispensed anytime a PA cannot be resolved within 24 hours for a medication on the Wellpoint or formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product packaged in a dosage form that is fixed and unbreakable (e.g., an albuterol inhaler) as a 72-hour emergency supply.

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information:

- "8" in "Prior Authorization Type Code" (Field 461-EU)
- "801" in "Prior Authorization Number Submitted" (Field 462-EV)
- "3" in "Days' Supply" (in the Claim segment of the billing transaction) (Field 405-D5)
- The quantity submitted in "Quantity Dispensed" (Field 442-E7) should not exceed the quantity necessary for a three-day supply according to the directions for administration given by the prescriber. If the medication is a dosage form that prevents a three-day supply from being dispensed (e.g., an inhaler), it is still permissible to indicate that the emergency prescription is a three-day supply and enter the full quantity dispensed

Call the CarelonRx Pharmacy Help Desk at **833-252-0329** for more information about the 72-hour emergency prescription supply policy.

Case Management for Children and Pregnant Women

The Case Management for Children and Pregnant Women (CPW) benefit assists eligible Medicaid members in accessing medically necessary medical, social, educational, and other services.

CPW is a Medicaid benefit that provides health-related case management services to children birth through 20 years of age with a health condition and to high-risk pregnant women of any age.

Wellpoint will contract with HHSC enrolled CPW providers to supply these services. CPW case managers assess a person's need for these services and then develop a service plan to address those needs. Case managers can help members:

- Get medical and dental services.
- Get medical supplies or equipment.
- Work on school or education issues.
- Work on other problems.

Prior authorization is not required for these services. Members will still have access to an Wellpoint case manager for all other case management services. For additional benefit details and requirements, refer to the *Texas Medicaid Provider Procedures Manual Behavioral Health and Case Management Services Handbook* at **tmhp.com/resources/provider-manuals/tmppm**.

To refer an Wellpoint member for CPW services, providers should call Provider Services at **855-878-1785**.

CHAPTER 5: LONG-TERM SERVICES AND SUPPORTS (LTSS)

Overview

Wellpoint provides an integrated approach to healthcare delivery that addresses those services members may require in the acute, behavioral, functional, social, and environmental areas. Service coordination is a major feature of Wellpoint and involves specialized person-centered thinking for members. Service coordinators provide assistance to members, family members and providers to develop a detailed service plan and provide the following services according to the member's needs:

- Nursing facility care
- Acute care
- Behavioral health
- Environmental care
- Functional care
- Home- and community-based care

Role of Long-Term Services and Supports Providers

Wellpoint long-term services and supports providers are responsible for (but not limited to) the following:

- Contacting us to verify member eligibility
- Obtaining authorizations for services prior to provision of those services
- Coordinating Medicaid/Medicare benefits
- Notifying us of changes in a member's physical condition or eligibility
- Partnering with our service coordinator in managing a member's healthcare
- Managing continuity of care
- Employment Assistance providers must develop and update quarterly a plan for delivering Employment Assistance Services
- Supported Employment providers must develop and update quarterly a plan for delivering Supported Employment Services
- Reporting any suspicion or allegation of member abuse, neglect, or exploitation in accordance with Texas Human Resources Code §48.051, Texas Health and Safety Code §260A.002, and Texas Family Code §261.101 71
- For Employment Assistance providers: Developing and updating quarterly a plan for delivering Employment Assistance Services
- For Supported Employment providers: Developing and updating quarterly a plan for delivering Supported Employment Services

Personal Attendant Wage Requirements

Persons providing attendant services that qualify as Personal Assistance Services or Day Activity Health Services in the Wellpoint program must be paid at least $10.60 per hour.

Title 40 Texas Administrative Code §49.312 contains these wage requirements, which apply to personal attendants working as either employees or contractors of a provider, or as employees or contractors of a subcontractor.

Electronic visit verification (EVV) general information

1. What is EVV?
EVV is a computer-based system that electronically documents and verifies the occurrence of a visit by a Service Provider or CDS Employee, as defined in Chapter 8.7.1 of the UMCM, to provide certain services to a member. The EVV System documents the following:

- Type of service provided (Service Authorization Data).
- Name of the member to whom the service is provided (Member Data).
- Date and times the visit began and ended.
- Service delivery location.
- Name of the Service Provider or CDS Employee who provided the service (Service Provider Data).
- Other information HHSC determines is necessary to ensure the accurate adjudication of Medicaid claims.

2. Is there a law that requires the use of EVV?
Yes, in December of 2016, the federal *21st Century Cures Act* added *Section 1903(l)* to the *Social Security Act (42 USC. § 1396b(l))* to require all states to implement the use of EVV. *Texas Government Code, Section 531.024172*, requires HHSC to implement an EVV System to electronically verify certain Medicaid services in accordance with federal law. To comply with these statutes, HHSC required the use of EVV for all Medicaid personal care services requiring an in-home visit, effective January 1, 2021. HHSC plans to require the use of EVV for Medicaid home healthcare services requiring an in-home visit, effective January 1, 2023.

3. Which services must a Service Provider or CDS Employee electronically document and verify using EVV?
The EVV required services that must be electronically documented and verified through EVV are listed on the HHSC EVV website. Refer to the *Programs, Services, and Service Delivery Options Required to Use Electronic Visit Verification*.

Check the **EVV Service Bill Codes Table** on the HHSC EVV website for up-to-date information and specific HCPCS code(s) and modifiers for EVV-required services at **Electronic Visit Verification | Texas Health and Human Services**.

4. Who must use EVV?
The following must use EVV:

- Provider: An entity who contracts with an MCO to provide an EVV service
- Service Provider: A person who provides an EVV required service and who is employed or contracted by a Provider or a CDS Employer
- CDS Employee: A person who provides an EVV required service and who is employed by a CDS Employer.

- Financial Management Services Agency (FMSA): An entity that contracts with an MCO to provide financial management services to a CDS Employer as described in *Texas Administrative Code, Title 40, Part 1, Chapter 41, Subchapter A, §41.103(25), Consumer Directed Services Option*
- CDS Employer: A member or LAR who chooses to participate in the CDS option and is responsible for hiring and retaining a Service Provider who delivers a service

EVV Systems

5. Do Providers and FMSAs have a choice of EVV Systems?

Yes, a Provider or FMSA must select one of the following two EVV Systems:

- EVV vendor system. An EVV vendor system is an EVV System provided by an EVV vendor selected by the HHSC Claims Administrator, on behalf of HHSC, that a Provider or FMSA may opt to use instead of an EVV proprietary system. More information about EVV vendors and their systems is available on the **TMHP EVV Vendors** webpage.
- EVV proprietary system. An EVV proprietary system is an HHSC-approved EVV System that a Provider or FMSA may choose to use instead of an EVV vendor system. An EVV proprietary system:
  - Is purchased or developed by a Provider or a FMSA.
  - Is used to exchange EVV information with HHSC or an MCO.
  - Complies with the requirements of *Texas Government Code Section §531.024172* or its successors.

Additional information is available on the TMHP Proprietary System webpage at **EVV Proprietary Systems | TMHP**.

6. Does a CDS Employer have a choice of EVV Systems?

No, a CDS Employer must use the EVV System selected by the CDS Employer's FMSA.

7. What is the process for a Provider or FMSA to select an EVV System?

- To select an EVV vendor from the state vendor pool, a Provider or FMSA, signature authority and the agency's appointed EVV System administrator must complete, sign, and date the *EVV Provider Onboarding Form* located on the EVV vendor's website. More information about EVV vendors and their systems is available on the **TMHP EVV Vendors** webpage.
- To use an EVV proprietary system, a Provider or FMSA, signature authority, and the agency's appointed EVV System administrator, must visit the TMHP Proprietary System webpage to review the EVV Proprietary System Operator (PSO) Onboarding process and HHSC EVV Proprietary System approval process. Additional information is available on the TMHP Proprietary System webpage at **EVV Proprietary Systems | TMHP**.

8. What requirements must a Provider or FMSA meet before using the selected EVV System?
Before using a selected EVV System:

- The Provider or FMSA must submit an accurate and complete form directly to the selected EVV vendor. EVV vendor information is available on the **TMHP EVV Vendors** webpage.
- Providers or FMSAs must submit the PSO Request Packet to enter the EVV PSO Onboarding Process which includes:
  - An EVV Proprietary System Request Form
  - EVV PSO Detailed Questionnaire (DQ)
  - TMHP Interface Access Request
- A program provider or FMSA must complete the EVV PSO Onboarding Process and receive written approval from HHSC to use an EVV proprietary system to comply with HHSC EVV requirements.
- If selecting either an EVV vendor or an EVV Proprietary System, a Provider or FMSA must:
  - Complete all required EVV training as described in the answer to **Question #18**.
  - Complete the EVV System onboarding activities:
    - Manually enter or electronically import identification data.
    - Enter or verify member service authorizations.
    - Set up member schedules (if required).
    - Create the CDS Employer profile for CDS Employer credentials to the EVV System.

9. Does a Provider or FMSA pay to use the selected EVV System?
If a Provider or FMSA selects an EVV vendor system, the Provider or FMSA uses the system free of charge.

If a Provider or FMSA elects to use an EVV proprietary system, the Provider or FMSA is responsible for all costs for development, operation, and maintenance of the system.

10. Can a Provider or FMSA change EVV Systems?
Yes, a Provider or FMSA may:

- Transfer from an EVV vendor to another EVV vendor within the state vendor pool.
- Transfer from an EVV vendor to an EVV proprietary system.
- Transfer from an EVV proprietary system to an EVV vendor.
- Transfer from one EVV proprietary system to another EVV proprietary system.

11. What is the process to change from one EVV System to another EVV System?
To change EVV Systems, a Provider or FMSA must request a transfer as follows:

- To request a transfer to an EVV vendor, a Provider or FMSA must submit an *EVV Provider Onboarding Form* to the new EVV vendor.
- To request a transfer to an EVV proprietary system, a Provider or FMSA must submit the PSO Request packet and complete the EVV PSO Onboarding Process.
- A Provider or FMSA must submit an EVV Provider Onboarding Form to the newly selected EVV vendor or an EVV PSO Request packet to TMHP at least 120 days before the desired effective date of the transfer.

- If a Provider or FMSA is transferring to an EVV vendor, the effective date of the transfer may be earlier than the desired effective date of the transfer if the Provider or FMSA and the newly selected EVV vendor agree on an earlier date.
- If a Provider or FMSA is transferring to an EVV proprietary system, the Provider or FMSA, TMHP, and HHSC will establish an effective date of transfer for the proprietary system that may be different than the desired effective date of the transfer.
- A FMSA must notify CDS Employers 60 days in advance of the planned Go-Live date to allow time for the FMSA to train CDS Employers and CDS Employees on the new EVV System.
- A Provider or FMSA must complete all required EVV System training before using the new EVV System.
- A Provider or FMSA who transfers to a new EVV vendor or proprietary system:
  - Will not receive a grace period and will be subject to all EVV policies including those related to compliance and enforcement.
  - May have EVV claims denied or recouped if there are no matching accepted EVV visit transactions in the EVV Aggregator.
- After a Provider or FMSA begins using a new EVV System, the Provider or FMSA must return all alternative devices supplied by the previous EVV vendor to the previous EVV vendor, if applicable.

12. Are the EVV Systems accessible for people with disabilities?

The EVV vendors provide accessible systems, but if a CDS Employer, Service Provider, or CDS Employee needs an accommodation to use the EVV System, the vendor will determine if an accommodation can be provided. However, vendors will not provide a device or special software if the system user needs this type of accommodation.

If the Provider or FMSA is using a proprietary system, the Service Provider, CDS Employer, or CDS Employee must contact the Provider or FMSA to determine accessibility features of the system and if an accommodation can be provided.

EVV service authorizations

13. What responsibilities do Providers and FMSAs have regarding service authorizations issued by an MCO for an EVV required service?

A Provider and FMSA must do the following regarding service authorizations issued by a MCO for an EVV-required service:

- Manually enter into the EVV System the most current service authorization for an EVV required service, including:
  - Name of the MCO.
  - Name of the Provider or FMSA.
  - Provider or FMSA Tax Identification Number.
  - National Provider Identifier (NPI) or Atypical Provider Identifier (API).
  - Member Medicaid ID.
  - Healthcare Common Procedural Coding System (HCPCS) code and Modifier(s).
  - Authorization start date.
  - Authorization end date.

- Perform Visit Maintenance if the most current service authorization is not entered into the EVV System.
- Manually enter service authorization changes and updates into the EVV System as necessary.

EVV clock-in and clock-out methods

14. What are the approved methods a Service Provider or CDS Employee may use to clock in and to clock out to begin and to end service delivery when providing services to a member in the home or in the community?

A Service Provider or CDS Employee must use one of the three approved electronic verification methods described below to clock in to begin service delivery and to clock out to end service delivery when providing services to a member in the home or in the community. A Service Provider or CDS Employee may use one method to clock in and a different method to clock out:

1. Mobile method:
   - A Service Provider must use one of the following mobile devices to clock in and clock out:
     - The Service Provider's personal smart phone or tablet.
     - A smart phone or tablet issued by the Provider.
   - A Service Provider must not use a member's smart phone or tablet to clock in and clock out.
   - A CDS Employee must use one of the following mobile devices to clock in and clock out:
     - The CDS Employee's personal smart phone or tablet.
     - A smart phone or tablet issued by the FMSA.
     - The CDS Employer's smart phone or tablet if the CDS Employer authorized the CDS Employee to use their smart phone or tablet.
   - To use a mobile method, a Service Provider or CDS Employee must use an EVV application provided by the EVV vendor or the PSO that the Service Provider or CDS Employee has downloaded to the smart phone or tablet.
   - The mobile method is the only method that a Service Provider or CDS Employee may use to clock in and clock out when providing services in the community.

2. Home phone landline:
   - A Service Provider or CDS Employee may use the member's home phone landline, if the member agrees, to clock in and clock out of the EVV System.
   - To use a home phone landline, a Service Provider or CDS Employee must call a toll-free number provided by the EVV vendor or the PSO to clock in and clock out.
   - If a member does not agree to a Service Provider's or CDS Employee's use of the home phone landline or if the member's home phone landline is frequently not available for the Service Provider or CDS Employee to use, the Service Provider or CDS Employee must use another approved clock in and clock out method.
   - The Provider or FMSA must enter the member's home phone landline into the EVV System and ensure that it is a landline phone and not an unallowable landline phone type.

3. Alternative device:
   - A Service Provider or CDS Employee may use an HHSC-approved alternative device to clock in and clock out when providing services in the member's home.
   - An alternative device is an HHSC-approved electronic device provided at no cost by an EVV vendor or EVV PSO.
   - An alternative device produces codes or information that identifies the precise date and time service delivery begins and ends.
   - The alternative device codes are active for only seven days after the date of service and must be entered into the EVV system before the code expires.
   - The Service Provider or CDS Employee must follow the instructions provided by the Provider or CDS Employer to use the alternative device to record a visit.
   - An alternative device must always remain in the member's home even during an evacuation.

15. What actions must the Provider or FMSA take if a Service Provider or CDS Employee does not clock in or clock out or enters inaccurate information in the EVV System while clocking in or clocking out?

- If a Service Provider does not clock in or clock out of the EVV System or an approved clock-in or clock-out method is not available, then the Provider must manually enter the visit in the EVV System.
- If a Service Provider makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the Provider must perform Visit Maintenance to correct the inaccurate service delivery information in the EVV System.
- If a CDS Employee does not clock in or clock out for any reason, the FMSA or CDS Employer must create a manual visit by performing Visit Maintenance in accordance with the CDS Employer's selection on *Form 1722* to manually enter the clock-in and clock-out information and other service delivery information, if applicable.
- If a CDS Employee makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the FMSA or CDS Employer must perform Visit Maintenance in accordance with the CDS Employer's selection on *Form 1722* to correct the inaccurate service delivery information in the EVV System.
- After the Visit Maintenance timeframe has expired, the EVV System locks the EVV visit transaction and the program provider, FMSA or CDS Employer may only complete Visit Maintenance if the MCO approves a *Visit Maintenance Unlock Request*.
- The *EVV Policy Handbook* requires the Provider, FMSA or CDS Employer to ensure that each EVV visit transaction is complete, accurate, and validated.

EVV Visit Maintenance

16. Is there a timeframe in which Providers, FMSAs, and CDS Employers must perform Visit Maintenance?

In general, a Provider, FMSA, or CDS Employer must complete any required Visit Maintenance after a visit prior to the end of the Visit Maintenance timeframe as set in the HHSC *EVV Policy Handbook.*

Note: The standard Visit Maintenance timeframe as set in the *EVV Policy Handbook* may be changed by HHSC to accommodate Providers impacted by circumstances outside of their control.

17. Are Providers, FMSAs, and CDS Employers required to include information in the EVV System to explain why they are performing Visit Maintenance?
Yes. Program providers, FMSAs, or CDS Employers must select the most appropriate **Reason Code Number(s)**, **Reason Code Description(s)**, and must enter any required free text when completing Visit Maintenance in the EVV System:

- **Reason Code Number(s)** describe the purpose for completing Visit Maintenance on an EVV visit transaction.
- **Reason Code Description(s)** describe the specific reason Visit Maintenance is necessary.
- Free text is additional information the program provider, FMSA or CDS Employer enters to further describe the need for Visit Maintenance.

Reason Codes information is located on the home page of the HHSC EVV website at **Electronic Visit Verification | Texas Health and Human Services**.

EVV training

18. What are the EVV training requirements for each EVV System user?

- Providers and FMSAs must complete the following training:
  - EVV System training provided by the EVV vendor or EVV PSO
  - EVV Portal training provided by TMHP
  - EVV Policy training provided by HHSC or the MCO
- CDS Employers must complete training based on delegation of Visit Maintenance on *Form 1722*, **CDS Employer's Selection for Electronic Visit Verification Responsibilities**:
  - Option 1: CDS Employer agrees to complete all Visit Maintenance and approve their employee's time worked in the EVV System:
    - EVV System training provided by the EVV vendor or EVV PSO
    - Clock-in and clock-out methods
    - EVV Policy training provided by HHSC, the MCO, or FMSA.
  - Option 2: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf; however, CDS Employer will approve their employee's time worked in the system:
    - EVV System training provided by EVV vendor or EVV PSO
    - EVV Policy training provided by HHSC, the MCO, or FMSA
  - Option 3: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf:
    - Overview of EVV Systems training provided by EVV Vendor or EVV PSO
    - EVV policy training provided by HHSC, the MCO or FMSA
- Providers and CDS Employers must train Service Providers and CDS Employees on the EVV methods used to clock in when an EVV required service begins and clock out when the service ends.

Wellpoint EVV training requirements and information is available on the Wellpoint EVV website at **Electronic Visit Verification (EVV) | Wellpoint Texas.**

Compliance Reviews

19. What are EVV Compliance Reviews?

- EVV Compliance Reviews are reviews conducted by the MCO to ensure Providers, FMSAs, and CDS Employers are in compliance with EVV requirements and policies.
- The MCO will conduct the following reviews and initiate contract or enforcement actions if Providers, FMSAs, or CDS Employers do not meet any of the following EVV compliance requirements:
  - EVV Usage Review — meet the minimum EVV Usage Score.
  - EVV Required Free Text Review — document EVV required free text.
  - EVV Landline Phone Verification Review — ensure valid phone type is used.

Information about Wellpoint EVV Compliance Reviews is available on the Wellpoint EVV website at **Electronic Visit Verification (EVV) | Wellpoint Texas**.

EVV claims

20. Are Providers and FMSAs required to use an EVV System to receive payment for EVV required services?

Yes. All EVV claims for services required to use EVV must match to an accepted EVV visit transaction in the EVV Aggregator before reimbursement of an EVV claim by the MCO. The MCO may deny or recoup an EVV claim that does not match an accepted visit transaction.

21. Where does a Provider or FMSA submit an EVV claim?

Providers and FMSAs must submit all EVV claims to the HHSC Claims Administrator in accordance with the MCO's submission requirements.

EVV claims and billing information is located on both the Wellpoint EVV website at **Electronic Visit Verification (EVV) | Wellpoint Texas** and the HHSC EVV website in the *Electronic Visit Verification Policy Handbook*, *Section 12000 EVV Claims* including all sub-sections, at **12000 EVV Claims | Texas Health and Human Services**.

22. What happens if a Provider or FMSA submits an EVV claim to the MCO instead of the HHSC Claims Administrator?

If a Provider or FMSA submits an EVV claim to the MCO instead of the HHSC Claims Administrator, the MCO will reject or deny the claim and require the Provider or FMSA to submit the claim to the HHSC Claims Administrator.

23. What happens after the HHSC Claims Administrator receives an EVV claim from a Provider or FMSA?

The HHSC Claims Administrator will forward the EVV claims to the EVV Aggregator for the EVV claims matching process. The EVV Aggregator will return the EVV claims and the EVV claims match result code(s) back to the HHSC Claims Administrator for further claims processing.

After completing the EVV claims matching process, the HHSC Claims Administrator forwards the claim to the MCO for final processing.

24. How does the automated EVV claims matching process work?

The claims matching process includes:

- Receiving an EVV claim line item.
- Matching data elements from each EVV claim line item to data elements from one or more accepted EVV transactions in the EVV Aggregator.
- Forwarding an EVV claim match result code to the MCO once the claim's matching process is complete.

The following data elements from the claim line item and EVV transaction must match:

- Medicaid ID
- Date of service
- National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Healthcare Common Procedure Coding System (HCPCS) code
- HCPCS modifiers
- Billed units to units on the visit transaction, if applicable

Note: No unit match is performed on CDS EVV claims and unit match is not performed on visit transactions against the billed units on the claim line item for specific services. Refer to the *EVV Service Bill Codes Table* for the specific services that bypass the units matching process.

Based on the result of the EVV claims matching process, the EVV Portal displays an EVV claims match result code. After the EVV claims matching process, the EVV Aggregator returns an EVV claims match result code to the claims management system for final claims processing.

EVV claim match codes viewable in the EVV Portal are:

- EVV01 — EVV Successful Match
- EVV02 — Medicaid ID Mismatch
- EVV03 — Visit Date Mismatch
- EVV04 — Provider Mismatch (NPI/API) or Attendant ID Mismatch
- EVV05 — Service Mismatch (HCPCS and Modifiers, if applicable)
- EVV06 — Units Mismatch
- EVV07 — Match Not Required
- EVV08 — Natural Disaster

If the EVV Aggregator identifies a mismatch between an accepted EVV visit transaction and an EVV claim line item, the EVV claims matching process will return one of the EVV claim match result codes of EVV02, EVV03, EVV04, EVV05, or EVV06. The MCO will deny the EVV claim line item if it receives an EVV claim match result code of EVV02, EVV03, EVV04, EVV05, or EVV06.

When HHSC implements a bypass of the claims matching process for disaster or other temporary circumstance:

- The EVV claims matching process will return a match result code of EVV07 or EVV08.
- The MCO will not immediately deny an EVV claim with either of these claims match result codes for an unsuccessful EVV match.
- The MCO may still deny an EVV claim if other claim requirements fail the claims adjudication process.
- If allowed by HHSC, the MCO may complete a retrospective review of a paid EVV claim line item with a match result code of EVV07 or EVV08 to ensure the paid claim line item has a successful EVV match.

25. How can a Provider and FMSA see the results of the EVV claims matching process?
Providers and FMSAs may view the results of the EVV claims matching process in the EVV Portal. The EVV Portal contains a claim identifier for both the TMHP system and the MCO system. The MCO's Provider Portal also provides additional claims status information, such as whether the MCO has paid or denied the claim. In addition, the MCO provides an Explanation of Payment (EOP) to Providers and FMSAs to inform them of whether the MCO paid or denied the claim, and if denied, the reason for denial.

Detailed information including job aids is located on the TMHP EVV Training webpage at **EVV Training | TMHP**.

26. Could an MCO deny payment of an EVV claim even if the EVV claim successfully matches the EVV visit transaction?
Yes, an MCO may deny payment for an EVV claim for a reason unrelated to EVV requirements, such as a member's loss of program eligibility or the Provider's or FMSA's failure to obtain prior authorization for a service.

Wellpoint Coverage

Wellpoint members get benefits for acute care such as doctor visits, hospitalizations, prescriptions, and behavioral health services, and they can also get long-term services and supports. A member may not need long-term services and supports right now, but they can get those benefits if needed in the future. If a member does need long-term services and supports benefits, the kind of benefits they can get is based on their category of Medicaid eligibility. There are three Medicaid eligibility levels:

- Other Community Care (OCC): basic coverage
- Community First Choice (CFC): mid-level coverage
- Home- and Community-Based Services (HCBS) STAR+PLUS Waiver (SPW): highest level of coverage for members with complex needs

Wellpoint long-term services and supports includes both residential nursing home care and community-based services.

The HCBS STAR+PLUS Waiver (SPW) and Community First Choice (CFC) provide community long-term services and supports to Medicaid-eligible adults with disabilities and elderly persons as a cost-effective alternative to living in a nursing facility. These members must be age 21 or older, enrolled in Medicaid or otherwise financially eligible for waiver services.

While eligible members covered under traditional Medicaid have access to these services through the Community Based Alternatives (CBA) program, the STAR+PLUS program provides these services to individuals enrolled in managed care under SPW or CFC.

All LTSS services require authorization before services are rendered. Coverage of these services is limited to members who need assistance with the activities of daily living. Some services are limited to members who meet the nursing home level of care. If you have an Wellpoint patient who needs these services, please direct him or her to contact Member Services at **855-878-1784** (TTY **711**), 8 a.m. to 8 p.m. local time. Our service coordinators will assess the member's needs and develop a service plan.

Community First Choice Program Provider Responsibilities:

- The CFC services must be delivered in accordance with the member's service plan.
- The program provider must have current documentation which includes the member's service plan, intellectual disability/related condition (ID/RC) (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable)
- The HCS or TxHmL program provider must ensure that the rights of the members are protected (e.g., privacy during visitation, send and receive sealed and uncensored mail, make, and receive telephone calls, etc.).
- The program provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the Member that are required to ensure the Member's health, safety, and welfare. The program provider must maintain documentation of this training in the member's record.
- The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation.
- The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that an investigation by the Texas Department of Family and Protective Services (DFPS) has begun through the completion of the investigation. Required actions include but are not limited to providing medical and psychological services as needed, restricting access by the alleged perpetrator, and cooperating with the investigation. The program provider must also provide the member/legally authorized representative (LAR) with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the DFPS hotline at
- **800-647-7418**.
- The program provider must address any complaints received from a member/LAR and have documentation showing the attempts at resolution of the complaint. The program provider must provide the member/LAR with the appropriate contact information for filing a complaint.
- The program provider must not retaliate against a staff member, service provider, member (or someone on behalf of a member), or other person who files a complaint,

presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.

- The program provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED or competency exam and three references from nonrelatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, Office of the Inspector General (OIG) checks). For CFC ERS, the program provider must ensure that the provider of ERS has the appropriate licensure.
- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per the *CFR §441.565* for CFC, the program provider must ensure that any additional training requested by the member/LAR of CFC PAS or habilitation (HAB) service providers is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The program provider must adhere to the MCO financial accountability standards.
- The program provider must prevent conflicts of interest between the program provider, staff member, or a service provider and a member, such as the acceptance of payment for goods or services from which the program provider, staff member, or service provider could financially benefit.
- The program provider must prevent financial impropriety toward a member, including unauthorized disclosure of information related to a member's finances and the purchase of goods that a member cannot use with the member's funds.

Wellpoint Coverage Table

Wellpoint members get benefits for acute care such as doctor visits, hospitalizations, prescriptions, and behavioral health services, and they also can get long-term services and supports. A member may not need long-term services and supports right now, but they can get these benefits if needed in the future.

Service Types	Dual Eligibles (Medicaid and Medicare) + OCC	Dual Eligibles (Medicaid and Medicare) + CFC	Dual Eligibles (Medicaid and Medicare) + SPW
Medical (such as doctor's visits and hospital services) and behavioral health services	Wellpoint*	Wellpoint*	Wellpoint*
Prescription drugs	Member's chosen Part D prescription drug vendor	Member's chosen Part D prescription drug vendor	Wellpoint*

Service Types	Dual Eligibles (Medicaid and Medicare) + OCC	Dual Eligibles (Medicaid and Medicare) + CFC	Dual Eligibles (Medicaid and Medicare) + SPW
Medicare coinsurance and deductibles	State's fiscal agent (TMHP) for regular Medicare; Medicare HMO	State's fiscal agent (TMHP) for regular Medicare; Medicare HMO	State's fiscal agent (TMHP) for regular Medicare; Medicare HMO)
Primary home care/ Personal assistance services	Wellpoint*	Wellpoint*	Wellpoint*
Day activity and health services (DAHS)	Wellpoint*	Wellpoint*	Wellpoint*
Consumer-directed attendant care	Wellpoint*	Wellpoint*	Wellpoint*
Nursing services (in home)	Wellpoint*	Wellpoint*	Wellpoint* or Medicare/ Medicare HMO
Acquisition, maintenance, and enhancement of skills services	N/A	Wellpoint*	Wellpoint*
Emergency response services (emergency call button)	N/A	Wellpoint*	Wellpoint*
Dental services	Supplemental benefit only	Supplemental benefit only	Wellpoint*
Home-delivered meals	Supplemental benefit only	Supplemental benefit only	Wellpoint*
Minor home modifications	N/A	N/A	Wellpoint*
Adaptive aids	N/A	N/A	Wellpoint*
Durable medical equipment	Wellpoint*	Wellpoint*	Wellpoint*
Medical supplies	N/A	N/A	Wellpoint*
Physical, occupational and speech therapy	Wellpoint*	Wellpoint*	Wellpoint*
Adult foster care/personal home care	N/A	N/A	Wellpoint*
Assisted living	N/A	N/A	Wellpoint*
Transition assistance services	N/A	N/A	Wellpoint*

Service Types	Dual Eligibles (Medicaid and Medicare) + OCC	Dual Eligibles (Medicaid and Medicare) + CFC	Dual Eligibles (Medicaid and Medicare) + SPW
(for members leaving a nursing facility) - $2,500 maximum			
Respite (with or without self-directed models)	N/A	N/A	Wellpoint*
Dietitian/nutritional assistance	N/A	N/A	Wellpoint*
Transportation assistance	Wellpoint*	Wellpoint*	Wellpoint*
Cognitive rehabilitation therapy	N/A	N/A	Wellpoint*
Financial management services	N/A	N/A	Wellpoint*
Support consultation/ Management	N/A	Wellpoint*	Wellpoint*
Employment assistance	N/A	N/A	Wellpoint*
Supported employment	N/A	N/A	Wellpoint*

***** Members should contact a service coordinator or call Member Services to find out if they qualify for services.

Primary Home Care/Personal Assistance Services (PAS)

Primary home care/personal assistance services (PAS) are available to all Wellpoint members based on medical and functional necessity and are provided to members living in their own home and community settings. Services include but are not limited to the following:

- Assisting with the activities of daily living, such as feeding, preparing meals, transferring and toileting
- Assisting with personal maintenance, such as grooming, bathing, dressing and routine care of hair and skin
- Assisting with general household activities and chores necessary to maintain the home in a clean, sanitary, and safe environment, such as changing bed linens, housecleaning, laundering, shopping, storing purchased items and washing dishes
- Providing protective supervision

- Providing extension of therapy services
- Providing ambulation and exercise
- Assisting with medications that are normally self-administered
- Performing nursing tasks delegated by registered nurses
- Escorting the member on trips to obtain medical diagnosis, treatment, or both

Day Activity and Health Services (DAHS)

All Wellpoint members may receive medically and functionally necessary DAHS. DAHS includes nursing and personal care services, physical rehabilitative services, nutrition services, transportation services and other supportive services. These services are provided at facilities licensed or certified by the Texas Department of Aging and Disability Services (DADS).

Adult Foster Care (AFC)

Adult foster care (AFC) is a benefit for Wellpoint members that provides a 24-hour living arrangement in a Department of Aging and Disability Services (DADS)-contracted foster home for persons who, because of physical, mental, or emotional limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, personal care, nursing tasks, supervision, companion services, daily living assistance and provision of, or arrangement for, transportation.

The member must reside in a SPW AFC home. Providers of AFC must live in the household and share a common living area with the member. Detached living quarters do not constitute a common living area. The individual enrolled to provide AFC must be the primary caregiver. Providers may serve up to three adult members in a DADS-enrolled AFC home without licensure as a personal care home. Up to four residents may be served in a foster home, though there are limitations as to the number of members at each level who may reside in one home.

Members are required to pay for their own room and board costs, and contribute to the cost of their care, if able, through a copay to the AFC provider.

Adaptive Aids and Medical Supplies

Adaptive aids and medical supplies are covered benefits for members when needs for the member to have optimal function, independence and well-being are identified and approved by Wellpoint. Adaptive aids and medical supplies are specialized medical equipment and supplies, including devices, controls or appliances specified in the plan of care, that enable individuals to increase their abilities to perform activities of daily living or perceive, control, or communicate with the environment in which they live. Adaptive aids and medical supplies are reimbursed with the goal of providing individuals a safe alternative to nursing facility (NF) placement. Items not of direct remedial benefit (providing a remedy to cure or restore health) or medical benefit to the individual are excluded from reimbursement.

Adaptive aids and medical supplies are limited to the most cost-effective items that can:

- Meet the member's needs.

- Directly aid the member to avoid premature NF placement.
- Provide NF residents an opportunity to return to the community.

The Wellpoint program is not intended to provide every member with any and all adaptive aids or medical supplies the member may receive as an NF resident. Details of items covered under this category can be found in the *STAR+PLUS Handbook* at: **hhs.texas.gov/lawsregulations/handbooks/sph/section-6000-specific-starplus-hcbs-program-services**.

Dental Services

Dental Services for Wellpoint members are services provided by a dentist to preserve teeth and meet the medical needs of the member. Allowable services include:

- Emergency dental treatment necessary to control bleeding, relieve pain, and eliminate acute infection.
- Preventative procedures required to prevent the imminent loss of teeth.
- The treatment of injuries to teeth or supporting structures.
- Dentures and the cost of preparation and fitting.
- Routine procedures necessary to maintain good oral health.

Dental services for HCBS STAR+PLUS Waiver members are limited to $5,000 per waiver plan year. This limit may be exceeded upon approval by Wellpoint up to an additional $5,000 per waiver plan year when medically necessary treatment requires the services of an oral surgeon. Wellpoint may also approve other dental services above the $5,000 waiver plan year limit on a case-by-case basis due to medical necessity, functional necessity, or the potential for improved health of the member. Wellpoint must review and approve any treatment in excess of the waiver plan year limit prior to services being rendered.

Cognitive Rehabilitation Therapy

Cognitive rehabilitation therapy is a service available to HCBS STAR+PLUS Waiver members that assists a member in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the member to compensate for the lost cognitive functions. Cognitive rehabilitation therapy may be provided when an appropriate professional assesses the member and determines it is medically necessary. Cognitive rehabilitation therapy is provided in accordance with the plan of care developed by the assessor and includes reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems.

Employment Assistance

Employment assistance means assistance provided to a member to help the member locate paid employment in the community. Employment assistance includes:

- Identifying an individual's employment preferences, job skills and requirements for a work setting and work conditions.

- Locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements.
- Contacting a prospective employer on behalf of a member and negotiating the member's employment.

Employment assistance is not available to members receiving services through a program funded by the *Rehabilitation Act of 1973* or the Individuals with *Disabilities Education Act*.

Supported Employment

Supported employment means assistance provided to a member in order to sustain paid employment to a member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home or perform in a work setting at which members without disabilities are employed. Supported employment includes employment adaptations, supervision and training related to a member's diagnosis.

Supported employment is not available to members receiving services through a program funded by the *Rehabilitation Act of 1973* or the *Individuals with Disabilities Education Act*.

Financial Management Services

Financial management services (FMS) are assistance provided to members who elect to participate in the consumer-directed services (CDS) option to manage funds associated with services elected for self-direction. The assistance is provided by the CDS agency. This includes initial orientation and ongoing training related to the responsibilities of being an employer and adhering to legal requirements for employers. A monthly administrative fee is authorized on the individual service plan and paid to the CDS agency for FMS.

Support Consultation

Support consultation services are available to members participating in the CDS option. It is an optional service. A member's service planning team may recommend the service when the employer (the individual or legally authorized representative (LAR)) or the designated representative (DR) would benefit from additional support with employer responsibilities.

Support consultation services must not duplicate or replace services to be delivered through a case manager, a service coordinator, the financial management services agency (FMSA) or other sources. A support advisor provides skills-specific training, assistance and supports to the employer or the employer's designated representative (DR) to meet responsibilities of the CDS option.

Examples of services a support advisor may provide include training related to recruiting and screening applicants for employment and verifying employment eligibility, assistance with developing job descriptions, coaching on problem solving and coordinating employee management activities, training on developing and implementing service backup and corrective action plans, and coaching on handling other employer responsibilities.

Service Coordination

We provide a single identified person as a service coordinator to all Wellpoint members, not limited to level 1, 2, and 3. The member will be notified by letter of the name and direct telephone number of their assigned personal service coordinator.

We will help ensure each Wellpoint member has access to a PCP or physician who is responsible for overall clinical direction. The PCP/physician, in conjunction with the service coordinator, serves as a central point of integration and coordination of covered services.

Service coordinators work with members and providers to coordinate all Wellpoint covered services and any other applicable services. Our service coordinators collaborate with the member's PCP/physician regardless of network status.

Discharge Planning

We will promptly assess the needs of a member discharged from a hospital, nursing facility, or other care or treatment facility. A service coordinator will work with the member's PCP, the hospital or nursing facility discharge planner, the attending physician, the member, and the member's family to assess and plan for the member's discharge. When long-term services and supports are needed, we will ensure the member's discharge plan includes arrangements for receiving community-based care whenever possible. The service coordinator will provide information to the member, the member's family, and the member's PCP regarding all service options available to meet the member's needs in the community.

Transition Plan for New Wellpoint Members

We will provide a transition plan for a member newly enrolled with Wellpoint who is already receiving long-term services and supports, including nursing facility services. HHSC, or the previous STAR+PLUS MCO, will give us information such as detailed care plans and names of current providers. We will ensure that current providers are paid for medically necessary and functionally necessary covered services that are delivered in accordance with the member's existing care plan beginning with the member's date of enrollment with Wellpoint until the transition plan is developed and implemented.

The transition planning process will include the following:

- Review of existing care plans prepared by HHSC or another STAR+PLUS MCO
- Preparation of a transition plan that ensures continuous care under the member's existing care plan during the transfer into the Wellpoint network while we conduct an appropriate assessment and development of a new plan (if needed)
- If durable medical equipment or supplies had been ordered prior to enrollment but have not been received by the date of enrollment, we will coordinate and follow through to ensure that the member receives the necessary supportive equipment and supplies without undue delay
- Payment to the existing provider of service under any existing authorization for up to six months, until we have completed the assessment and service plan and issued a new authorization

We will review any existing care plan for a new member and develop a transition plan within 30 days of receiving notice of the member's enrollment. The transition plan will remain in place until we contact the member or the member's representative, and we coordinate modifications to the member's current care plan. We will ensure that existing services continue and there is no break in services.

A transition plan will include the following:

- The member's history
- A summary of current medical, behavioral health and social needs and concerns
- Short-term and long-term needs and goals
- A list of services required and their frequency
- A description of who will provide the services

The transition plan may include information about services outside the scope of covered services such as how to access affordable, integrated housing. We will ensure the member or the member's representative is involved in the assessment process and fully informed about options, is included in the development of the transition plan, and is in agreement with the plan when completed.

Claims

Timely Filing

Providers must ensure clean claims are submitted and received at Wellpoint within 95 calendar days of the date of service and/or date of discharge. In the case of other insurance, submit a clean claim within 95 days of receiving a response from the third-party payer. Clean claims for members whose eligibility have not been added to the state's system must be received within 95 days from the date the eligibility is added. We must receive clean claims from out-of-network providers rendering services outside of Texas within one year of the date of service and/or date of discharge. Refer to the "Billing and Claims Administration" chapter of this manual for the definition of a clean claim.

Claims can be submitted electronically or by paper at the provider's preferred frequency (daily, weekly, etc.), but cannot exceed the filing limit deadline. When billing a span of dates on a single outpatient claim, the filing timeline is calculated from the first or earliest service date on the claim. Acute care and outpatient claims should be submitted in accordance with the requirements in the "Billing and Claims Administration" chapter of this manual.

Uniform Billing Code Guidelines

Providers must follow the uniform coding guidelines for LTSS as defined by the Texas Health and Human Services Commission (HHSC). Refer to our website at **provider.wellpoint.com/tx** for the current guidelines. Use only the uniform billing defined code, modifier, type, and place of service combinations. For STAR+PLUS, the *Long Term Services and Supports Codes and Modifiers* grid at **https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/appendices/appendix-xvi-long-term-services-supports-codes-modifiers**.

Claim Submission
LTSS providers have three options for submitting claims: Availity Essentials at **Availity.com**, Electronic Data Interchange (EDI) or paper.

Website
We provide a free online claim submission tool through **Availity.com**. Submission via Availity requires provider registration.

Electronic Data Interchange (EDI)
We encourage electronic submission of claims through Electronic Data Interchange (EDI). Wellpoint has designated Availity to operate and service your EDI entry point (EDI Gateway).

Wellpoint uses Availity as its exclusive partner for managing all electronic data interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient, and cost-effective way for providers and employers to do business.

Use Availity for the following EDI transactions
- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Claim: Dental (837D)
- 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)

Ways you can use the Availity EDI Gateway
Availity Essentials 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 clearinghouse or billing vendor (work with your vendor to ensure connection to the Availity EDI Gateway)

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

Availity Payer ID's
https://apps.availity.com/public-web/payerlist-ui/payerlist-ui/#/

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

Contact Availity
Please contact Availity Client Services with any questions at **800-Availity** (**282-4548**)

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

- Log in to **availity.com**
- Select **My Providers**
- Select **Enrollment Center** and select **Transaction Enrollment**

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

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

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

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

Please work with your vendor on how to submit corrected claims.

Useful EDI Documentation:

- **Availity EDI Connection Service Startup Guide** — This guide includes information to get you started with submitting Electronic Data Interchange (EDI) transactions to Availity, from registration to on-going support.
- **Availity EDI Companion Guide** — This Availity EDI Guide supplements the HIPAA TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity.
- **Availity Get Started Page** — Availity registration page for users new to Availity.

Paper Claims

For more effective claims processing, paper claim forms:

- Must be submitted on original claim forms (*CMS-1500* or *CMS-1450* [UB-04]) with dropout red ink and printed or typed (not handwritten) in a large, dark font.
- Cannot be submitted with alterations to key billing information; we do not accept claims with information that is marked through, handwritten or whited out.

Claims that have been altered are rejected and returned to the provider with an explanation of the reason for the return.

Submit LTSS paper claims to us at:

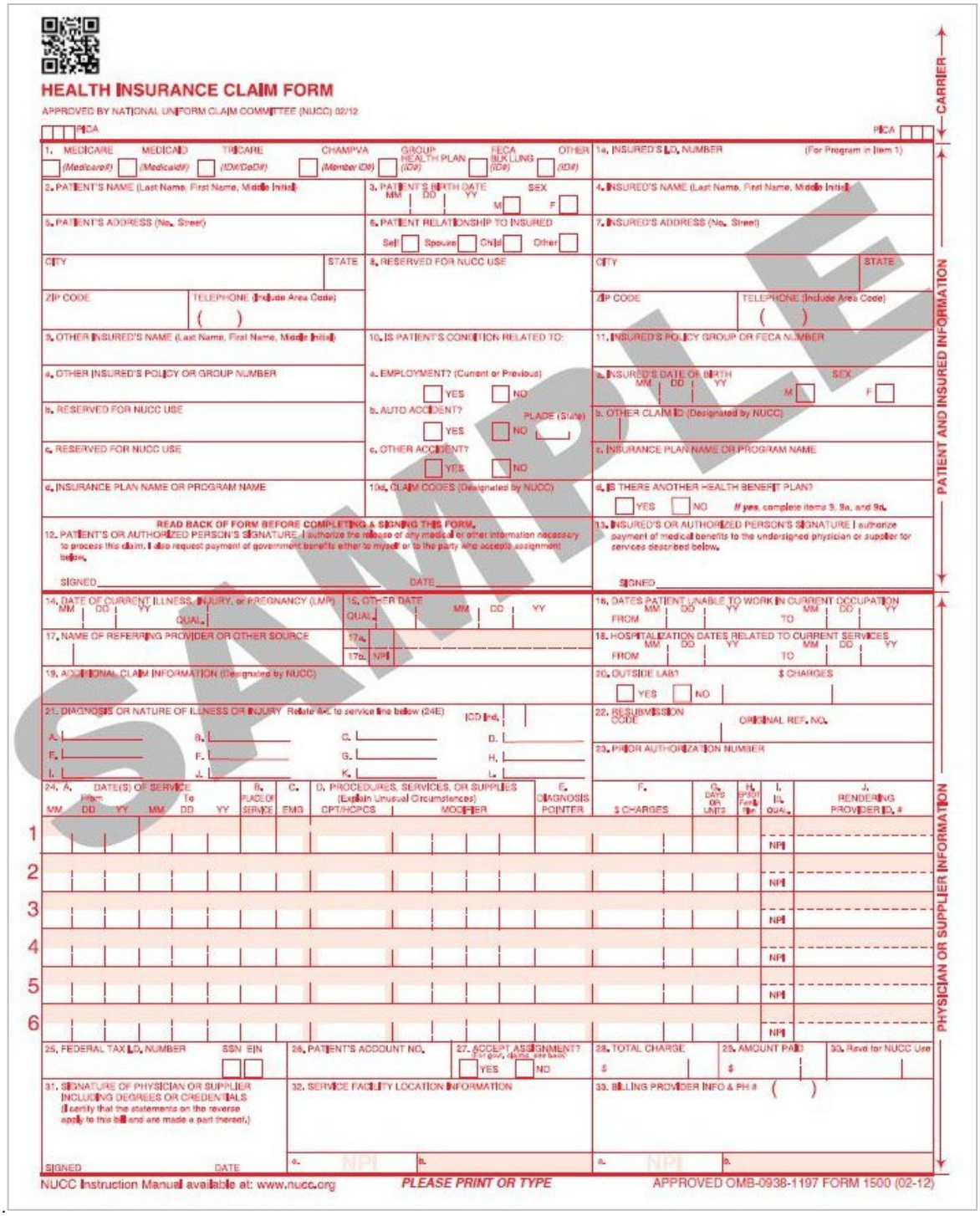
Long-Term Care Claims
Wellpoint
P.O. Box 61010
Virginia Beach, VA 23466-1010

***CMS 1500* Claim Form**

Noninstitutional providers and suppliers must use the CMS 1500 form.

- You may bill either individual dates of service or bill using a span of dates.
- Example: Claim may be submitted for dates of service from January 1, 2024, to January 15, 2024, on one claim. Box 24 should indicate service dates from January 1, 2024, to January 15, 2024.
- You must include your state-issued LTSS provider ID appropriate for the service being billed. IDs are assigned to specific categories of service. Place the number in Box 33B:
  - Sample ID
  - Statewide = S00000000
  - Facility-based provider = F00000000

This form and instructions are available on the CMS website at **https://cms.hhs.gov**. See a sample on the following page:



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH #

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

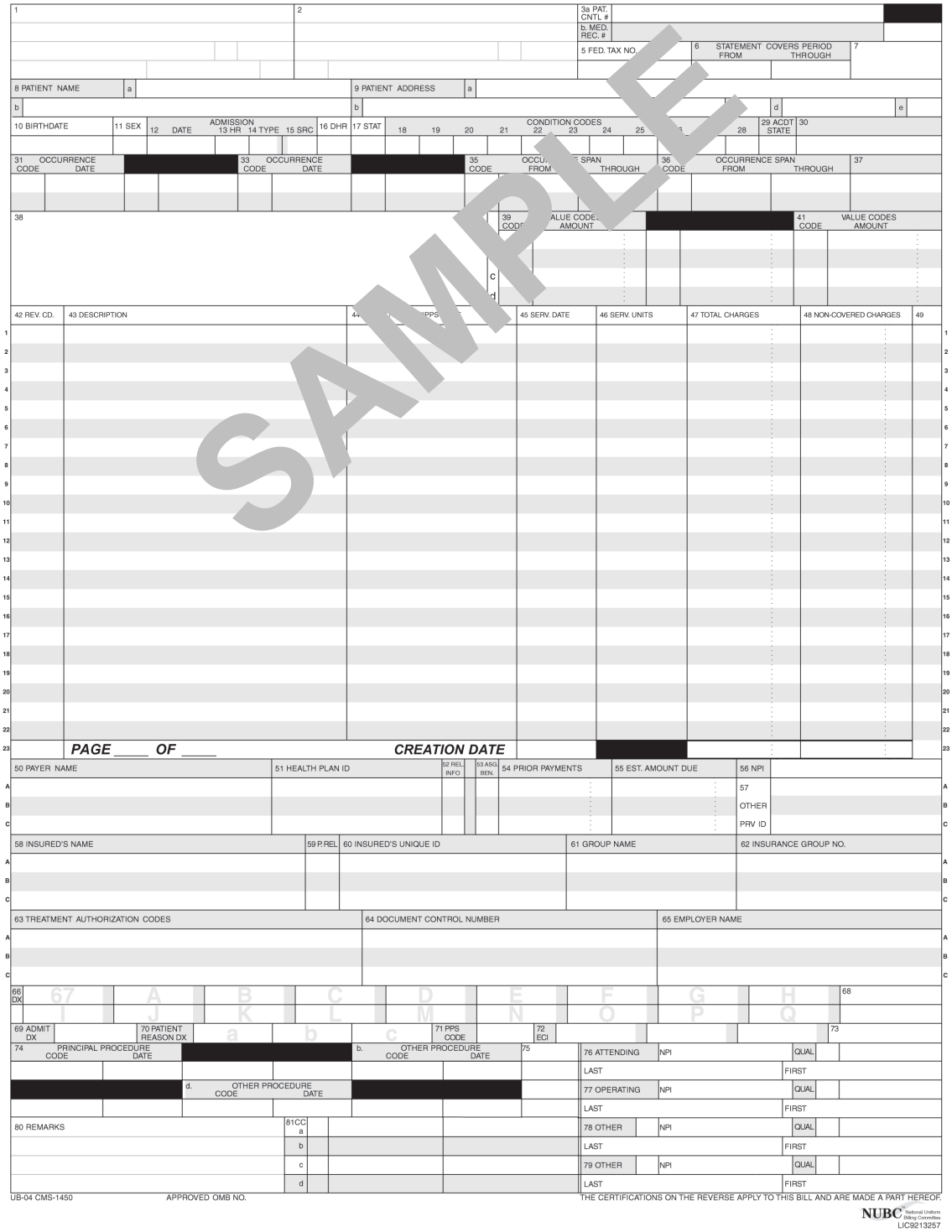
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

CMS 1450 Claim Form

Institutional and other selected providers must use the *CMS 1450* (UB-04) form. This form and instructions are available on the CMS website at **https://cms.hhs.gov**. See sample below:



Claim Adjudication and Reimbursement

Our members must not be balance billed for covered services. Additional information can be found in the "Claims Submission and Adjudication Procedures" chapter of this manual.

Clean claims for members are adjudicated within 30 days from the date we receive them. Clean claims not adjudicated within 30 days of receipt by us are subject to interest payments. Adjudication edits are based on the member's eligibility, benefit plan, authorization status, *HIPAA* coding compliance and our claim processing guidelines. Claim coding is subject to review using code-editing software.

Claim reimbursement is based on the provider's contract. We are responsible for paying an enhanced fee to LTSS providers who are part of the Health and Human Services Commission (HHSC) Attendant Enhancement Payment program. When contracted with us for this program, the fees will be built into the provider's fee schedule. We are not required to match the DADS program.

Cost Reporting to HHSC

LTSS providers must submit periodic cost reports and supplemental reports to HHSC in accordance with *1 T.A.C. Chapter 355*, including *Subchapter A (Cost Determination Process)* and *1 T.A.C. §355.403 (Vendor Hold)*. If an LTSS provider fails to comply with these requirements, HHSC will notify Wellpoint to hold payments to the provider until HHSC instructs us to release the payments.

Attendant Care Enhancement Payment Program (ACEP)

The Attendant Care Enhancement Payments (ACEP) is a legislatively mandated program providing additional compensation to long-term care direct care providers. We administer the enhanced payments for direct care providers rendering services to our members.

Attendant Care Enhancement Payments Program Enrollment

Providers, including nursing facility providers, are eligible to enroll in the ACEP program for the following services: assisted living/residential care (ALRC), day activity and health services (DAHS), and personal attendant services (PAS).

We allow contracted providers in the HHSC attendant care enhancement program to enroll in our ACEP program. The agreement between these providers and us includes language defining the requirements for enhancement payments.

Any provider joining our ACEP program or requesting a change in participation level will be required to demonstrate enrollment in good standing in the HHSC program. Acceptable documentation includes either a copy of the HHSC letter to the provider indicating the level of participation or the provider's HHSC contract number that can be verified with the HHSC participation list. A newly contracted provider's enrollment into our program will be effective concurrently with the effective date of his or her provider participation agreement/contract.

A provider with an existing participation agreement/contract with us may request an amendment for participation in our ACEP program during our annual open enrollment period.

In some cases, LTSS providers in STAR+PLUS-defined counties are no longer afforded the opportunity to hold HHSC program contracts, because HHSC does not administer a particular program in those counties. In these instances, we will allow new or contracted providers to enroll in our ACEP program. This exception is granted under the following conditions:

- The provider is licensed by HHSC.
- The provider has not been sanctioned, disciplined, restricted, prohibited from contracting and/or disenrolled from the HHSC program contracts in the previous three fiscal state periods.

Participants in our ACEP program must demonstrate timely response to Wellpoint audits and reviews.

The ACEP program enrollment form and attestation is required to be completed by the participating provider by September 30th of each year. If the enrollment form and attestation is not completed each year, the provider will be disenrolled.

Attendant Care Enhancement Program Payment Levels

We will increase our fee schedule rates for those codes included within the enhancement program for contracted providers who enroll. Services eligible for the additional payment under the program are PAS, DAHS, and assisted living/residential care (ALRC). Enhancement levels are available in 35 levels, which mirror the HHSC ACEP participation levels. The amount of the fee schedule increase will be determined based on a financial analysis of the historic costs of the enhancement program to the extent these are available. The enhancement payment amount will be added to the provider's negotiated rate schedule for eligible services. The enhancement payment is made as part of the claim payment. The payment and *Explanation of Payment (EOP)* issued to the provider will not indicate that the provider was paid at the enhanced rate.

We reserve the right to adjust and amend the ACEP program fee schedule at any time with appropriate notice to program participants. The ACEP program from Wellpoint administers 35 levels of payment:

Level	Payment	Level	Payment	Level	Payment
Level 1	Base rate + $0.05	Level 13	Base rate + $0.65	Level 25	Base rate + $1.25
Level 2	Base rate + $0.10	Level 14	Base rate + $0.70	Level 26	Base rate + $1.30
Level 3	Base rate + $0.15	Level 15	Base rate + $0.75	Level 27	Base rate + $1.35
Level 4	Base rate + $0.20	Level 16	Base rate + $0.80	Level 28	Base rate + $1.40
Level 5	Base rate + $0.25	Level 17	Base rate + $0.85	Level 29	Base rate + $1.45
Level 6	Base rate + $0.30	Level 18	Base rate + $0.90	Level 30	Base rate + $1.50
Level 7	Base rate + $0.35	Level 19	Base rate + $0.95	Level 31	Base rate + $1.55
Level 8	Base rate + $0.40	Level 20	Base rate + $1.00	Level 32	Base rate + $1.60
Level 9	Base rate + $0.45	Level 21	Base rate + $1.05	Level 33	Base rate + $1.65
Level 10	Base rate + $0.50	Level 22	Base rate + $1.10	Level 34	Base rate + $1.70
Level 11	Base rate + $0.55	Level 23	Base rate + $1.15	Level 35	Base rate + $1.75
Level 12	Base rate + $0.60	Level 24	Base rate + $1.20		

Level amounts are subject to change based on the funds available for our ACEP program. Providers will be notified of rate changes through provider updates. The enhanced payment for ACEP does not apply to the Consumer Directed Services (CDS) option.

Attendant Care Enhancement Payment (ACEP) Program Monitoring and Assurance

We require each contracted provider participating in the ACEP program to attest to the funds paid by us for the ACEP program for each State Fiscal Year are used to compensate direct care works as intended by the T.A.C., Title 1, Part 15, Chapter 355, Subchapter A, §355.112. Wellpoint tracks the submission of annual attestations. Based on the review of the attestations submitted by each provider, Wellpoint will conduct detailed audits when necessary.

Should the provider have failed to distribute the funds appropriately, Wellpoint will take corrective action against the provider(s) to ensure that the funds are distributed correctly within 45 days of the notice of corrective action to the provider. Should the provider fail to comply with the corrective action, we will take action, including but not limited to:

- Retracting the funds.
- Reporting inappropriate use of funds by the provider to HHSC.
- Suspending or terminating the provider's participation in the ACEP program under Wellpoint.
- Terminating the Wellpoint *Provider Participation Agreement*.

The enrollment form and attestation are required to be completed by the participating provider by September 30th of each year. If the enrollment form and attestation is not completed each year, the provider will be disenrolled from the health plan's Attendant Care Enhancement Payment Program.

CHAPTER 6: BEHAVIORAL HEALTH SERVICES

Overview

Behavioral health services are covered services for the treatment of mental, emotional, or chemical dependency disorders.

We provide coverage of medically necessary behavioral health services that:

- Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain or prevent deterioration of functioning resulting from such a disorder.
- Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral healthcare.
- Are furnished in the most appropriate and least restrictive setting in which services can be safely provided.
- Are the most appropriate level or supply of service that can safely be provided.
- Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered.
- Are not experimental or investigative.
- Are not primarily for the convenience of the member or provider.

We do not cover behavioral health services that are experimental or investigative. Covered services are not intended primarily for the convenience of the member or the provider. For more information about behavioral health services:

- Providers should call **855-878-1785**.
- Members should call **855-878-1784**

Covered Behavioral Health Services

Medicaid-covered behavioral health services are not subject to the quantitative treatment limitations that apply under traditional, fee-for-service (FFS) Medicaid coverage. The services may be subject to the HMO's nonquantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 behavioral health services, including the following:

- Inpatient mental health services
- Outpatient mental health services
- Psychiatry services
- Counseling services
- Outpatient substance use disorder treatment services, including:
- Assessment
- Detoxification services
- Counseling treatment
- Medication-assisted therapy
- Residential substance use disorder treatment services, including detoxification services
- Substance use disorder treatment, including room and board

- Mental Health Rehabilitative Services
- Targeted Case Management

Mental Health Rehabilitative Services and Targeted Case Management

For members with severe and persistent mental illness (SPMI), mental health rehabilitative (MHR) services and targeted case management (TCM) must be available to eligible members.

Severe and persistent mental illness (SPMI) means a diagnosis of bipolar disorder, major clinical depression, schizophrenia, or another behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) accompanied by:

- Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder.
- Impaired emotional or behavioral functioning that interferes substantially with the member's capacity to remain in the community without supportive treatment or services.

Mental Health Rehabilitative Services (MHR) are those age-appropriate services determined by HHSC and federally-approved protocol as medically necessary to reduce a member's disability resulting from severe mental illness for adults and to restore the member to his or her best possible functioning level in the community. Services that provide assistance in maintaining functioning may be considered rehabilitative when necessary to help a member achieve a rehabilitation goal as defined in the member's rehabilitation plan.

MHR services include training and services that help the member maintain independence in the home and community, such as the following:

- Medication training and support – curriculum-based training and guidance that serves as an initial orientation for the member in understanding the nature of his or her mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and the increased tenure in the community
- Psychosocial rehabilitative services – social, educational, vocational, behavioral, or cognitive interventions to improve the member's potential for social relationships, occupational or educational achievement, and living skills development
- Skills training and development – skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers
- Crisis intervention – intensive community-based one-to-one service provided to members who require services in order to control acute symptoms that place the member at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting
- Day program for acute needs – short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting

Mental Health Targeted Case Management (TCM) means services designed to assist members with gaining access to needed medical, social, educational, and other services and supports. TCM services include case management for members who have SPMI (adult, 18 years of age or older).

MHR services and TCM services and any limitations to these services are described in the most current TMPPM, including the Behavioral Health, Rehabilitation, and Case Management Services Handbook. We will authorize these services using the Department of State Health Services (DSHS) Resiliency and Recovery Utilization Management Guidelines (RRUMG), but Wellpoint is not responsible for providing any services listed in the RRUMG that are not covered services.

Texas Resilience and Recovery Utilization Management Guidelines for Adult Mental Health Services can be found at Texas Resilience and Recovery Utilization Management Guidelines—Adult Services (PDF):
dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589981162

Providers of MHR services and TCM services must use and be trained and certified to administer the Adult Needs and Strengths Assessment (ANSA) tool to assess a member's need for services and recommend a level of care. Providers must use these tools to recommend a level of care to Wellpoint by using the current DSHS Clinical Management for Behavioral Health Services (CMBHS) web-based system. Providers must also complete the Mental Health Rehabilitative and Mental Health Targeted Case Management Services Request Form and submit the completed form to Wellpoint. A provider entity must attest to Wellpoint that the organization has the ability to provide, either directly or through sub-contract, the full array of RRUMG services to members.

Primary and Specialty Services

Wellpoint members have access to the following primary and specialty services:

- Behavioral health clinicians available 24 hours a day, 7 days a week to assist with identifying the most appropriate and nearest behavioral health service
- Routine or regular laboratory and ancillary medical tests or procedures to monitor behavioral health conditions of members; these services are furnished by the ordering provider at a lab located at or near the provider's office; in most cases, our network of reference labs is conveniently located at or near the provider's office
- Behavioral health case managers to coordinate with the hospital discharge planner and member to ensure appropriate outpatient services are available
- Support and assistance for network behavioral healthcare providers in contacting members within 24 hours to reschedule missed appointments

Behavioral Healthcare Provider Responsibilities

We maintain a behavioral health provider network, including psychiatrists, psychologists and other behavioral health providers experienced in serving children, adolescents, and adults. The network provides accessibility to qualified providers for all eligible individuals in the service area.

PCPs providing behavioral health services must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. Screening and assessment tools to assist with the detection, treatment, and referral of behavioral healthcare services are found on our website.

Providers who furnish routine outpatient behavioral health services must schedule appointments within the earlier of 10 business days or 14 calendar days of a request. Providers who furnish inpatient psychiatric services must schedule outpatient follow-up and/or continuing treatment prior to a patient's discharge. The outpatient treatment must occur within seven days from the date of discharge. Behavioral health providers must contact members who have missed appointments within 24 hours to reschedule appointments.

PCPs should:

- Educate members with behavioral health conditions about the nature of the condition and its treatment.
- Educate members about the relationship between physical and behavioral health conditions.
- Contact a behavioral health clinician when behavioral health needs go beyond his or her scope of practice.

PCPs can offer behavioral health services when:

- Clinically appropriate and within the scope of his or her practice.
- The member's current condition is not so severe, confounding, or complex as to warrant a referral to a behavioral health provider.
- The member is willing to be treated by the PCP.
- The services rendered are within the scope of the benefit plan.

Behavioral health providers:

- Must refer members with known or suspected physical health problems or disorders to the PCP for examination and treatment.
- Must utilize the most current DSM multi-axial classification when assessing members; network providers must document DSM and assessment/outcome information in the member's medical record.
- May only provide physical healthcare services if licensed to do so.
- Must send initial and quarterly summary reports of a member's behavioral health status to the PCP with the member's consent.

Care Continuity and Coordination Guidelines

PCPs and behavioral healthcare providers are responsible for actively coordinating and communicating continuity of care. Appropriate and timely sharing of information is essential when the member is receiving psychotropic medications or has a new or ongoing medical condition. The exchange of information facilitates behavioral and medical healthcare strategies.

Our care continuity and coordination guidelines for PCPs and behavioral health providers include:

- Coordinating medical and behavioral health services with the local mental health authority (LMHA) and state psychiatric facilities regarding admission and discharge planning for members with serious emotional disorders (SED) and serious mental illness (SMI), if applicable.
- Completing and sending the member's consent for information release to the collaborating provider.
- Using the release as necessary for the administration and provision of care.
- Noting contacts and collaboration in the member's chart.
- Responding to requests for collaboration within one week or immediately if an emergency is indicated.
- Sending a copy of a completed Coordination of Care/Treatment Summary form to us and the member's PCP when the member has seen a behavioral health provider; the form can be found on our website.
- Sending initial and quarterly (or more frequently, if clinically indicated) summary reports of a member's behavioral health status from the behavioral health provider to the member's PCP.
- Contacting the PCP when a behavioral health provider changes the behavioral health treatment plan.
- Contacting the behavioral health provider when the PCP determines the member's medical condition could reasonably be expected to affect the member's mental health treatment planning or outcome and documenting the information on the coordination of care/treatment summary.

Emergency Behavioral Health Services

An emergency behavioral health condition means any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate intervention and/or medical attention. And in an emergency and without immediate intervention and/or medical attention, the member would present an immediate danger to himself, herself or others or would be rendered incapable of controlling, knowing, or understanding the consequences of his or her actions.

In the event of a behavioral health emergency, the safety of the member and others is paramount. The member should be instructed to seek immediate attention at an emergency room or other behavioral health crisis service. An emergency dispatch service or 911 should be contacted if the member is a danger to self or others and is unable to go to an emergency care facility.

A behavioral health emergency occurs when the member's mental health condition is causing member to be:

- Suicidal.
- Homicidal.
- Violent towards others.

- Suffering a precipitous decline in functional impairment and is unable to take care of activities of daily living.
- Alcohol or drug dependent with signs of severe withdrawal.

We do not require precertification or notification of emergency services, including emergency room and ambulance services.

Urgent Behavioral Services

An urgent behavioral health situation is defined as a condition that requires attention and assessment within 24 hours. In an urgent situation, the member is not an immediate danger to himself or herself or others and is able to cooperate with treatment.

Care for non-life-threatening emergencies should be within six hours.

Precertification and Referrals for Behavioral Health

Members may self-refer to any Wellpoint network behavioral health services provider. No precertification or referral is required from the PCP. Providers may refer members for services by calling Provider Services at **855-878-1785**.

All behavioral health authorization requests should be submitted using our preferred electronic method via **availity.com.**

Our staff is available 24 hours a day, 7 days a week, 365 days a year for crisis or emergency calls and inpatient authorization requests. We are responsible for authorized inpatient hospital services, including freestanding psychiatric facilities for Wellpoint members.

CHAPTER 7: CREDENTIALING AND RECREDENTIALING

Overview

To be reimbursed for services rendered to Wellpoint members, providers must be enrolled in Texas Medicaid. Providers are not considered participating with us until they have enrolled in Texas Medicaid and have been credentialed with a duly executed contract with us.

We adhere to NCQA standards and state requirements for credentialing and recredentialing. In accordance with these standards, providers must submit all requested information necessary to complete the credentialing or recredentialing process. Each provider must cooperate with us as necessary to conduct credentialing and recredentialing pursuant to our policies and procedures.

To initiate the network enrollment process, email Wellpoint at TXCredentialing@Wellpoint.com. Wellpoint will use the Credentialing Verification Organization (CVO), Aperture, for all initial credentialing and recredentialing requests. We will notify Verisys of a provider's intent to become a credentialed provider. Verisys will collect all credentialing applications, forms, licenses, and other relevant information needed to validate a provider's credentials — this is called primary source verification (PSV).

Upon review of the PSV, Verisys will notify Wellpoint whether a file is complete or incomplete. If a file is deemed complete, we perform an internal review for accuracy and completeness. Once the internal process is complete, the file will be submitted to the Credentialing Committee for review. You will receive a final notification from Wellpoint upon completion of all credentialing-related actions. Upon completion of PSV, Verisys will notify Wellpoint for the Credentialing Committee review. You will receive a final notification from Wellpoint upon completion of all credentialing-related actions.

The CVO process is for credentialing only — providers must still contract with Wellpoint. The initial credentialing process and our claims system will be able to recognize a newly contracted provider no later than 90 calendar days after Verisys' receipt of a complete application.

A provider has the right to inquire about the status of a network enrollment request by the following methods:

- To check the status of your credentialing application, call Verisys at **855-743-6161**, option 3.
- Email — TXCredentialing@Wellpoint.com

If a provider qualifies for expedited credentialing under *Texas Insurance Code 1452, Subchapters C, D and E*, regarding providers joining established medical groups or professional practices that are already contracted with us, our claims system will be able to process claims from the provider as if the provider was a network provider, no later than 30 days after Verisys' receipt of a complete application, even if the credentialing process is not yet complete.

Providers are required to notify us of a change in address or practice status within 10 days of the effective date of the change. Practice status is defined as a change in office hours, panel status, etc. The inclusion of a new address on a recredentialing application is not an acceptable form of notification. The Provider Data Management (PDM) tool in Availity Essentials at **Availity.com** should be used to submit demographic change requests for all professional and facility providers. The HHSC administrative services contractor must also be notified of all demographic changes. A notice of termination must adhere to the advance notice timelines stated in the provider's agreement and be sent to:

Provider Configuration
Wellpoint
P.O. Box 62509
Virginia Beach, VA 23466-2509

Credentialing Criteria and Process

Discretion of Wellpoint

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit the discretion of Wellpoint in any way to amend, change or suspend any aspect of the credentialing program ("Credentialing Program") at Wellpoint nor is it intended to create rights on the part of practitioners or health delivery organizations (HDOs) who seek to provide healthcare services to members. Wellpoint further retains the right to approve, suspend, or terminate individual physicians and healthcare professionals, and sites in those instances where it has delegated credentialing decision making.

Credentialing Scope

Credentialing requirements apply to the following:

1. Practitioners who are licensed, certified, or registered by the state to practice independently (without direction or supervision);
2. Practitioners who have an independent relationship with Wellpoint
   - An independent relationship exists when Wellpoint directs its members to see a specific practitioner or group of practitioners, including all practitioners whom a member can select as primary care practitioners; and
3. Practitioners who provide care to members under Wellpoint medical benefits.

The criteria listed above apply to practitioners in the following settings:

1. Individual or group practices;
2. Facilities;
3. Rental networks:
   - That are part of the Wellpoint primary network and include Wellpoint members who reside in the rental network area.
   - That are specifically for out-of-area care and members may see only those practitioners or are given an incentive to see rental network practitioners; and
4. Telemedicine.

Wellpoint credentials the following licensed/state certified independent healthcare practitioners:

- Medical Doctors (MD)
- Doctor of Osteopathic Medicine (DO)
- Doctor of Podiatry
- Chiropractors
- Optometrists providing health services covered under the health benefit plan
- Doctors of dentistry providing health services covered under the health benefit plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral healthcare specialists who provide treatment services under the health benefit plan
- Telemedicine practitioners who provide treatment services under the health benefit plan
- Medical therapists (e.g., 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 Abuse 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 abuse 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 Abuse
  - Methadone Maintenance Clinics
  - Outpatient Mental Health Clinics
  - Outpatient Substance Abuse Clinics
  - Partial Hospitalization – Mental Health and/or Substance Abuse
  - Residential Treatment Centers (RTC) – Psychiatric and/or Substance Abuse
- Birthing Centers
- Home Infusion Therapy when *not* associated with another currently credentialed HDO

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
- End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission
- Portable x-ray Suppliers (CMS Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)

Credentials Committee

The decision to accept, retain, deny, or terminate a practitioner's or HDO's participation in one or more of the health plan's networks or plan programs is conducted by a peer review body, known as the Wellpoint Credentials Committee (the "CC").

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated. In states or regions where an Wellpoint affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or an Wellpoint medical director designee and the vice-chair must be a lead medical officer or an Wellpoint medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types

of credentialed health providers (e.g., 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 (e.g., Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more networks or plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. Specifically, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulatory agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, the Wellpoint 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 the health plan's networks or plan programs

Wellpoint will verify those elements related to an applicants' legal authority to practice, relevant training, experience, and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Wellpoint will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating members.
Hospital admitting privileges at a TJC, NIAHO or AOA accredited hospital, or a network hospital previously approved by the committee.
DEA/CDS and state-controlled substance registrations

Verification Element
• The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating members. Practitioners who see members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

Re-credentialing

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Wellpoint credentialing standards ("Credentialing Standards").

All applicable practitioners and HDOs in the Network within the scope of the Credentialing Program are required to be re-credentialed every three years unless otherwise required by applicable state contract or state regulations.

Health Delivery Organizations

New HDO applicants will submit a standardized application to Wellpoint for review. If the candidate meets Wellpoint screening criteria, the credentialing process will commence. To assess whether network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail below, in the "Wellpoint Credentialing Program Standards" section, all network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Wellpoint may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

Ongoing Sanction Monitoring

To support certain Credentialing Standards between the re-credentialing cycles, Wellpoint has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with Credentialing Standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General ("OIG")
- Federal Medicare/Medicaid Reports
- Office of Personnel Management ("OPM")
- State licensing Boards/Agencies
- Member/Customer services departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Wellpoint departments
- Any other information received from sources deemed reliable by Wellpoint.

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

Appeals Process

Wellpoint has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of the health plan'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 the

health plan'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 the intent of Wellpoint to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of the health plan'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 determines that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

Reporting Requirements

When Wellpoint takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its networks or plan programs, Wellpoint may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

Wellpoint Credentialing Program Standards

Eligibility Criteria

A. Healthcare practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

1. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;
2. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to members;
3. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating members. Practitioners who see members in more than one state must have a DEA/CDS registration for each state; and
4. Meet the education, training and certification criteria as required by Wellpoint.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

1. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.
2. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
3. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
4. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.:
    a. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training, and certification requirement:
        i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;
        ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
        iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in the health plan's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.
    b. Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Wellpoint education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Wellpoint review and approval. Reports submitted by delegates to Wellpoint must contain sufficient documentation to support the above alternatives, as determined by Wellpoint.

5. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO), Center for Improvement in Healthcare Quality (CIHQ), a Healthcare Facilities Accreditation Program (HFAP) accredited hospital, or a network hospital previously approved by the committee. Some clinical disciplines may function

exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

6. For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

Criteria for Selecting Practitioners

New Applicants (Credentialing):

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
4. No evidence of potential material omission(s) on application.
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to members.
6. No current license actions.
7. No history of licensing board action in any state.
8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating members. Practitioners who treat members in more than one state must have a valid DEA/CDS registration for each applicable state.
10. Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:
    a. It can be verified that this application is pending.
    b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. Wellpoint is not required to arrange an alternative prescriber;
    c. The applicant agrees to notify Wellpoint upon receipt of the required DEA/CDS registration.
    d. Wellpoint will verify the appropriate DEA/CDS registration via standard sources.

i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day timeframe will result in termination from the network.

Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Wellpoint members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if *all* the following criteria are met:

a. It can be verified that the applicant's application is pending; and
b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
c. The applicant agrees to notify Wellpoint upon receipt of the required DEA registration; and
d. Wellpoint will verify the appropriate DEA/CDS registration via standard sources; and
e. The applicant agrees that failure to provide the appropriate DEA registration within a 90-day timeframe will result in termination from the network.

Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:

a. controlled substances are not prescribed within his/her scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and
b. he or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. Wellpoint is not required to arrange an alternative prescriber; and
c. DEA/CDS registration is or was not suspended, revoked, surrendered, or encumbered for reasons other than those aforementioned.

11. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.
12. No history of or current use of illegal drugs or history of or current alcohol use disorder.
13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
14. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be

accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six (months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.

15. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
16. A minimum of the past 10 years of malpractice claims history is reviewed.
17. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in the health plan's network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
18. No involuntary terminations from an HMO or PPO.
19. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
    a. Investment or business interest in ancillary services, equipment, or supplies;
    b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. Voluntary surrender of state license related to relocation or nonuse of said license;
    d. A NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window.
    g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Additional Participation Criteria and Exceptions for Behavioral Health practitioners (Non-Physician) Credentialing:

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
    a. Master or doctoral degree in social work.
    b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a Doctor of Social Work will be viewed as acceptable.

2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC) or other master level license type:

a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
b. Master or doctoral degrees in divinity, master's in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
c. Practitioners with PhD training as a clinical psychologist can be reviewed.
d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
d. Licensure to practice independently or in states without licensure or certification:
    i. Marriage & Family Therapists with a master's degree or higher: 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).

3. Pastoral Counselors:
    a. Master's or doctoral degree in a mental health discipline.
    b. Licensed as another recognized behavioral health provider type (e.g., MD/DO, PsyD, SW,RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.
    c. A fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) OR meet all requirements to become a fellow or diplomat member of the ACPE (documentation of eligibility of ACPE required).

4. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
    a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
    b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
    c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing, or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and
    d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating members.

5. Clinical Psychologists:
    a. Valid state clinical psychologist license.
    b. Doctoral degree in clinical or counseling, psychology, or other applicable field of

study.

c. Master's level therapists in good standing in the network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the network and will not be subject to the above education criteria.

6. Clinical Neuropsychologist:
   a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
   b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
   c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
      i. Transcript of applicable pre-doctoral training;
      ii. Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
      iii. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
      iv. Minimum of five years' experience practicing neuropsychology at least ten hours per week.

7. Licensed Psychoanalysts:
   a. Applies only to practitioners in states that license psychoanalysts.
   b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Wellpoint Credentialing Policy (e.g., psychiatrist, clinical psychologist, licensed clinical social worker).
   c. Practitioner must possess a valid psychoanalysis state license.
      (a) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
      (b) Meet examination requirements for licensure as determined by the licensing state.

Additional Participation Criteria and Exceptions for Nurse Practitioners, Certified Nurse Midwives, Physicians Assistants (Non-Physician) Credentialing:

1. Process, requirements, and Verification – Nurse Practitioners:
   a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
   b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if

that board provides documentation that it performs primary verification of the professional education and training If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.

c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted, and not subject to probation, terms, or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested, and primary source verified via normal Wellpoint procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
    i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
    ii. American Academy of Nurse Practitioners – Certification Program;
    iii. National Certification Corporation;
    iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner) ;
    v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
    vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Wellpoint is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.
g. The NP applicant will undergo the standard credentialing processes outlined in Wellpoint Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for CC review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the NP may be listed in the health plan's provider directories. As with all providers, this listing will accurately reflect

their specific licensure designation and these providers will be subject to the audit process.

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

2. Process, Requirements and Verifications – Certified Nurse Midwives:
    a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training, and board certification.
    b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted, and not subject to probation, terms, or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested, and primary source verified via normal Wellpoint procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
    e. All CNM applicants will be certified by either:
        i. The National Certification Corporation for Ob/Gyn and neonatal nursing; or
        ii. 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.

    f. 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 CC 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.

g. The CNM applicant will undergo the standard credentialing process outlined in Wellpoint 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.
h. Upon completion of the credentialing process, the CNM may be listed in the health plan's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. CNMs will be clearly identified:
    - On the credentialing file;
    - At presentation to the CC; and
    - Upon notification to network services and to the provider database.

3. Process, Requirements and Verifications – Physician's Assistants (PA):
    a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted, and not subject to probation, terms, or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested, and primary source verified via normal Wellpoint procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
    e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Wellpoint is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or

amended by each Wellpoint Health Plan and submitted for individual review by the CC.

f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the CC. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
g. The PA applicant will undergo the standard credentialing process outlined in Wellpoint Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the PA may be listed in Wellpoint provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. PA's will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

Currently Participating Applicants (Re-credentialing):

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in the health plan's 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 the health plan's other credentialed provider networks.
4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a network practitioner of similar specialty at a network HDO who provides inpatient care to

members needing hospitalization;

9. No new (since previous credentialing review) history of or current use of illegal drugs or alcohol use disorder;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    b. Voluntary surrender of state license related to relocation or nonuse of said license;
    c. A NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;
    f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
15. No quality improvement data or other performance data including complaints above the set threshold.
16. Re-credentialed at least every three years to assess the practitioner's continued compliance with Wellpoint standards.

*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed network practitioners and HDOs that do not meet one or more of the criteria for re-credentialing.

B. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Wellpoint may evaluate the most recent site survey by

Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Wellpoint may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for member access need only when the CC review indicates compliance with Wellpoint standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are re-credentialed at least every three years to assess the HDO's continued compliance with Wellpoint standards.

1. General Criteria for HDOs:
   a. Valid, current, and unrestricted license to operate in the state(s) in which it will provide services to members. The license must be in good standing with no sanctions.
   b. Valid and current Medicare certification.
   c. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. ***Note:*** *If, once an HDO participates in the health plan's 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 the health plan's other credentialed provider networks.*
   d. Liability insurance acceptable to Wellpoint.
   e. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if the Wellpoint quality and certification criteria standards have been met.

2. Additional Participation Criteria for HDO by Provider Type:

HDO Type and Wellpoint Approved Accrediting Agent(s)

Medical Facilities

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, CTEAM, DNV/NIAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, CTEAM , DNV/NIAHO, TJC
Home Infusion Therapy (HIT)	ACHC, CHAP, CTEAM, HQAA, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC

Behavioral Health

Facility Type (Behavioral Healthcare)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	CTEAM, DNV/NIAHO, HFAP, TJC
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Abuse	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 Abuse	CARF, DNV/NIAHO, HFAP, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Abuse	CARF, COA, DNV/NIAHO, HFAP, TJC

Rehabilitation

Facility Type (Behavioral Healthcare)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	CTEAM, DNV/NIAHO, HFAP, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Abuse Clinics	CARF, TJC, COA,

Practitioner Office Site Quality

We establish standards and thresholds for office site criteria and medical/treatment record-keeping practices. To protect the health and safety of our members, we developed a process for evaluating a physician office site for one or more of the following reasons:

- Receipt of a member complaint concerning physical accessibility, physical appearance, adequacy of waiting or examining room space, or adequacy of medical/treatment records
- Receipt of a member complaint determined to be severe enough to potentially endanger or which endangers members' health and well-being
- When a pattern related to the quality of the site is identified
- To complete the open investigation of any quality or quality of service issue

All physicians/practitioners are required to meet standards set forth by us and to comply with state and federal regulations.

If we identify a physician/practitioner office site receiving three or more complaints within a six-month period related to the following components (with the exception of physical accessibility for which the complaint threshold is one), a Practitioner Office Site Quality Assessment will be conducted that will include a review of the following:

- Physical accessibility
- Physical appearance
- Adequacy of waiting or examining room space
- Adequacy of medical/treatment record-keeping practices

The Wellpoint Practitioner Office Site Evaluation form is used to score the office site quality measurements. A minimum threshold of 80 percent or greater in each component is considered a passing audit score. The acceptable performance for on-site visits for each office location and medical record reviews for the applicant is a minimum passing score of 80 percent in each of the four designated components outlined above. Any exception to the minimum passing score is at the discretion of the health plan credentialing committee and must be based on compelling circumstances.

Practitioner Office Site Assessment Criteria		
Physical Accessibility		**Scoring**
1	Is there accessibility for people with disabilities? If not, does staff have an alternative plan of action?	Must have first-floor ramp or elevator access. Bathroom and hallways must accommodate a wheelchair. If yes, 2 points; if no, 0 points.
2	Is accessible parking clearly marked?	Off-street accessible parking is identified by a sign or a painted symbol on the pavement. Score as N/A if street-side parking only is available. If yes, 1 point; if no, 0 points.
3	Are doorways and stairways that provide access free from obstructions at all times, and do they allow easy access by wheelchair or stretcher?	There should be no boxes, furniture, etc. blocking doorways or stairways If yes, 2 points; if no, 0 points.
4	Are exits clearly marked, and is there emergency lighting in instances of power failure?	Exits are marked with appropriate chevrons and emergency powered in case of power outage. There is a posted evacuation plan by either staff design or building management If yes, 2 points; if no, 0 points
5	Are building and office suite clearly identifiable (clearly marked office sign)?	The sign identifying the office is clearly posted. If yes, 1 point; if no, 0 points

Physical Appearance		
1	Is the office clean, well-kept, and smoke-free?	Mark yes if there are no significant spills on furniture or floor, the trash is confined, and the office and waiting area appears neat. Does the office prevent hazards that might lead to slipping, falling, electrical shock, burns, poisoning, and other trauma? If yes, 2 points; if no, 0 points
2	Is treatment area clean and well kept? (No significant spills on floors, counters or furnishings, no trash on floor)	Mark yes if there are no significant spills on furniture or floor, the trash is confined, the treatment area appears neat. If yes, 2 points; if no, 0 points
3	Does office have smoke detector(s)?	Smoke detectors should be in place and tested twice yearly. How does the office log the twice-yearly check? Is the office a smoke-free facility? If yes, 2 points; if no, 0 points
4	Is there easy access to a clean, supplied bathroom?)	• Soap, toilet paper, and hand towels are available. • Hand washing instructions are posted. • Lavatory is clean; toilet is functioning. If yes, 1 point; if no, 0 points
5	Is the waiting room well lit?	Is there adequate lighting and comfort level for reading? If yes, 1 point; if no, 0 points
6	Are fire extinguishers clearly present and fully charged with a current inspection (even if the office has a sprinkler system)?	Fire extinguisher tag is dated within the last year. There should be an adequate number of fire extinguishers for the square footage placed at opposite ends of office. If yes, 1 point; if no, 0 points
Adequacy of Waiting/Examining Room Space		
1	Is there adequate seating in the waiting area (based on the number of physicians/practitioners)?	1 provider = 6 seats, 2 providers = 8 seats, 3 providers = 11 seats, 4 providers = 14 seats, 5 providers = 17 seats If yes, 1 point; if no, 0 points
2	Does the staff provide extra seating when the waiting room is full?	Ask the staff where patients go when waiting area is full. If yes, 1 point; if no, 0 points
3	Is there a minimum of two exam rooms per scheduled provider? (two consultation rooms for BH providers	Count exam/consultation rooms and compare against provider schedule. If yes, 1 point; if no, 0 points
4	Is there privacy in exam/consultation rooms?	There must be door or curtain closures, exam/consultation rooms cannot be seen from waiting room. If yes, 1 point; if no, 0 points
5	Are exam/consultation rooms reasonably soundproof to ensure	Conversations cannot be heard from waiting room or other exam/consultation rooms. If yes, 2 points; if no, 0 points

	patient privacy during interviews/examinations?	
6	Is an otoscope, an ophthalmoscope, a blood pressure cuff, and a scale readily accessible?	Applies to all physicians/practitioners except BH providers. If yes, 1 point; if no, 0 points
7	7a - For OB/GYNs only or any physician/practitioner providing OB care: 7b – Is a fetal scope (DeLee and/or Dopler) and a measuring tape for fundal height measurement readily accessible - Supplies for dipstick urine analysis (glucose, protein)?	Score 7a and 7b as N/A if provider does not provide OB services. If yes, 1 point for each; if no, 0 points
Adequacy of Medical Records		
1	Are there individual patient records?	Each patient has an individual record. There should be no family charts. If yes, 2 points; if no, 0 points
2	Are records stored in a manner that ensures confidentiality? Who is the designated person in charge of clinical records? (provide name)	Records are maintained in locations not easily accessible to patients and office visitors. If yes, 2 points; if no, 0 points
3	Are all items secured in the chart?	All patient medical information must be secured within the chart. If yes, 2 points; if no, 0 points
4	Are medical records readily available?	Medical records should be available within 15 minutes of request. Providers with more than one office location must have a mechanism to assure the medical record is available for reference if a patient is seen at an alternate site to the usual office. If yes, 2 points; if no, 0 points
5	Medical recordkeeping practices:	We are only determining there is a place within a blank chart to document the information in 5a thru 5f. Due to HIPAA regulations and other reasons related to the legal right to access, we **must not** ask to review an actual patient chart for providers in the initial credentialing process. We may only review charts of those Wellpoint members actually assigned or currently being seen by the providers/practitioners. There would be none for initial providers. When medical records are retired, what is the procedure for storage and final destruction?

5a	Is there a place to document allergies?	Allergies or the absence of allergies, along with the reactions, should be prominently displayed in or on the medical record. The absence of medicine sensitivities should also be noted. If yes, 2 points; if no, 0 points
5b	Is there a place to document a current medication list?	All medications, both prescription and over-the-counter/herbal medications, should be documented in the chart along with the dosages. A notation should also include No Medications to attest that the inquiry was made. If yes, 2 points; if no, 0 points
5c	Is there a place to document current chronic problems list?	A problem list would be generated as part of each visit's assessment. If yes, 2 points; if no, 0 points
5d	Is there an immunization record on pediatric charts? N/A for BH providers	The immunization record should be completed to the age the child has reached at the time of the last encounter. If shots were completed prior to the first encounter with the current physician/practitioner, the notation *Immunizations are up-to-date* is acceptable. If yes, 2 points; if no, 0 points
5e	Is there a growth chart on pediatric charts? N/A for BH providers	Height and weight are documented annually; head circumference is documented until age 2. If yes, 2 points; if no, 0 points
5f	Is there a place to document presence/absence and discussion of a patient self-determination/advance directive?	There is a place for documentation that an advance directive has been executed or that the physician/practitioner has inquired as to whether the patient has a written advance directive. If yes, 2 points; if no, 0 points Score as N/A if patient is < 21 years old.
Appointment Availability		
1	Please see specific appointment availability requirements	If yes, 1 point for each; if no, 0 points
Documentation Evaluation		
1	Is there a no-show follow-up procedure/policy?	A written policy should be available. If not, the staff should verbally describe the follow-up process. Staff should be encouraged to adapt policy into a written format. If yes, 2 points; if no, 0 points
2	Is there a chaperone policy? May not apply to some specific BH situations – ask for clarification and document same on form.	A written policy should be available. If a written policy is not in place, the staff should verbally describe the process and provide a statement on the office letterhead stating a chaperone will be in the exam room. Staff should be encouraged to adapt the policy into a written format. **The provider must have this element in place to pass the site evaluation and participate with Wellpoint.** If yes, 2 points; if no, 0 points

3	Is the Patient Bill of Rights posted? Are copies available upon request?	A notice should be posted in a prominent location, and copies should be available upon request. If yes, 1 point; if no, 0 points
4	Is a medical license/occupational license displayed? Are the hours of operation posted?	Licensures and hours of operation should be posted within the office. If yes, 1 point; if no, 0 points
5	Is there a notice of member complaint process?	A notice should be posted in a prominent location. If yes, 1 point; if no, 0 points
6	Is there a written policy for hand washing, gloved procedures, and disposal of sharps? May not be applicable for BH providers in private practice setting.	A written policy for hand washing should be available (1 point) A written policy for sharp disposal should be available (1 point). Sharps should be disposed of immediately. Reusable containers must not be opened, emptied, or cleaned manually. Policies may be located in the office OSHA manual. If yes, 2 points; if no, 0 points
7	Is there a written OSHA exposure control plan that includes universal precautions and blood-borne pathogen exposure procedures for staff?	A written policy should be in place detailing the process to protect staff from exposure to hazardous waste materials and the cleanup/disposal of same. Are MSDS sheets available? If yes, 2 points; if no, 0 points
8	Is a copy of the **Clinical Laboratory Improvement Amendments (CLIA)** certificate or certificate of waiver if applicable posted? **If the PCP provides Texas Health Steps services, must have CLIA/waiver or lab services within the same building**.	If the provider offers laboratory services that require a CLIA or certificate of waiver, the current notice should be posted, and a copy obtained and attached to the site visit form. If yes, 1 point; if no, 0 points
9	Is there a copy of the current radiology services certification or licensure if applicable posted?	If the provider offers radiology services, current licensure and/or certification must be posted, and copy obtained and attached to the site visit form. Are pregnancy signs posted? If yes, 1 point; if no, 0 points
10	If provider employs nurse practitioners, physicians' assistants, or other mid-level providers that will assess healthcare needs of members, do they have written policies describing	A written policy should be available describing the level/type of care provided by the mid-level practitioners within the physician's/practitioner's office and the level/type of supervision of same. If yes, 2 points; if no, 0 points

	the duties and supervision of such providers?	
***HIPAA* Requirements/Regulations**		
1	Is there a written policy and procedure addressing permitted uses/disclosures and required disclosures of patient Personal Health Information (PHI)/Individually Identifiable Heath Information (IIHI)?	There should a written policy and procedure addressing permitted uses and disclosures as well as required disclosures of patient PHI/IIHI, as required by HIPAA regulations. Providers should have appropriate forms available for members and patients If yes, 2 points; if no, 0 points
2	Does the provider have authorization forms available to designate personal representative(s) to which PHI/IIHI may be released and/or disclosed?	Does the provider have an authorization form for disclosure of PHI/IIHI, as required by HIPAA regulations? Form should include an expiration date. Should also include description of how members/patients may revoke authorization in writing. If yes, 2 points; if no, 0 points
3	Are there physical safeguards in place to protect the privacy of patient PHI/IIHI?	There should be no papers with PHI in areas accessible to other patients. Examples: All patient information is securely placed in locked cabinet. No confidential information is left out in the open for other patients or staff members to see (e.g., patient sign-in sheet). Is there a shredding machine and policy on storage and disposal of medical records? Computer has safeguards in place: security codes for access, safety. If yes, 2 points; if no, 0 points
4	Is there a designated compliance and privacy person?	**You must include the name of the individual in the space provided on the site evaluation form.** If yes, 2 points; if no, 0 points
Office Evaluation		
1	Is there an approved process for biohazardous disposal?	There is a written policy for biohazardous waste disposal in a manner that protects employees from occupational exposure. Biohazardous waste includes liquid or semi-liquid blood or other potentially infectious materials. Biohazardous items include contaminated items that would release blood if compressed, items caked with blood, contaminated sharps, and pathological and microbiological waste. If yes, 2 points; if no, 0 points
2	Are pharmaceutical supplies and medication stored in a locked area that is not readily accessible to patients?	• Medications are in a locked area, including samples. • Prescription pads are kept in a secured location away from patient access; pads should not be found in exam rooms or left on countertops unsupervised by office staff.

		If yes, 2 points; if no, 0 points
3	Is there a plan/procedure for narcotic inventory, control, and disposal?	There is a plan to randomly check that sample medications are current and there is a procedure for disposing of expired medications – wasting of medications. If yes, 1 point; if no, 0 points
4	Are vaccines and other biologicals refrigerated as appropriate?	If refrigeration is required for medication, there is a separate space provided. There should be no other items – including food and biological specimens – on the same shelf as medication (preferably these are in a separate refrigerator). Look for Penny Test in freezer to document power outages. If yes, 1 point; if no, 0 points
5	Is emergency equipment available? If not, note how the staff accommodates emergency situations.	The minimum requirement is an oral airway and Ambu bag (for children and/or adults based on age range) If the office has an emergency kit or cart, check for routine inspections and expired supplies or medications. If yes, 1 point; if no, 0 points
6	Observe 2-3 office staff interactions: Are they professional and helpful? Is CPR-trained staff in the office at all times when patients are present?	If yes, 2 points; if no, 0 points

CHAPTER 8: PERFORMANCE AND TERMINATION

Performance Standards and Compliance

All providers must meet specific performance standards and compliance obligations. When evaluating a provider's performance and compliance, Wellpoint reviews a number of clinical and administrative practice dimensions including:

- Quality of care — measured by clinical data related to the appropriateness of care and outcomes.
- Efficiency of care — measured by clinical and financial data related to healthcare costs.
- Member satisfaction — measured by the members' reports regarding accessibility, quality of healthcare, member/provider relations and the comfort of the office setting.
- Administrative requirements — measured by the provider's methods and systems for keeping records and transmitting information.
- Participation in clinical standards — measured by the provider's involvement with panels used to monitor quality of care standards.

Providers must:

- Comply with all applicable laws and licensing requirements.
- Furnish covered services in a manner consistent with professionally recognized standards of medical and surgical practice generally accepted in the professional community at the time of treatment.
- Comply with Wellpoint standards, including:
  - Guidelines established by the Centers for Disease Control and Prevention (or any successor entity)
  - Federal, state, and local laws regarding professional conduct
- Comply with Wellpoint policies and procedures regarding the following:
  - Participating on committees and clinical task forces to improve the quality and cost of care
  - Prenotification and/or precertification requirements and time frames
  - Provider credentialing requirements
  - Referral policies
  - Case Management Program referrals
  - Appropriately releasing inpatient and outpatient utilization and outcomes information
  - Providing accessibility of member medical record information to fulfill Wellpoint business and clinical needs as well as member needs
  - Cooperating with efforts to assure appropriate levels of care
  - Maintaining a collegial and professional relationship with Wellpoint personnel and fellow providers
  - Providing equal access and treatment to all Wellpoint members

The following types of noncompliance issues are key areas of concern:

- Member complaints and grievances filed against the provider

- Underutilization, overutilization, or inappropriate referrals
- Inappropriate billing practices, such as balance billing of Wellpoint members for amounts that are not their responsibility
- Unnecessary out-of-network referrals and utilization (which require precertification)
- Failure to provide advance notice of admissions or precertification of discharges from inpatient facilities, comprehensive outpatient rehabilitation facilities or home healthcare services
- Nonsupportive actions and/or attitude

Provider noncompliance is tracked on a calendar year basis. Corrective actions are taken as appropriate.

Physician-Patient Communications

Providers acting within the lawful scope of practice are encouraged to advise Wellpoint members of the following:

- Health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options
- Risks, benefits, and consequences of treatment or nontreatment
- Opportunity for the individual to refuse treatment and to express preferences about future treatment decisions

Physician and patient communications are a necessary component of standard medical practice. Although coverage under this program is determined by Wellpoint, the provider along with the member remains responsible for all treatment decisions related to the Wellpoint member.

Provider Participation Decisions: Appeals Process

Upon a denial, suspension, termination or nonrenewal of a provider's participation in the Wellpoint provider network, Wellpoint acts as follows:

- The affected physician is given a written notice of the reasons for the action, including if relevant the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by Wellpoint.
- The physician is allowed to appeal the action to a hearing panel.
- The physician is provided written notice of the right to a hearing and the process and timing for requesting a hearing.
- Wellpoint ensures the majority of the hearing panel members are peers of the affected physician.
- Wellpoint notifies the National Practitioner Data Bank, the appropriate state licensing agency, and any other applicable licensing or disciplinary body to the extent required by law if a suspension or termination is the result of quality-of-care deficiencies.
- Subcontracted physician groups must ensure these procedures apply equally to physicians within those subcontracted groups.

- Wellpoint notifies CMS and HHSC within seven calendar days when it terminates, suspends, or declines a provider from its network because of fraud, integrity, or quality.

Wellpoint decisions subject to an appeal include decisions regarding reduction, suspension or termination of a provider's participation resulting from quality deficiencies. Wellpoint notifies the National Practitioner Data Bank, the appropriate state licensing agency and any other applicable licensing or disciplinary body to the extent required by law. Written communication to the provider details the deficiencies and informs him or her of the right to appeal.

Notification to Members of Provider Termination

Wellpoint makes a good faith effort to provide notice to each member who received his or her care from the provider or was seen on a regular basis by the provider within 15 calendar days of receipt or issuance of the termination notice. Wellpoint may provide member notification in less than 15 days' notice as a result of a provider's death or exclusion from the federal health programs.

When a termination involves a PCP or any medical, behavioral health or long-term services and supports provider, all members who are patients of that provider are notified of the termination.

For members who are receiving treatment for a chronic or ongoing medical condition or LTSS, Wellpoint will ensure there is no disruption in services provided.

CHAPTER 9: QUALITY MANAGEMENT

Overview

Wellpoint maintains a comprehensive Quality Management (QM) program to objectively and systematically monitor and evaluate care and service provided to members. The scope and content of the program reflects the demographic, epidemiologic, medical, and behavioral health needs of the population served. Key components of the program include but are not limited to the following:

- Quality of member care and service
- Accessibility and availability of services
- Member safety and prevention
- Continuity and coordination of care
- Appropriateness of service utilization
- Cultural competency
- Member outcomes
- Member and provider satisfaction
- Regulatory and accreditation standards

Members and providers have opportunities to participate in quality management and make recommendations for areas of improvement through complaints, grievances, appeals, satisfaction or other surveys, committee participation where applicable, quality initiatives/projects, and calls to the health plans. QM program goals and outcomes are available to providers and members upon request.

Quality activities are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program.

The Wellpoint QM program tracks and trends quality of care issues and service concerns identified for all care settings. QM staff review member complaints, grievances, reported adverse events and other information to evaluate the quality of service and care provided to our members.

On a quarterly basis, Wellpoint submits the number of Service Coordinators that received CDS training to HHSC. On a quarterly basis, Wellpoint submits a number of critical incidents and abuse reports for members receiving LTSS services to HHSC.

Centers for Medicare & Medicaid Services (CMS)

CMS evaluates all Medicare-Medicaid Plans through the use of Healthcare Effectiveness Data and Information Set (HEDIS®) metrics. Many of the measures included in the CMS evaluation are measures of preventive care management. Some of these are listed below and are subject to change:

- Staying healthy — screening, tests, and vaccines:
  - Breast cancer screening
  - Colorectal cancer screening
  - Cholesterol screening for cardiovascular and diabetes care
  - Annual flu vaccine
  - Improving and maintaining physical and mental health
  - Monitoring physical activity
  - Adult body mass index assessment
- Managing chronic conditions:
  - Care for the older adult: medication review, functional status assessment and pain screening
  - Managing osteoporosis in women who had a fracture
  - Obtaining diabetes care for eye exams, kidney disease monitoring, and blood sugar and cholesterol control
  - Controlling blood pressure
  - Managing rheumatoid arthritis
  - Improving bladder control
  - Reducing the risk of falling
  - Plan all-cause readmissions
  - Medication adherence and management (oral diabetics, hypertension, and cholesterol medications)

With the growing focus on quality healthcare and plan member satisfaction, CMS and the state assess plan performance. One of the assessment tools used is the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. Members who receive healthcare services through the Texas STAR+PLUS Medicare-Medicaid Plan will receive CAHPS surveys each year through the mail in late February.

The survey asks the Texas STAR+PLUS MMP member to assess his or her health and the care received from his or her primary care providers and specialists over the past six months. The survey includes questions regarding providers' communication skills and the member's perception about his or her access to needed healthcare services. The survey questions ask the member to report his or her opinion about access to care and the health plan's customer service. It also asks the member to rate the communication received from his or her providers.

A second assessment tool used by CMS is the Health Outcomes Survey (HOS) to evaluate all managed care organizations' ability to maintain or improve the physical and mental health functioning of its Medicare beneficiaries over a two-year period of time. The survey is used as a way of measuring how the care provided by the health plan is affecting the functional status of their enrollees. CMS includes the HOS in their performance assessment program.

This survey is sent out in two cohorts. The first cohort records baseline data. If a member answers the first survey, they are sent a second survey in two years, and these results become part of the effectiveness of care ratings for the health plan.
CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Wellpoint encourages participating providers to help improve member satisfaction by:

- Ensuring members receive appointments within acceptable time frames as outlined in the "Access and Availability Standards Table" in this manual.
- Educating members and talking to them during each visit about their preventive healthcare needs.
- Ensuring providers answer any questions members have regarding newly prescribed medications.
- Ensuring members know to bring all medications and medical histories to their specialists and know the purpose of a specialist referral.
- Allowing time during the appointment to validate members' understanding of their health conditions and the services required for maintaining a healthy lifestyle.
- Referring members to the Member Services department and speaking to a case manager.

Committee Structure

Wellpoint maintains a comprehensive quality management committee structure as noted below with program oversight by the board of directors.

Quality Improvement Committee

The purpose of the Quality Improvement Committee is to provide leadership and oversight of the health plan quality management programs, improve safety and quality of care and services, improve customer service, and improve operating efficiencies.

Responsibilities include the following:

- Review and approval of the program descriptions
- Work plans and annual evaluations for quality management, utilization management, health promotion, credentialing, case management and pharmacy
- Review and approval reporting of complaints, appeals and Service Level Agreements (SLAs)
- Review of regular standardized reports (at least semi-annually) delineating progress towards goals of the program, actions taken, improvements made, focused study results and follow-up actions on identified opportunities
- Evaluation of resource adequacy to ensure effective implementation of the programs and ongoing effectiveness
- Recommending policy decisions
- Instituting needed actions and ensure completion
- Ensuring practitioner participation

Quality Management Committee

The purpose of our Quality Management Committee (QMC) is to maintain quality as a cornerstone of Wellpoint culture and to be an instrument of change through demonstrable improvement in care and service.

The QMC's responsibilities are to:

- Review regular standardized reports, at least semi-annually, delineating progress towards clinical goals, actions taken and improvements.
- Establish processes and structure that ensure CMS compliance.
- Analyze, review, and make recommendations regarding the planning, implementation, measurement, and outcomes of the clinical/service quality improvement projects (QIP).
- Coordinate communication of quality management activities throughout the health plan.
- Review CMS Stars, HEDIS, HOS and CAHPS data and action plans for improvement.
- Review, monitor and evaluate program compliance against the health plan, state, federal and CMS standards.
- Review of LTSS credentialing issues as applicable.
- Review and approve the annual Quality Management Program Description and Work Plan and the QM Program Evaluation.
- Evaluate the overall effectiveness of the SNP Model of Care including regular reports, performance outcomes and satisfaction, barrier analysis, effectiveness of interventions and adequacy of resources.
- Oversee the compliance of delegated services and delegation oversight activities.
- Assure inter-departmental collaboration, coordination, and communication of quality improvement activities.
- Measure compliance to medical and behavioral health practice guidelines.
- Monitor continuity of care between medical and behavioral health services.
- Monitor accessibility and availability.
- Publicly make information available to members and practitioners about the network hospital actions to address and improve patient safety.
- Make information available about the QM program to members and practitioners.

Focus Studies and Utilization Management Reporting Requirements

The Wellpoint Quality Management team is involved in conducting clinical and service utilization studies that may or may not require medical record review. We conduct gap analysis of the data and share opportunities for improvement with our network providers.

CHAPTER 10: HEALTH CARE MANAGEMENT SERVICES

Overview

Wellpoint continuously seeks to improve the quality of care provided to its members. We encourage and expect our providers to participate in health promotion programs. Providers are encouraged to collaborate with Wellpoint in efforts to promote healthy lifestyles through member education and information sharing.

Providers must fully comply with:

- Healthcare management services policies and procedures.
- Quality improvement and other performance improvement programs.
- All regulatory requirements.

The healthcare delivery system is a gatekeeper model that supports the role and relationship of the PCP. The model includes direct contracts with PCPs, hospitals, specialty physicians and other providers, as required, to deliver Medicare and Medicaid benefits for members with complex medical needs. All contracted providers are available to Wellpoint members by PCP or self-referral for the services identified below.

The gatekeeper model requires all members to select a PCP upon joining the plan. Members who do not choose a PCP are assigned one. Wellpoint works with the member, the physician and the member's representative, as appropriate, to ensure the PCP is suitable to meet the member's individual needs. Members must have access to their PCP or a covering physician 24 hours a day, 7 days a week.

Self-Referral Guidelines

Wellpoint members may self-refer for the following services:

- Screening mammograms
- Routine outpatient behavioral health
- Influenza and pneumococcal vaccinations
- Routine physical examinations, prostate screening, and preventive women's health services (e.g., Pap smears)
- Family planning services

Except for emergent or out-of-area urgent care and dialysis services, in general, members must obtain services within the Wellpoint network or obtain a precertification for covered services outside the network.

Referral Guidelines

PCPs may only refer members to Wellpoint-contracted network specialists to ensure the specialist receives appropriate clinical background data and is aware of the member's ongoing primary care relationship. If a member wants to receive care from a different specialist or the required specialty is not available within the contracted network, the PCP

should contact Provider Services at **855-878-1785**. PCPs must obtain precertification from Wellpoint before referring members to nonparticipating providers.

Authorization/Precertification

Certain services/procedures require precertification from Wellpoint for participating and nonparticipating PCPs and specialists and other providers. Please refer to the list below or the Precertification Lookup Tool online or call Provider Services at **855-878-1785** for more information. You can access information concerning precertification requirements on our website at **provider.wellpoint.com/tx** > Resources > Prior authorization requirements.

The following are examples of services requiring precertification before providing the nonemergent or urgent care services: (Please note this is not an all-inclusive list of services that require prior authorization; this listing is provided as guidance only.)

- Inpatient mental health services
- Behavioral health partial hospitalization
- Skilled nursing facility (SNF)
- Home healthcare
- Diagnostic tests including but not limited to MRI, MRA, PET scans, etc.
- Hospital or ambulatory care center-based outpatient surgeries for certain procedures
- Elective inpatient admissions
- Transplant evaluation and services
- Nonemergency service from or referral to a noncontracted provider
- Durable medical equipment (DME)
- Outpatient IV infusion or injectable medications
- Prosthetics
- Certain reconstructive procedures
- Occupational, speech and physical therapy services
- Long-term services and supports (LTSS)

Precertification

Precertification requests or notifications can be submitted digitally through Availity Essentials and is the preferred method.

Availity Essentials: **availity.com**

A complete list of services that require precertification can be found at **provider.wellpoint.com/tx**.

Mental Health/Substance Use Disorder: All requests for prior authorizations should be submitted using Availity Essentials via **availity.com.**

If you prefer paper fax, please use the appropriate form posted on **provider.wellpoint.com/tx** > Resources > Forms:

- Home health, durable medical equipment, and discharge planning fax: **888-235-8468**
- Concurrent review clinical documentation for inpatient fax: **888-700-2197**

- Initial admission notification and all other services fax: **866-959-1537**
- Medical injectable/infusible drugs fax: **844-494-8344**
- Nursing facility fax: **844-206-3449** (Part A Services)
- Nursing facility fax: **866-959-1537** (Part B Services)

Radiology Services

Wellpoint collaborates with Carelon Medical Benefits Management, Inc. to provide certain outpatient imaging utilization management services for Wellpoint members. The ordering provider is responsible for obtaining prior authorization for the following services:

- Computer tomography (CT/CTA) scans
- Stress echocardiography (SE)
- Echocardiogram (Echo)
- Resting transthoracic echocardiography (TTE)
- Magnetic resonance (MRI/MRA)
- Positron emission tomography (PET) scans
- Transesophageal echocardiography (TEE)
- Nuclear cardiology

Authorization review requests can be initiated by visiting **providerportal.com** or calling Carelon Medical Benefits Management at **833-305-1809**, Monday through Friday, 8 a.m. to 5 p.m.

Medically Necessary Services and Medical Criteria

Medically necessary services are medical services determined by Wellpoint to be:

- Rendered for the diagnosis or treatment of an injury or illness.
- Appropriate for the symptoms, consistent with diagnosis and otherwise in accordance with sufficient scientific evidence and professionally recognized standards.
- Not furnished primarily for the convenience of the member, the attending provider or other provider of service.

Medical necessity decisions are objective, based on medical evidence and applied according to the individual needs of the member and an assessment of the local delivery system. Wellpoint makes utilization management criteria available to providers on the provider website. If a medical necessity decision results in a denial, practitioners are welcome to discuss the denial decision with the medical director. All denial decisions are made by appropriately licensed and qualified physicians. Practitioners can obtain utilization management criteria or speak to a medical director by calling Provider Services at **855-878-1785**.

Wellpoint makes determinations of medical necessity based on CMS national coverage determinations (NCD), local coverage determinations (LCD), other coverage guidelines and instructions issued by CMS and the state of Texas and legislative changes in benefits. In coverage situations where there is no NCD, LCD, or guidance on coverage in original Medicare or Medicaid manuals, Wellpoint will make a determination on medical necessity based on authoritative evidence as documented by Milliman, CMS and state guidelines and Wellpoint policies as a guideline.

In some instances, Wellpoint may develop its own coverage policies. In these instances, the following standards apply to the development of the criteria:

- Criteria are developed with involvement from appropriate providers with current knowledge relevant to the content of treatment guidelines under development.
- Criteria are objective, based on medical evidence, review of market practice, national standards, and best practices.
- Criteria are evaluated at least annually by appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria of treatment guidelines under review and updated, as necessary.
- The criteria must reflect the names and qualifications of those involved in the development, the process used in the development and when and how often the criteria will be evaluated and updated.
- The criteria cannot be more restrictive or limiting than CMS or state guidelines or requirements.

These guidelines are communicated to providers through Wellpoint fax notices, letters, and newsletters. Communications are also posted to the provider website at **provider.wellpoint.com/tx.**

CHAPTER 11: MEDICAL MANAGEMENT

Member Record Standards

Our providers are required to maintain medical records that conform to good professional medical practice and appropriate health management. A permanent medical record is maintained at the primary care site for every member and is available to the PCP and other providers. Medical records must be kept in accordance with Wellpoint and state standards as outlined below:

The records reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to *HIPAA* requirements and other federal and state laws.

Documentation of each visit must include the following:

1. Date of service
2. Complaint or purpose of visit
3. Diagnosis or medical impression
4. Objective finding
5. Assessment of patient's findings
6. Plan of treatment, diagnostic tests, therapies, and other prescribed regimens
7. Medications prescribed
8. Health education provided
9. Signature or initials and title of the provider rendering the service

Note: If more than one person documents in the medical record, there must be a record on file as to which signature is represented by which initials.

These standards will, at a minimum, meet the following medical record requirements:

1. Patient identification information: Each page or electronic file in the record must contain the patient's name or patient ID number.
2. Personal/biographical data: The record must include the patient's age, sex, address, employer, home and work telephone numbers, and marital status.
3. Date and corroboration: All entries must be dated and author-identified.
4. Legibility: Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
5. Allergies: Medication allergies and adverse reactions must be prominently noted on the record. Absence of allergies (no known allergies – NKA) must be noted in an easily recognizable location.
6. Past medical history for patients seen three or more times: Past medical history must be easily identified, including serious accidents, operations, and illnesses. For children, the history must include prenatal care of the mother and birth.
7. Physical examination: A record of physical examination(s) appropriate to the presenting complaint or condition must be noted.

8. Immunizations: For pediatric records of members age 13 and younger, a completed immunization record or a notation of prior immunization must be recorded. This should include vaccines and their dates of administration when possible.
9. Diagnostic information: Documentation of clinical findings and evaluation for each visit should be noted.
10. Medication information: This notation includes medication information and instruction(s) to the patient.
11. Identification of current problems: Significant illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record. A current problem list must be included in each patient record.
12. Instructions: The record must include evidence that the patient was provided with basic teaching/instructions regarding physical/behavioral health condition.
13. Smoking/alcohol/substance abuse: A notation concerning cigarettes and alcohol use and substance abuse must be stated if present for patients age 12 and older. Abbreviations and symbols may be appropriate.
14. Preventive services/risk screening: The record must include consultation and provision of appropriate preventive health services and appropriate risk screening activities.
15. Consultations, referrals, and specialist reports: Notes from any referrals and consultations must be in the record. Consultation, lab, and X-ray reports filed in the chart must have the ordering physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans.
16. Emergencies: All emergency care provided directly by the contracted provider or through an emergency room and the hospital discharge summaries for all hospital admissions while the patient is part of the PCP's panel must be noted.
17. Hospital discharge summaries: Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the patient is enrolled and for prior admissions as appropriate. Prior admissions pertaining to admissions that may have occurred prior to the patient being enrolled may be pertinent to the patient's current medical condition.
18. Advance directive: Medical records of adult patients must document whether or not the individual has executed an advance directive. An advance directive is a written instruction, such as a living will or durable power of attorney, which directs healthcare decision-making for individuals who are incapacitated.
19. Security: Providers must maintain a written policy to ensure that medical records are safeguarded against loss, destruction, or unauthorized use. Physical safeguards require records to be stored in a secure manner that allows access for easy retrieval by authorized personnel only. Staff receives periodic training in member information confidentiality.
20. Release of information: Written procedures are required for the release of information and obtaining consent for treatment.
21. Documentation: Documentation is required setting forth the results of medical, preventive, and behavioral health screening and of all treatment provided and results of such treatment.
22. Multidisciplinary teams: Documentation of the team members involved in the multidisciplinary team of a patient needing specialty care is required.

23. Integration of clinical care: Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include the following:
    a. Notation of screening for behavioral health conditions (including those which may be affecting physical healthcare and vice versa) and referral to behavioral health providers when problems are indicated
    b. Notation of screening and referral by behavioral health providers to PCPs when appropriate
    c. Notation of receipt of behavioral health referrals from physical medicine providers and the disposition and outcome of those referrals
    d. A summary (at least quarterly or more often if clinically indicated) of the status/progress from the behavioral health provider to the PCP
    e. A written release of information that will permit specific information sharing between providers
    f. Documentation that behavioral health professionals are included in primary and specialty care service teams when a patient with disabilities, or chronic or complex physical or developmental conditions, has a co-occurring behavioral disorder

Requirements Overview

Wellpoint providers must maintain permanent medical records that are:

- Current, detailed and organized; permit effective, confidential patient care; and allow quality reviews.
- In conformity with good professional medical practice and appropriate health management.
- Located at the primary care site for every Wellpoint member.
- Kept in accordance with Wellpoint and state standards as described in this manual.
- Retained for 10 years from the final date of the contract or from the date of completion of any audit.
- Accessible upon request to Wellpoint, any state agency, and the federal government.

Wellpoint will:

- Systematically review medical records to ensure compliance with standards. The health plan's MAC oversees and directs Wellpoint in formalizing, adopting, and monitoring guidelines.
- Institute actions for improvement when standards are not met.
- Maintain a record-keeping system that is designed to collect all pertinent medical management information for each member.
- Make information readily available to appropriate health professionals and appropriate state agencies.
- Use nationally recognized standards of care and work with providers to develop clinical policies and guidelines of care for members.

Case Management

The Wellpoint Case Management Solutions Program is a member-centric, integrated continuum of care model that strives to address the totality of each member's physical, behavioral, cognitive, functional, and social needs.

The scope of the Case Management Solutions Program includes but is not limited to:

- Member identification using a prospective approach that is designed to focus case management resources for members expected to be at the highest risk for poor health outcomes.
- Initial and ongoing assessment.
- Problem-based, comprehensive care planning to include measurable goals and interventions tailored to the complexity level of the member as determined by initial and ongoing assessments.
- Coordination of care with PCPs and specialty providers.
- Member education.
- Member empowerment using motivational interviewing techniques.
- Facilitation of effective member and provider communications.
- Program monitoring and evaluation using quantitative and qualitative analysis of data.
- Satisfaction and quality of life measurement.

Using a prospective systematic approach, members with a risk of poor health outcomes are identified and targeted for case management services that are tailored to their condition and risks. This continuous case finding system evaluates members of a given population based on disease factors and claims history with the goal of improving quality of life through proper utilization of necessary services and a reduction in the use of unnecessary services.

Case management member candidate lists are updated monthly and prioritized to identify members with the highest expected needs for service. Case management resources are focused on meeting listed members' needs by using a combination of standardized and individualized approaches.

A core feature of the Wellpoint Case Management Solutions Program is the emphasis on an integrated approach to meeting the needs of members. The program considers the whole person, including the full range of each member's physical, behavioral, cognitive, functional, and social needs. The role of the case manager is to engage members of identified risk populations and to follow them across healthcare settings, to collaborate with other healthcare team members to determine goals and to provide access to resources and monitor utilization of resources. The case manager works with the member to identify specific needs and interfaces with the member's providers with the goal of facilitating access to quality, necessary, cost-effective care.

Using information gathered through the assessment process, including a review of the relevant evidence-based clinical guidelines, the case manager develops a goal-based care plan that includes identified interventions for each diagnosis, short- and long-term goals,

interventions designed to assist the member in achieving these goals and identification of barriers to meeting goals or complying with the care plan.

Assessment information, including feedback from members, family/caregivers and in some cases providers, provides the basis for identification of problems. Areas identified during the assessment that may warrant intervention include but are not limited to the following:

- Conditions that compromise member safety
- History of high service utilization
- Use of inappropriate services
- Current treatment plan that has been ineffective
- Permanent or temporary loss of function
- Comorbid conditions
- Pregnancy
- Medical/psychological/functional complications
- Health education deficits
- Poor or inconsistent treatment/medication adherence
- Inadequate social support
- Lack of financial resources to meet health or other basic needs
- Identification of barriers or potential barriers to meeting goals or complying with the care plan

Preparation of the care plan includes an evaluation of the member's optimal care path as well as the member's wishes, values, and degree of motivation to take responsibility for meeting each of the care plan goals. Wherever possible, the case manager encourages the member to suggest his or her own goals and interventions, as this may increase their investment in their successful completion.

Our case managers work closely with the member and providers to develop and implement the plan of care. As a provider, you may receive a call from the case manager, or a copy of the member's care plan may be sent to you.

Taking Care of Baby and Me®

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

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

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

- Individualized, one-on-one case management support for pregnant members at the highest risk
- Care coordination for those who may need a little extra support
- Digital perinatal educational tools
- Information on community resources

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

After risk assessment is complete, the digital program delivers gestational-age-appropriate education directly to the member. This program does not replace the high-touch, individual case management approach for our highest risk pregnant members; however, it does serve as a supplementary tool to extend our health education outreach. The goal of the expanded outreach is to ensure maternity education is available to all perinatal members and help Wellpoint to identify members who experience a change in risk acuity throughout the perinatal period.

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

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

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

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

For more information about the Taking Care of Baby and Me program or the digital maternity tools, reach out to your OB Practice Consultant or Provider Services at **855-878-1785**, or refer to our website at **provider.wellpoint.com/tx**.

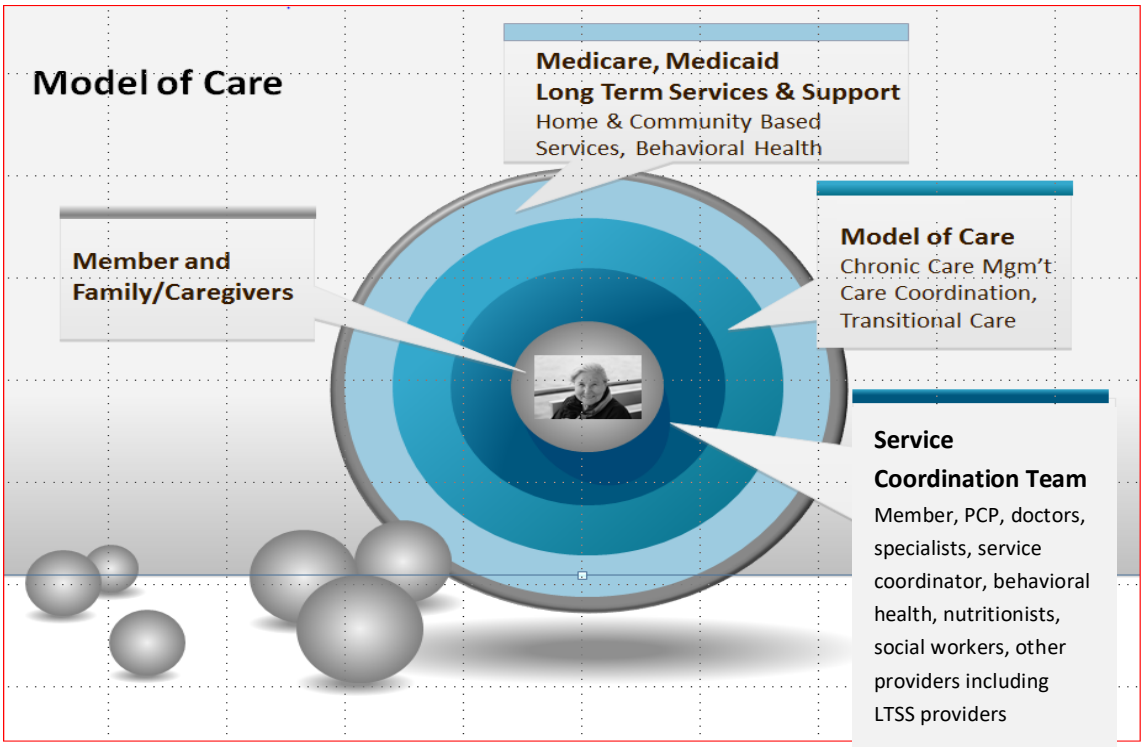
Model of Care

Wellpoint has developed an evidenced-based model of care that offers coordinated care delivered by a network of providers with expertise to meet the needs of the specialized population. The effectiveness of the model of care is measured annually as part of our Quality Management Program. We have designed a care system to meet the intentions of Wellpoint, a coordinated, integrated person-centered system of care that assures high quality and an excellent member experience.

The model of care is a comprehensive care management and care coordination program that incorporates our experience and the goals of Wellpoint, which are to:

- Improve the quality of care for members.
- Maximize the ability of members to remain safely in their homes and communities with appropriate services and supports, in lieu of institutional care.
- Coordinate Medicare and Medicaid benefits across healthcare settings and improve continuity of care across acute care, long-term care, behavioral health, and home and community-based services settings by using a person-centered approach.
- Promote a system that is both sustainable and person- and family-centered and enables members to attain or maintain personal health goals by providing timely access to appropriate, coordinated healthcare services and community resources, including home-and community-based services and mental health and substance use disorder services.
- Increase the availability and access to LTSS including HCBS.
- Improve transitions of care across healthcare settings, providers and HCBS.
- Preserve and enhance the ability for members to self-direct their care and receive high quality care.
- Optimize the use of Medicare, Medicaid, and other state/county resources.

Each member has a service coordination team (SCT) assigned to assist with developing care plans, collaborating with other team members and providing recommendations for the management of the member's care. The representative of the team and the mode of communication are determined by the needs of the member. Typically, the team can be made up of the member and/or his or her designee, assigned service coordinator, primary care physician, behavioral health professional, the member's home care attendant or LTSS provider and other providers either as requested by the member or his/her designee or as recommended by the service coordinator or primary care physician and approved by the member and/or his/her designee.



The member is an important part of the team and is involved in the planning process. The member's participation is voluntary, and they can choose to decline at any time. The service coordinator is the coordinator of the team and reaches out to providers and other team members to coordinate the needs of the member. Important information about the member including the assessment and care plan details are available to you through the secured provider portal. Healthcare practitioners and providers of care in the home or community are also very important members of the team and help to establish and execute the care plan. All case management and SCT are person-centered and built on the member's specific preferences and needs, ensuring transparency, individualism, accessibility, respect, linguistic and cultural competency, and dignity.

The figure above demonstrates the person-centricity of the model. Depending on member conditions, needs, and desires, a team comprised of experts in physical health, behavioral health, LTSS and social work works with the member, their representative (if desired) and the PCP and specialists as required. Communication among all the constituents is critical and is supported by Wellpoint systems.

Member Medical Records Standards

We require medical records to be current, detailed and organized for effective, confidential patient care and quarterly review. Your medical records must conform to good professional medical practice and be permanently maintained at the primary care site.

Members are entitled to one copy of their medical record each year provided, at no cost. Members or their representatives should have access to these records.

Our medical records standards include the following:

- Patient identification information — patient name or ID number must be shown on each page or electronic file
- Personal/biographical data — age, sex, address, employer, home and work telephone numbers, and marital status
- Date and corroboration — dated and identified by the author
- Legibility — if someone other than the author judges it illegible, a second reviewer must evaluate it
- Allergies — must note prominently:
  - Medication allergies
  - Adverse reactions
  - No Known Allergies (NKA)
- Past medical history — for patients seen three or more times. Include serious accidents, operations, illnesses and prenatal care of mother and birth for children
- Immunizations — a complete immunization record for pediatric members age 20 and younger with vaccines and dates of administration
- Diagnostic information
- Significant illnesses and chronic and recurrent medical conditions are indicated in the problem list on all member medical records
- Report contributory and/or chronic conditions if they are monitored, evaluated, addressed, or treated at the visit and impact of the care.
- All diagnoses reported on the claim should be fully documented in the medical record, and each diagnosis noted in the medical record should be reported in the claim corresponding to that encounter.
- Medical information, including medication(s) and instruction to patient
- Identification of current problems:
  - Serious illnesses
  - Medical and behavioral conditions
  - Health maintenance concerns
- Instructions including evidence the patient was provided basic teaching and instruction for physical or behavioral health condition
- Smoking/alcohol/substance abuse — notation required for patients age 12 and older and seen three or more times
- Consultations, referrals, and specialist reports — consultation, lab and X-ray reports must have the ordering physician's initials or other documentation signifying review; any consultation or abnormal lab and imaging study results must have an explicit notation
- Emergencies — all emergency care and hospital discharge summaries for all admissions must be noted
- Hospital discharge summaries — must be included for all admissions while enrolled and prior admissions when appropriate
- Advance Directives — must document whether the patient has executed an advance directive such as a living will or durable power of attorney
- All documentation required by the State for existing programs

Documentation Standards for an Episode of Care

When we request clinical documentation from you to support claims payments for services, you must ensure the information provided to us:

- Identifies the member.
- Is legible.
- Reflects all aspects of care.

To be considered complete, documentation for episodes of care will include, at a minimum, the following elements:

- Patient identifying information
- Consent forms
- Health history, including applicable drug allergies
- Types and dates of physical examinations
- Diagnoses and treatment plans for individual episodes of care
- Physician orders
- Face-to-face evaluations
- Progress notes
- Referrals
- Consultation reports
- Laboratory reports
- Imaging reports (including X-ray)
- Surgical reports
- Admission and discharge dates and instructions
- Preventive services provided or offered appropriate to the member's age and health status
- Evidence of coordination of care between primary and specialty physicians

Refer to the standard data elements to be included for specific episodes of care as established by The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A single episode of care refers to continuous care or a series of intervals of brief separations from care to a member by a provider or facility for the same specific medical problem or condition.

Documentation for all episodes of care must meet the following criteria:

- Is legible
- Contains information that identifies the member on each page in the medical record
- Contains entries in the medical record that are dated and include author identification (e.g., handwritten signatures, unique electronic identifiers, or initials)

Other Documentation Not Directly Related to the Member

Records should contain information relevant to support clinical practice and used to support documentation regarding episodes of care, including:

- Policies, procedures, and protocols.
- Critical incident/occupational health and safety reports.

- Statistical and research data.
- Clinical assessments.
- Published reports/data.

Wellpoint may request that you submit additional documentation, including medical records or other documentation not directly related to the member, to support claims you submit. If documentation is not provided following the request or notification or if documentation does not support the services billed for the episode of care, we may:

- Deny the claim.
- Recover and/or recoup monies previously paid on the claim.

Wellpoint is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

Patient Visit Data Records Standards

You must provide:

- A history and physical exam with both subjective and objective data for presenting complaints
- Behavioral health treatment, including at-risk factors:
  - Danger to self/others
  - Ability to care for self
  - Affect
  - Perpetual disorders
  - Cognitive functioning
  - Significant social health
- Admission or initial assessment must include:
  - Current support systems
  - Lack of support systems
- Documented assessment at each visit for client status and symptoms, indicating:
  - Decreased
  - Increased
  - Unchanged
  - A plan of treatment, including:
    - Activities
    - Therapies
    - Goals to be carried out
    - Diagnostic tests
    - Evidence of family involvement in therapy sessions and/or treatment
- Follow-up care encounter forms or notes indicating follow-up care, call or visit in weeks, months, or PRN
- Referrals and results of all other aspects of patient care and ancillary services

We systematically review medical records to ensure compliance and institute actions for improvement when our standards are not met.

We maintain a professional recordkeeping system for services to our members. We make all medical management information available to health professionals and state agencies and retain these records for seven years from the date of service.

Medical Record Review

Federal regulations require MCOs, and their agents review medical records to avoid over- or under-payment and verify documentation to support of diagnostic conditions. Additionally, health plan leadership for quality management and the quality management committee conduct medical record audits periodically and use the results in the provider recredentialing process.

Risk Adjustment Data Validation

Participation in risk adjustment data validation is required of all providers, and it is important that you are aware that medical records may be requested from your office. Data validation through a review of medical record documentation ensures the accuracy of risk-adjusted payments. These medical record reviews verify the accuracy of claim and encounter data and identify additional conditions not captured through this mechanism.

Wellpoint may contract with a third-party vendor to acquire medical records or conduct onsite reviews. Under 45 CFR §164.502 (HIPAA implementation), providers are permitted to disclose requested data for the purpose of healthcare operations after they have obtained the general consent of the member. A general consent form should be an integral part of your medical record file.

More information related to risk adjustment can be found at **cms.gov**.

Clinical Practice Guidelines

Using nationally recognized standards of care, Wellpoint works with providers to develop clinical policies and guidelines for the care of its membership. The medical advisory committee (MAC) oversees and directs Wellpoint in formulating, adopting, and monitoring guidelines.

Wellpoint selects at least four evidence-based Clinical Practice Guidelines (CPGs) relevant to the member population for analysis. The guidelines are reviewed and revised by the Wellpoint quality improvement council at least every two years, or whenever the guidelines change.

The Wellpoint CPGs are located online at **provider.wellpoint.com/tx** > Resources > Provider Manuals and Guides.

Patient360

Patient360 is an interactive dashboard available through **availity.com** that gives you instant access to detailed information about your Wellpoint patients. By clicking on each tab in the dashboard, you can drill down to specific items in a patient's medical record:

- Demographic information – member eligibility, other health insurance, assigned PCP and assigned case managers
- Care summaries – emergency department visit history, lab results, immunization history, and due or overdue preventive care screenings
- Claims details – status, assigned diagnoses and services rendered
- Authorization details – status, assigned diagnoses and assigned services
- Pharmacy information – prescription history, prescriber, pharmacy, and quantity
- Care management-related activities – assessment, care plans and care goals

To access Patient360, log in to **availity.com**, select **Wellpoint** under *Payer Spaces*, and it will appear under the *Applications* tab on the bottom portion of the screen. Note: Your organization's Availity Administrator must assign you the P360 role for the application to be accessible.

Advance Directives

Advance directives are written instructions that:

- Give direction to healthcare providers as to the provision of healthcare.
- Provide for treatment choices when a person is incapacitated.
- Are recognized under state law when signed by a competent person.

There are three types of advance directives:

- A durable power of attorney for healthcare (durable power) allows the member to name a patient advocate to act on behalf of the member.
- A living will allow the member to state his or her wishes in writing but does not name a patient advocate.
- A declaration for mental health treatment gives instructions about a member's future mental health treatment if the member becomes unable to make those decisions. The instructions state whether the member agrees or refuses to have the treatments described in the declaration with or without conditions and limitations.

Wellpoint advance directives policies include the following:

- Respecting the rights of the member to control decisions relating to his or her own medical care, including the decision to have provided, withheld, or withdrawn the medical or surgical means or procedures calculated to prolong his or her life; this right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession
- Adhering to the Patient Self-Determination Act and maintaining written policies and procedures regarding advance directives; providers must adhere to this Act and to all state and federal standards as specified in *SSA 1902(a)(57), 1903(m)(1)(A), 42 CFR 438.6(i)* and *42 CRF 489 subpart I*

- Advising members of their right to self-determination regarding advance directives
- Encouraging members to request an advance directives form and education from their PCP at their first appointment
- Assisting members with questions about an advance directives; no Wellpoint employee may serve as witness to an advance directives or as a member's authorized agent or representative
- While members have the right to formulate an advance directive, an Wellpoint associate, a facility or a provider may conscientiously object to an advance directives within certain limited circumstances if allowed by state law
- Having Member Services, Health Promotion, Provider Relations and/or Health Care Management Services staff review and update advance directives notices and education materials for members on a regular basis
- Member materials will contain information, as applicable, regarding provisions for conscience objection. Materials explain the differences between institution-wide objections based on conscience and those that may be raised by individual physicians
- Wellpoint or the practitioner must issue a clear and precise written statement of this limitation to CMS and request a conscience protection waiver. The conscientious objection will be stated clearly and describes the following:
  - Describes the range of medical conditions or procedures affected by the conscience objection
  - Identifies the state legal authority permitting such objection
- Noting the presence of advance directives in the medical records when conducting medical chart audits

Providers must do the following:

- Comply with the Patient Self-Determination Act requirements
- Make sure the first point of contact in the PCP's office asks the member if he or she has executed an advance directive
- Document in the member's medical record his or her response to an offer to execute any advance directive in a prominent place, including a do-not-resuscitate directive or the provider and member's discussion and action regarding the execution or non-execution of an advance directive
- Ask members who have executed an advance directive to bring a copy of the advance directive(s) to the PCP/provider at the first point of contact
- Make an advance directive part of the member's medical record and put it in a prominent place
  - The physician discusses potential medical emergencies with the member and/or family/significant other and with the referring physician if applicable
  - If an advance directive has not been executed, the first point of contact at the PCP/provider's office will ask the member if he or she would like advance directive information. If the member desires further information, member advance directive education will be provided
- Not discriminate or retaliate against a member based on whether he or she has executed an advance directive

A specific advance directive, which meets compliance with the state of Texas, can be located at: **https://hhs.texas.gov/laws-regulations/forms/advance-directives.**

Psychiatric advance directive information can be found at: **https://nrc-pad.org/states/texas-forms/.**

CHAPTER 12: HOSPITAL AND ELECTIVE ADMISSION MANAGEMENT

Overview

Wellpoint requires precertification of all inpatient elective admissions. The referring primary care or specialist physician is responsible for precertification. The referring physician identifies the need to schedule a hospital admission and must submit the request to the Wellpoint Health Care Management Services department.

Requests for precertification with all supporting documentation should be submitted immediately upon identifying the inpatient request or at least 72 hours prior to the scheduled admission. This will allow Wellpoint to verify benefits and process the precertification request. For services that require precertification, Wellpoint makes case-by-case determinations that consider an individual's healthcare needs and medical history in conjunction with nationally recognized standards of care.

The hospital can confirm a precertification is on file by calling Provider Services at **855-878-1785** (see the Wellpoint website and the Provider Inquiry Line section of this manual for instructions on use of the Provider Inquiry Line). If coverage of an admission has not been approved, the facility should call Provider Services at **855-878-1785**. Wellpoint will contact the referring physician directly to resolve the issue.

Wellpoint is available 24 hours a day, 7 days a week to accept precertification requests. When a request is received from the physician via telephone or fax for medical services, the care specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse.

The precertification nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the precertification nurse will assist the physician in identifying alternatives for healthcare delivery as supported by the medical director.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with nationally recognized standards of care, an Wellpoint reference number will be issued to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

If a request is submitted for a service for which precertification is not required, the provider will receive a response stating that precertification is not required. This is not an approval or a guarantee of payment.

If medical necessity criteria for the admission are not met on the initial review, the medical director will contact the requesting physician to discuss the case. If the precertification

documentation is incomplete or inadequate, the precertification nurse will notify the referring provider to submit the additional necessary documentation. If the medical director denies coverage of the request, the appropriate denial letter, including the appropriate appeal rights, will be mailed to the member and provider. Providers will be held liable for all other inpatient denials issued. Any subsequent appeals should follow the correct process as outlined in the denial letter.

Emergent Admission Notification Requirements

Wellpoint prefers immediate notification by network hospitals of emergent admissions. Network hospitals must notify Wellpoint of emergent admissions within one business day. Wellpoint Health Care Management Services staff will verify eligibility and determine benefit coverage.

Wellpoint is available 24 hours a day, 7 days a week to accept emergent admission notification via **Availity.com** or by contacting Provider Services at **855-878-1785**.

Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets nationally recognized standards of care, an Wellpoint reference number will be issued to the hospital.

If the notification documentation provided is incomplete or inadequate, Wellpoint will not approve coverage of the request but will notify the hospital to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter will be mailed to the member and/or provider, including the appropriate appeal rights depending on the nature of the denial.

Nonemergent Outpatient and Ancillary Services — Precertification and Notification Requirements

Wellpoint requires precertification for coverage of selected nonemergent outpatient and ancillary services. Requests for precertification with all supporting documentation should be submitted immediately upon identifying the need for the request or at least 72 hours prior to the scheduled service.

To ensure timeliness of the decision, the following must be provided:

- Member name and ID number
- Name, telephone number and fax number of physician performing the elective service
- Name of the facility and telephone number where the service is to be performed
- Date of service
- Member diagnosis
- Name of elective procedure to be performed with CPT-4 code

- Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans and medications)

Utilization Management Hours of Operation

- Staff are available at least eight hours a day Monday through Friday during normal business hours for inbound collect or toll-free calls and can receive inbound communication by fax after normal business hours. Electronic submissions are available 24/7 at **Availity.com**. Messages will be returned within one business day. Our staff will identify themselves by name, title and organization name when initiating or returning calls.
- TDD/TTY services and language assistance services are available for members as needed, free of charge.

Online Digital Authorization Application

The preferred method for submitting preauthorization requests is digitally through the authorization application accessed on the Availity Essentials multi-payer platform This application offers a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for our members. Additionally, providers can use this tool to make inquiries on previously submitted requests, regardless of how they were sent (phone, fax, or other online tool). Capabilities and benefits of using the authorization application include:

- Initiating preauthorization requests online — eliminating the need to fax. Detailed text, photo images and attachments can be submitted along with your request.
- Making inquiries on previously submitted requests via phone, fax, or other online tool.
- Having instant accessibility from almost anywhere, including after business hours.
- Utilizing a dashboard that provides a complete view of all utilization management requests with real-time status updates,.
- Viewing real-time results for common procedures with immediate decisions.

You can access the authorization application from the Availity Essentials home page under Patient Management > **Authorizations and Referrals.**. For an optimal experience with the application , use a browser that supports 128-bit encryption. This includes Microsoft Edge, Chrome, and Firefox.

The authorization application is not currently available for:

- Transplant services.
- Services administered by vendors, such as Carelon Medical Benefits Management, Inc. For these requests, follow the same preauthorization process you use today.

We'll update our website as additional functionality is added.

Inpatient Admission Reviews

All inpatient hospital admissions, including urgent and emergent admissions, will be reviewed within one business day. The Wellpoint utilization review clinician determines the member's medical status through communication with the hospital's Utilization Review department. Appropriateness of the stay is documented, and concurrent review is initiated. Cases may be referred to the medical director who renders a decision regarding the coverage of hospitalization. Diagnoses meeting specific criteria are referred to the medical director for possible coordination by the care management program.

Affirmative Statement About Incentives

Wellpoint requires associates who make Utilization Management (UM) decisions to adhere to the following principles:

- UM decision-making is based only on the appropriateness of care and service and existence of coverage.
- Wellpoint does not reward practitioners or other individuals for issuing denials of coverage or service.
- Financial incentives for Wellpoint UM decision makers do not encourage decisions that result in underutilization.

Discharge Planning

Discharge planning is designed to assist the provider in the coordination of a member's discharge when acute care (hospitalization) is no longer necessary. The Wellpoint concurrent review nurse or case manager (working with the Wellpoint medical director) will assist providers and hospitals with the discharge planning process in accordance with Wellpoint requirements. At the time of admission and during the hospitalization, the Wellpoint case manager will discuss discharge planning with the provider, ICT, member and/or member advocate.

When the provider and/or SCT identifies medically necessary and appropriate services for the member, Wellpoint will assist the provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care or coordination of services.

The nurse or case manager will also assist the member and/or member advocate with:

- Notification and participation of the member's SCT in discharge planning, coordination and reassessment as needed.
- Identification of nonclinical supports and the role they serve in the member's treatment and aftercare plans.
- Scheduling of discharge/aftercare appointments in accordance with the access and availability standards.
- Identification of barriers to aftercare and the strategies developed to address such barriers.
- Assurance that inpatient and 24-hour diversionary behavioral health providers provide a discharge plan following any behavioral health admission to SCT members.

- Ensuring members who require medication monitoring will have access to such services within fourteen (14) business days of discharge from a behavioral health inpatient setting.
- Making best efforts to ensure a smooth transition to the next service or to the community.
- Documenting all efforts related to these activities, including the member's active participation in discharge planning

During the transition period referenced above, Wellpoint may change a member's existing provider only in the following circumstances:

- Member requests a change.
- The provider chooses to discontinue providing services to a member as currently allowed by Medicare and Medicaid.
- Wellpoint, CMS or HHSC identify provider performance issues that affect a member's health and welfare.
- The provider is excluded under state or federal exclusion requirements.

Confidentiality Statement

Members have the right to privacy and confidentiality regarding their healthcare records and information in accordance with Wellpoint and provisions of *HIPAA* concerning members' rights with respect to their protected health information and obligations of covered entities.

Utilization management, case management, discharge planning, quality management and claims payment activities are designed to ensure patient-specific information, particularly protected health information obtained during review, is kept confidential in accordance with applicable laws, including *HIPAA*. Information is used for the purposes defined above and shared only with entities who have the authority to receive such information and only with those individuals who need access to such information in order to conduct utilization management and related processes.

Providers must comply with all state and federal laws concerning privacy, confidentiality, accuracy and timely maintenance of health and other member information. Providers must have policies and procedures regarding use and disclosure of health information and comply with applicable laws.

Emergency Services

Wellpoint provides a 24-hour-a-day, 7-day-a-week Nurse HelpLine service with clinical staff to provide triage advice and referral and, if necessary, to make arrangements for treatment of the member. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies.

Wellpoint does **not** discourage members from using the 911 emergency system nor does Wellpoint deny access to emergency services. Emergency services are provided to members without requiring precertification. Any hospital or provider calling for precertification for emergency services will be granted one immediately upon request. Emergency services coverage includes services needed to evaluate or stabilize an emergency medical condition.

Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

An emergency medical condition is defined as a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: 1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; and/or 3) serious dysfunction of any bodily organ or part; or 4) with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency response is coordinated with community services, including the police, fire, and emergency medical services (EMS) departments; the judicial system; chemical dependency; emergency services; and local mental health authorities if applicable.

When a member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine. The physician or other appropriate personnel will indicate in the member's chart the results of the emergency medical screening examination. Wellpoint will compensate the provider for the screening, evaluations and examinations that are reasonable and calculated to assist the healthcare provider to determine whether or not the patient's condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (i.e., whether the patient is stable enough for discharge or transfer or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the member at the treating facility prevails and is binding on Wellpoint. If the emergency department is unable to stabilize and release the member, Wellpoint will assist in coordination of the inpatient admission regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care.

If the member is admitted, the Wellpoint concurrent review nurse will implement the concurrent review process to ensure coordination of care.

Post-Stabilization Care Services

Post-stabilization care services are covered services related to an emergency condition provided after a patient is stabilized to maintain the stabilized condition or improve or resolve the patient's condition. Precertification is not required for emergency services in or out of the network. All emergency services are reimbursed at least at the Medicare network rate.

Wellpoint will cover emergency and post-stabilization care services that are medically necessary until the emergency condition is stabilized and maintained.

Nonemergency Services

For routine, non-symptomatic, beneficiary-initiated outpatient appointments for primary preventive medical care, the request-to-appointment time must be no greater than 30 days unless the member requests a later time. For routine, non-symptomatic, beneficiary-initiated outpatient appointments for nonurgent primary medical care, the request-to-appointment time must be no greater than 30 calendar days unless the member requests a later time.

Primary medical urgent care, including dental care outpatient appointments for urgent conditions, must be available within 24 hours. For specialty outpatient referral and/or consultation appointments, the request-to-appointment time must be consistent with the clinical urgency, but no greater than 21 days unless the member requests a later time. For outpatient scheduled appointments, the time the member is seen must not be more than 30 minutes after the scheduled time unless the member is late.

For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time must be consistent with the clinical urgency, but no greater than seven days unless the member requests a later time. For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability will be consistent with the clinical urgency but no greater than 24 hours. The timing of scheduled follow-up outpatient visits with practitioners must be consistent with the clinical need.

Urgent Care Services

Wellpoint requests its members to contact their PCP in situations when urgent, unscheduled care is necessary. Precertification with Wellpoint is not required for a member to access a network urgent care center.

CHAPTER 13: MEMBER MANAGEMENT SUPPORT

Welcome Call

As part of our member management strategy, Wellpoint offers a welcome call to new members. Additionally, Member Services representatives offer to assist members with any current needs, such as scheduling an initial checkup.

Appointment Scheduling

Through our participating providers, Wellpoint ensures members have access to primary care services for routine, urgent and emergency services and to specialty care services for chronic and complex care. Providers will respond to a member's needs and requests in a timely manner. The PCP should make every effort to schedule members for appointments using the PCP access and availability guidelines.

Routine Care

Healthcare for covered preventive and medically necessary healthcare services that are nonemergent or nonurgent is considered routine care.

Urgent Care

A health condition (including an urgent behavioral health situation) that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment by the member's PCP or PCP designee within 24 hours to prevent serious deterioration of the member's condition or health.

Emergency Care

Emergency care is defined as any medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in any of the following:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- Serious jeopardy to the health of a woman or her unborn child (in the case of a pregnant woman)

Appointment and Access Standards

We are dedicated to arranging access to care for our members. Our ability to provide quality access depends upon the accessibility of network providers. We evaluate HHSC, TDI and

National Committee for Quality Assurance (NCQA) requirements and follow the most stringent standards among the three sources.

24-Hour Nurse HelpLine

The Wellpoint 24-Hour Nurse HelpLine is a service designed to support the provider by offering information and education about medical conditions, healthcare and prevention to members after normal physician practice hours. The 24-Hour Nurse HelpLine provides triage services and helps direct members to appropriate levels of care. The phone number is **855-878-1784** and is listed on the member's ID card. This ensures members have an additional avenue of access to healthcare information when needed.

Features of the 24-Hour Nurse HelpLine include:

- Availability 24 hours a day, 7 days a week for crisis and triage services.
- Information based upon nationally recognized and accepted guidelines.
- Free translation services for over 200 different languages and for members with difficulty hearing.
- Education for members about appropriate alternatives for handling nonemergent medical conditions.
- Member assessment reports faxed to providers' offices within 24 hours of the call.

Care Management Support

Wellpoint Care Management Support is a service designed to support the provider as well as the member. Providers can speak with a service coordinator about referring members to the care management programs a specific member's care plan or general questions concerning care management. Members have access to information regarding all covered services. Wellpoint Care Management Support is available 24 hours a day, 7 days a week at **855-878-1785**.

Interpreter Services

Wellpoint provides your office with interpreter services for your Wellpoint members. Services are available 24 hours a day, 7 days a week and include over 200 languages, as well as services for members who are deaf or hard of hearing. Interpretation is a free service offered to our network providers by calling Provider Services at **855-878-1785**.

Health Promotion

Wellpoint strives to improve healthy behaviors, reduce illness, and improve the quality of life for our members through comprehensive programs. Educational materials are developed or purchased and disseminated to our members, and health education classes are coordinated with community organizations and network providers contracted with Wellpoint.

Wellpoint manages projects that offer our members education and information regarding their health. Ongoing projects include:

- Creation and distribution of health education tools used to inform members of health promotion issues and topics.

- Health Tips on Hold (educational telephone messages while the member is on hold).
- Health education programs offered to members.
- Development of health education curricula and procurement of other health education tools (e.g., breast self-exam cards).
- Relationship development with community-based organizations to enhance opportunities for members.

Member Satisfaction

Wellpoint periodically surveys members to measure overall customer satisfaction, including satisfaction with the care received from providers. Wellpoint reviews survey information and shares the results with network providers.

Members are also surveyed by CMS twice a year through the CAHPS and HOS surveys. The results of both CMS surveys are part of the Wellpoint HEDIS and Star ratings. Participating providers should encourage members to actively participate in their healthcare, to receive preventive services timely and to improve their quality of life by following the provider's treatment plan.

CHAPTER 14: CLAIMS SUBMISSION and ADJUDICATION PROCEDURES

Claims — Billing and Reimbursement

Clean claims for members are generally adjudicated within 30 calendar days from the date Wellpoint receives the claim. However, clean claims for Nursing Facility Unit Rate Services and Nursing Facility Medicare Coinsurance will be processed within 10 calendar days of receipt of the clean claim. For Nursing Facility Add-on Services and other Medicaid claims, the timeframe is 30 calendar days. Pharmacy nonelectronic claims will be processed within 21 calendar days and pharmacy electronic claims within 18 calendar days.

Wellpoint will pay interest charges on claims in compliance with requirements set forth in the Demonstration between CMS, the state and the Wellpoint contract as applicable.

For nonclean claims, the provider receives written notification identifying the claim number, the reason the claim could not be processed, the date the claim was received by Wellpoint and the information required from the provider in order to adjudicate the claim. Wellpoint produces and mails an Explanation of Payment (EOP) on a twice weekly basis. The EOP delineates for the provider the status of each claim that has been paid or denied during the previous week.

Reimbursement by Wellpoint constitutes payment in full. Balance billing the Wellpoint member is prohibited per the participating Provider Agreement and, for LTSS providers only, the Attachment A rate sheet.

Wellpoint follows Strategic National Implementation Process (SNIP) level 1-6 editing for all claims received in accordance with HIPAA. Providers must bill all electronic and paper submitted claims and use HIPAA-compliant billing codes. When billing codes are updated, the provider is required to use appropriate replacement codes for submitting claims for covered services. An amendment to the participating Provider Agreement will not be required to replace such billing codes. Wellpoint will not reimburse any claims submitted using noncompliant billing or SNIP codes.

Providers resubmitting claims for corrections must clearly mark the claim “Corrected Claim.” Failure to mark the claim appropriately may result in denial of the claim as a duplicate. Corrected claims must be received within the applicable timely filing requirements of the originally submitted claim.

International Classification of Diseases, 10th Revision (ICD-10) Description

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).

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. In the United States, the codes are the foundation for documenting the diagnosis and associated services provided across healthcare settings.

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

- Clinical modification (CM): ICD-10-CM is used for diagnosis coding.
- Procedure coding system (PCS): ICD-10-PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaces the code sets ICD-9-CM, volumes one and two for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume three for inpatient hospital procedure coding.

Claims Status

Providers should visit the Availity website at **availity.com** or call the automated Provider Services line at **855-878-1785** to check claims status.

Providers are encouraged to review EDI reports from their EDI vendors and address any issues with claims submissions such as rejected claims.

Provider Claims

Providers should submit claims to Wellpoint as soon as possible after service is rendered. Providers are encouraged to submit their claims electronically as the preferred method for claims submission. Providers must submit electronic claims using the 837I (Institutional) or 837P (Professional) standard format. Provider must use the industry standard claim form CMS-1450, also known as the UB-04, or CMS-1500 (02-12) for all paper submissions.

CMS-1500 (08-05)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH
MM DD YY SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

25. FEDERAL TAX I.D. NUMBER

33. BILLING PROVIDER INFO & PHONE NUMBER
( )

Hospitals
CMS-1450, also known as the UB-04

5. FEDERAL TAX NUMBER
51. HEALTH PLAN I.D.

Coordination of Benefits

Wellpoint will coordinate and process the claim upon initial submission from the provider.

Paper Claim Submission

Providers also have the option of submitting paper claims. Wellpoint uses optical character recognition (OCR) technology as part of its front-end claims processing procedures. The benefits include the following:

- Faster turnaround times and adjudication
- Claims status availability within five days of receipt
- Immediate image retrieval by Wellpoint staff for claims information, allowing more timely and accurate response to provider inquiries

To use OCR technology, claims must be submitted on original red claim forms (not black and white or photocopied forms) and laser printed or typed (not handwritten) in a large, dark font. Providers must submit a properly completed *UB-04* or *CMS-1500 (08-05)* within 95 days (365 days for nursing facilities other than nursing facility add-on services) from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third-party documents resolution of the claim.

In accordance with the implementation timelines set by CMS and NUCC, Wellpoint requires the use of the new *CMS-1500 (08-05)* for the purposes of accommodating the National Provider Identifier (NPI).

In accordance with the implementation timelines set by CMS and NUBC, Wellpoint requires the use of the new UB-04 CMS-1450 for the purposes of accommodating the NPI.

CMS-1500 (08-05) and *UB-04 CMS-1450* must include the following information (HIPAA-compliant where applicable):

- Patient's ID number
- Patient's name
- Patient's date of birth
- ICD-10 diagnosis codes/revenue codes
- Date of service
- Place of service

- Description of services rendered CPT-4 codes/HCPCS codes/DRGs
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Wellpoint provider number
- NPI of billing provider when applicable
- Name of ordering physician
- NPI of ordering physician when applicable
- Name of performing physician
- NPI of performing provider when applicable
- State Medicaid ID number
- Coordination of Benefits/other insurance information
- Authorization/precertification number or copy of authorization/precertification
- Name of referring physician
- NPI of referring physician when applicable
- Any other state-required data

Wellpoint cannot accept claims with alterations to billing information. Claims that have been altered will be returned to the provider with an explanation of the reason for the return. Wellpoint will not accept handwritten claims.

Paper claims must be submitted within the timely filing limit of 95 days from the date of service (365 days for nursing facilities other than nursing facility add-on services). Submit paper claims to:

Wellpoint
P.O. Box 61010
Virginia Beach, VA 23466-101

Electronic Data Interchange (EDI)

We encourage electronic submission of claims through Electronic Data Interchange (EDI). Wellpoint has designated Availity to operate and service your EDI entry point (EDI Gateway).

Wellpoint uses Availity as its exclusive partner for managing all electronic data interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient, and cost-effective way for providers and employers to do business.

Use Availity for the following EDI transactions

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Claim: Dental (837D)
- 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)

Ways you can use the Availity EDI Gateway

Availity Essentials 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 clearinghouse or billing vendor (work with your vendor to ensure connection to the Availity EDI Gateway)

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

Availity Payer ID's
https://apps.availity.com/public-web/payerlist-ui/payerlist-ui/#/

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

Contact Availity
Please contact Availity Client Services with any questions at **800-Availity** (**282-4548**)

Electronic Remittance Advice (ERA)

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

- Log in to **availity.com**
- Select **My Providers**
- Select **Enrollment Center** and select **Transaction Enrollment**

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

Electronic Funds Transfer (EFT)

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

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

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

Please work with your vendor on how to submit corrected claims.

Useful EDI Documentation

- **Availity EDI Connection Service Startup Guide** — This guide includes information to get you started with submitting Electronic Data Interchange (EDI) transactions to Availity, from registration to on-going support.
- **Availity EDI Companion Guide** — This Availity EDI Guide supplements the HIPAA TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity.
- **Availity Get Started Page** — Availity registration page for users new to Availity.

Encounter Data

Wellpoint has a system to collect member encounter data. Due to reporting needs and requirements, network providers who are reimbursed by capitation must send encounter data to Wellpoint for each member encounter. Encounter data can be submitted through EDI submission methods or on a CMS-1500 (08-05) or a UB-04 claim form unless other arrangements are approved by Wellpoint. Data will be submitted in a timely manner but no later 95 days (365 days for nursing facilities other than nursing facility add-on services) from the date of service.

The encounter data will include the following:

- Wellpoint member ID number
- Wellpoint member name (first and last name)
- Wellpoint member date of birth
- Provider name according to contract
- NPI provider number
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (utilizing current procedure codes and modifiers if applicable)

- Provider tax ID number and state Medicaid ID number

Encounter data should be submitted to the address provided on the previous page.
Through claims and encounter data submissions, HEDIS information is collected. This includes but is not limited to the following:

- Preventive services (e.g., childhood immunization, mammography, Pap smears)
- Prenatal care (e.g., low birth weight, general first trimester care)
- Acute and chronic illness (e.g., ambulatory follow-up and hospitalization for major disorders)

Compliance is monitored by Wellpoint utilization and quality improvement staff, coordinated with the medical director and reported to the quality management committee on a quarterly basis. The PCP is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and could result in termination.

Claims Adjudication

Wellpoint is dedicated to providing timely adjudication of provider claims for services rendered to members. All network and non-network provider claims submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT-4 and ICD-10 manuals. Institutional claims should be submitted using EDI submission methods or a CMS-1450 (UB-04) and provider claims using the CMS-1500.

Providers must use *HIPAA*-compliant billing codes when billing Wellpoint. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitted claims. Wellpoint will not pay any claims submitted using noncompliant billing codes.

Wellpoint reserves the right to use code-editing software to determine which services are considered part of incidental to or inclusive of the primary procedure. The automated claims auditing system verifies the coding accuracy of claims for CPT and HCPCS procedures. This system ensures the same auditing criteria are applied across all claims. Editing decisions are supported by online medical coding policy statements published by CMS as a part of the National Correct Coding Initiative (NCCI, also known as CCI).

For claims payment to be considered, providers must adhere to the following time limits:

- Submit claims within the number of days specified from the date the service is rendered, or for inpatient claims filed by a hospital, within the number of days specified from the date of discharge.
- In the case of other insurance, submit the claim within 95 days specified after receiving a response from the third-party payer.
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within 95 days of the eligibility notification but no later than 365 days from date of service.
- Claims submitted after the market-specific timely filing deadline will be denied.

EOP Reporting

After filing a claim with Wellpoint, review the twice weekly EOPs. If the claim does not appear on an EOP within 30 business days as adjudicated or you have no other written indication the claim has been received, check the status of your claim on the Availity website at **availity.com** or by calling Provider Services at **855-878-1785**. If the claim is not on file with Wellpoint, resubmit your claim within the timely claim filing guidelines. If filing electronically, check the confirmation reports you receive from your EDI or practice management vendor for acceptance of the claim.

Clean Claims Payment

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted in a timely manner.
- Is free of defects.
- Is submitted on a *HIPAA*-compliant standard claim form *CMS-1500 (02-12)* or *CMS-1450 (UB-04)* or successor forms thereto or the electronic equivalent.
- Does not require developing, outreach to an external source, adjustment, or alteration by the provider or by a third party to be processed and paid by Wellpoint.

Clean claims are typically adjudicated within 30 calendar days of receipt. However, clean claims for Nursing Facility Unit Rate Services and Nursing Facility Medicare Coinsurance will be processed within 10 calendar days of receipt of the clean claim. For Nursing Facility Add-on Services and other Medicaid claims, the timeframe is 30 calendar days. Pharmacy nonelectronic claims will be processed within 21 calendar days and pharmacy electronic claims within 18 calendar days. Wellpoint will pay all applicable interest as required by law on clean claims not adjudicated within the required time frames.

Wellpoint produces and mails an *Explanation of Payment (EOP)* twice per week. The EOP delineates for the provider the status of each claim adjudicated during the previous payment cycle.

Electronic claims determined to be unclean will be returned to the clearinghouse that submitted the claim.

In accordance with the contract with the state of Texas, Wellpoint will adjudicate at least 98 percent of all clean claims within 30 calendar days of the date of receipt except for shorter time frames required for pharmacy and certain nursing facility services.
The date of receipt is the date Wellpoint receives the claim as indicated by its date stamp on the claim and the date of receipt for electronic claims. The date of payment is the date on the check or other form of payment.

Specialist Reimbursement

Specialty care providers must obtain Wellpoint approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized or beyond the scope permitted under this program. Specialty care provider services will be covered only when there is

documentation of appropriate notification or prior authorization as appropriate, and receipt of the required claims and encounter information to Wellpoint.

Reimbursement Policies

These reimbursement policies serve as a guide to assist you with accurate claims submissions and outline the basis for reimbursement if the services are covered by the member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use 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. These codes denote the services and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must 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 professional 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 claim payment

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/ or requirements. Wellpoint strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Reimbursement Hierarchy

Claims submitted for payments 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, authorization requirements or stipulations within a reimbursement policy. Neither payment rates nor methodologies are considered to be conditions of payments.

Review Schedule and Updates

Reimbursement policies undergo reviews every two years for updates to state contracts, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to an Wellpoint business decision. When there is an update, we will publish the most current policies to our provider website.

Reimbursement by Code Definition

Wellpoint allows reimbursements for covered services based on their procedure code definitions or descriptors as opposed to their appearance under particular CPT categories or sections unless otherwise noted by state, federal or CMS contracts and/or requirements. There are eight CPT sections:

- Evaluation and management
- Anesthesia
- Surgery
- Radiology (nuclear medicine and diagnostic imaging)
- Pathology and laboratory
- Medicine
- Category II codes: supplemental tracking codes that can be used for performance measurement
- Category III codes: temporary codes for emerging technology, services, or procedures

At times, procedure codes are located in particular CPT categories when those procedures may not, as a general understanding, be classified within that particular category (e.g., venipuncture is located in the CPT surgical section but is not considered to be a surgical procedure).

Documentation Standards for an Episode of Care

When we request clinical documentation from you to support claims payments for services, you must ensure the information provided to us:

- Identifies the member.
- Is legible.
- Reflects all aspects of care.

To be considered complete, documentation for episodes of care will include, at a minimum, the following elements:

- Patient identifying information.
- Consent forms.
- Health history, including applicable drug allergies.
- Types and dates of physical examinations.
- Diagnoses and treatment plans for individual episodes of care.
- Physician orders.
- Face-to-face evaluations.
- Progress notes.
- Referrals.
- Consultation reports.
- Laboratory reports.
- Imaging reports (including X-rays).
- Surgical reports.
- Admission and discharge dates and instructions.

- Preventive services provided or offered appropriate to the member's age and health status.
- Evidence of coordination of care between primary and specialty physicians.

Refer to the standard data elements to be included for specific episodes of care as established by The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A single episode of care refers to continuous care or a series of intervals of brief separations from care to a member by a provider or facility for the same specific medical problem or condition.

Documentation for all episodes of care must meet the following criteria:
- Is legible to someone other than the writer
- Contains information that identifies the member on each page in the medical record
- Contains entries in the medical record that are dated and include author identification (e.g., handwritten signatures, unique electronic identifiers, or initials)

Other Documentation Not Related to the Member

Other documentation not directly related to the member but relevant to support clinical practice may be used to support documentation regarding episodes of care, including:
- Policies, procedures, and protocols.
- Critical incident/occupational health and safety reports.
- Statistical and research data.
- Clinical assessments.
- Published reports/data.

Wellpoint may request that you submit additional documentation, including medical records or other documentation not directly related to the member, to support claims you submit. If documentation is not provided following the request or notification or if documentation does not support the services billed for the episode of care, we may deny the claim or recover and/or recoup monies previously paid on the claim.

Wellpoint is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

Outlier Reimbursement — Audit and Review Process

Requirements and Policies

This section includes guidelines on reimbursement to providers and facilities for services on claims paid by diagnosis related group (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 and Blood Products

Administration of blood or blood products are not separately reimbursable on inpatient claims. Administration charges on outpatient claims are separately reimbursable when submitted without observation/treatment room charges.

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

Emergency Room Supplies and Services Charges

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

Facility Personnel Charges

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

Implants

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

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

IV sedation and local anesthesia

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

Lab Charges

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

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

Labor Care Charges

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

Nursing Procedures

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

Operating Room Time and Procedure Charges

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

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

Personal Care Items and Services

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

Pharmacy Charges

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

Portable Charges

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

Pre-Operative Care or Holding Room Charges

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

Preparation (Set-Up) Charges

Charges for set-up, equipment, or materials in preparation for procedures or tests are included in the reimbursement for that procedure or test and will not be reimbursed separately.

Recovery Room Charges

Reimbursement for recovery room services (time or flat fee) includes the use of all and/or available services, equipment, monitoring, and nursing care that is necessary for the patient's welfare and safety during his/her confinement. This will include but is not limited to cardiac/vital signs monitoring, pulse oximeter, medication administration fees, nursing services, equipment, supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

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

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

Supplies and Services

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

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

Special Procedure Room Charge

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

Stand-by Charges

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

Stat Charges

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

Supplies and Equipment

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

In addition, oxygen charges, including but not limited to, oxygen therapy per minute/per hour, mechanical ventilation and ventilation management, continuous positive airway pressure (CPAP), and bi-level positive airway pressure (BIPAP), when billed with room types ICU/CCU/NICU or any Specialty Care area, where equipment is a requirement to be authorized for specialty category, are not separately reimbursable.

Telemetry

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

Time Calculation

- **Operating Room (OR)** –Time should be calculated on the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.
- **Hospital/ Technical Anesthesia** - Reimbursement of technical anesthesia time will be based on the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse's notes. The time the anesthesiologist spends with the patient in pre-op and the recovery room will not be reimbursed as part of the hospital anesthesia time.

- **Recovery Room** – The reimbursement of recovery room charges will be based on the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit (PACU) record.
- **Post Recovery Room** – Reimbursement will be based on the time the patient leaves the recovery room until discharge.

Video or Digital Equipment used in Operating Room

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

Additional Reimbursement Guidelines for Disallowed Charges

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

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

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0990 – 0999	Personal Care Items • Courtesy/Hospitality Room • Patient Convenience Items (0990) • Cafeteria, Guest Tray (0991) • Private Linen Service (0992) • Telephone, Telegraph (0993) • TV, Radio (0994) • Non-patient Room Rentals (0995) • Beauty Shop, Barber (0998) • Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	**Supplies and Equipment** • Blood Pressure cuffs/Stethoscopes • Thermometers, Temperature Probes, etc. • Pacing Cables/Wires/Probes • Pressure/Pump Transducers • Transducer Kits/Packs • SCD Sleeves/Compression Sleeves/Ted Hose • Oximeter Sensors/Probes/Covers • Electrodes, Electrode Cables/Wires • Oral swabs/toothettes • Wipes (baby, cleansing, etc.) • Bedpans/Urinals • Bed Scales/Alarms • Specialty Beds • Foley/Straight Catheters, Urometers/Leg Bags/Tubing • Specimen traps/containers/kits • Tourniquets

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• Syringes/Needles/Lancets/Butterflies • Isolation carts/supplies • Dressing Change Trays/Packs/Kits • Dressings/Gauze/Sponges • Kerlix/Tegaderm/OpSite/Telfa • Skin cleansers/preps • Cotton Balls; Band-Aids, Tape, Q-Tips • Diapers/Chucks/Pads/Briefs • Irrigation Solutions • ID/Allergy bracelets • Foley stat lock • Gloves/Gowns/Drapes/Covers/Blankets • Ice Packs/Heating Pads/Water Bottles • Kits/Packs (Gowns, Towels and Drapes) • Basins/basin sets • Positioning Aides/Wedges/Pillows • Suction Canisters/Tubing/Tips/Catheters/Liners • Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) • Preps/prep trays • Masks (including CPAP and Nasal Cannulas/Prongs) • Bonnets/Hats/Hoods • Smoke Evacuator Tubing • Restraints/Posey Belts

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

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) • Medication prep • Nonspecific descriptions • Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges • IV Solutions 250 cc or less, except for pediatric claims • Miscellaneous Descriptions • Non-FDA Approved Medications
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	• Specimen collection • Draw fees • Venipuncture • Phlebotomy • Heel stick • Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399) • Thawing/Pooling Fees
0270, 0272, 0300 – 0309	• Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment • Oxygen (ICU/CCU/Progressive) O.R., ER and Recovery • Instrument Trays and/or Surgical Packs • Drills/Saws (All power equipment used in O.R.) • Drill Bits • Blades

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• IV 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

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

Overpayment Process

Refund notifications may be identified either by the Wellpoint Cost Containment Unit (CCU) or the provider. The CCU researches and notifies the provider of an overpayment by requesting 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, the CCU will notify the provider of the overpayment and include a *Refund Notification Form*. The provider will submit the *Refund Notification Form* along with the refund check.

If a provider identified the overpayment and returns the Wellpoint check or sends a refund check, a completed *Refund Notification Form* specifying the reason for the overpayment should be included. This form can be found on the provider website at **provider.wellpoint.com/tx** > Resources > Forms > Claims & Billing. Submission of the *Refund Notification Form* will allow the CCU to process and reconcile the overpayment in a timely manner. Once the CCU has reviewed the overpayment, the provider will receive a confirmation letter explaining the details of the reconciliation. For questions regarding the refund notification procedure, call Provider Services at **855-878-1785**.

Wellpoint uses an automated claims auditing system to ensure claims are adjudicated in accordance with industry billing and reimbursement standards. Claims auditing software ensures compliance with an ever-widening array of edits and rules, as well as consistency of payment for providers, by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, our code editing system determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology, and anesthesia codes and processes those services according to the National Correct Coding Initiative (NCCI). NCCI was implemented to promote national correct coding methodologies and control improper coding leading to inappropriate payment. NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services.

In addition to code pair edits, the NCCI includes a set of edits known as medically unlikely edits (MUEs). An MUE is a maximum number of units of service (UOS) allowable under most circumstances for a single HCPCS/CPT code billed by a provider on a date of service for a single beneficiary.

CHAPTER 15: PROVIDER COMPLAINT AND GRIEVANCE PROCEDURES

Overview

Wellpoint has a formal process for the handling of complaints pertaining to administrative issues and nonpayment-related matters. For payment disputes, see the "Claim Payment Disputes" section. For MMP member liability appeals, see Member Appeals. Providers may access this process by filing a written grievance. Provider grievances will be resolved fairly and consistently with Wellpoint policies and covered benefits.

Providers are not penalized for filing complaints. Any supporting documentation should accompany the complaint and be forwarded to:

ATTN: Provider Complaints
Provider Complaints and Grievances
Wellpoint
Mailstop: OH0205-A5374
4361 Irwin Simpson Road
Mason, OH 45040
Fax: **888-458-1406**

When submitting complaint information, we recommend providers retain all documentation including fax cover pages, email correspondence and logs of telephone communications at least until the complaint is resolved.

Wellpoint will contact the complainant by telephone, email or in writing within 30 calendar days of receipt of the complaint with the resolution.

Wellpoint will not cease coverage of care pending a complaint investigation. If a provider is not satisfied with the resolution of the complaint by Wellpoint, that provider may complain to the state. A complaint to the state should contain a written explanation of the provider's position on the issue and be accompanied by all materials related to the complaint including medical records and the written response from Wellpoint. Complaints may be sent to:

Texas Health and Human Services Commission
ATTN: Resolution Services
MCCO Research and Resolution
P.O. Box 149030, MC: 0210
Austin, TX 78714-9030

Provider Obligations and Notifications

Denial Notification and Member Complaints, Appeals and Grievances

Providers are required to adhere to CMS and Wellpoint requirements concerning issuing letters and notices.

Skilled Nursing Facilities and Home Health Agencies

The Notice of Medicare Noncoverage (NOMNC) is a statutorily required notice issued to members to alert them of a discontinuation of skilled nursing facility, comprehensive outpatient rehabilitation facility or home health services. This notice explains it has been determined that continued coverage after a specific effective date will no longer be covered by the plan. A NOMNC should be issued at least two days prior to discharge, or in advance of the last two covered visits (for home health). This notice informs the member his or her stay or visits no longer meet coverage criteria and will end in two days or after two visits.

In most cases, the notice is required to be issued by the provider, and the provider is required to ensure proper delivery and that the member's signature is obtained. The member's signature is not an agreement with the denial; however, it is documentation he or she has received the notification. If a member refuses to sign the notice, the provider may contact the member's representative to have that person sign. If no representative is available, the provider may annotate the notice to indicate the refusal and document that notification was provided to the member, but the member refused to sign. If a representative can be contacted, the representative should sign the notice. If in-person notification cannot be provided to a representative, he or she can be contacted by telephone to advise him or her of the notice and appeal rights. If agreed by both parties, the notice can be emailed or faxed (in accordance with *HIPAA* privacy and security requirements). The notice should be annotated by the person providing the notification to the representative indicating the date, time, person's name, relation to the member, telephone number called and that the notice was read to the representative, including all appeal rights. If a member (or representative) elects to exercise his or her right to an immediate review, the member (or representative) must submit a request to the appropriate Quality Improvement Organization (QIO) for the state by the deadline indicated in the notice. The provider is responsible for submitting any documents or medical records as requested by the QIO or the Wellpoint Complaints, Appeals and Grievance department within the time frame indicated on the request.

Hospitals

The Important Message from Medicare (IMM) is a statutorily required notice issued to Medicare Advantage members to alert them of a discontinuation of acute inpatient hospital services. Within two days after an admission or at the preadmission visit (but not more than seven calendar days in advance of the admission), the hospital providing the inpatient services is required to issue the IMM. This statutorily required notice explains the Medicare beneficiary's rights as a hospital inpatient, including discharge appeal rights. The hospital is required to deliver the notice in person and obtain the signature of the member or representative and provide a copy at that time. The hospital is also responsible for ensuring the member can comprehend the contents of the notice before obtaining the signature. It is the responsibility of the hospital to explain the notice if necessary and be able to answer any questions about the notice the member or representative may have.

Notices should not be delivered while the member is receiving emergency treatment but should be delivered once the patient is stable. If a member refuses to sign the notice, the hospital may annotate the notice to indicate the refusal and document notification was attempted. If in-person notification cannot be provided to a representative, the hospital is responsible for telephonically contacting the representative to advise him or her of their appeal rights. If agreed by both parties, the notice can be emailed or faxed (in accordance with HIPAA privacy and security requirements). In addition, prior to discharge (but not more than two days in advance of discharge), the hospital must deliver another copy of the signed notice to the member or representative in person. If the notice is being given on the day of discharge, the member must be provided at least four hours to consider his or her rights and to request the QIO review. Hospitals should not routinely provide the notice on the day of discharge. If the member requests additional information on the discharge, the detailed notice can be issued prior to an immediate review request being initiated. If discharge occurs within two calendar days of the original notice, no additional copy needs to be delivered. If a member elects to exercise his or her right to an immediate review, he or she must submit a request to the appropriate QIO, as outlined in the notice, by midnight of the day of discharge either verbally or in writing before that person leaves the hospital.

In-Office Denials

There may be situations where a member disagrees with the provider's decision about a request for service or a course of treatment. At each patient encounter with an Wellpoint member, the provider must notify the member of his or her right to receive, upon request, a detailed written notice from Wellpoint regarding the member's services. The provider's notification must provide the member with the information necessary to contact Medicare or HHSC. If a member (or provider) requests us to provide a detailed notice of a provider's decision to deny a service in whole or part, we must give the member a written notice of the determination.

Precertification

Providers are responsible for obtaining precertification from Wellpoint before performing certain procedures or when referring members to noncontracted providers. Please refer to **provider.wellpoint.com/tx** > Resources > Precertification Lookup Tool for those procedures that require precertification or call Provider Services at **855-878-1785**.

Wellpoint will render a determination on the request within the appropriate time frame and provide notification of the decision. Requests that are denied will generate a notice that includes the denial rationale and applicable appeal rights. Members will receive a denial letter as well that includes appeal rights. Denials that are the result of contractual issues between Wellpoint and the provider will not generate a member denial letter.

- An initial *organization* determination is any determination (e.g., an approval or denial) made by Wellpoint for coverage of medical services
- An initial *coverage* determination is any determination (e.g., an approval or denial) made by Wellpoint for coverage of prescription drugs.

Complaints, Appeals, Grievances And Disputes

Distinguishing between Provider and Member Complaints, Appeals & Grievances

Wellpoint has separate and distinct processes for requests to reconsider a decision on an authorization or request for payment upon claims submission. Upon processing of each request, assignment of liability for the service is determined. All member liability denials are subject to the Medicare Complaints, Appeals and Grievances (MCAG) process as outlined in the Member Appeals and Grievances section. Disputes between the Health Plan and the provider that do not involve an adverse determination or liability for the Wellpoint member would follow the Wellpoint Participating Provider Appeals and Disputes or Non-Participating Provider Payment Disputes processes.

Providers must cooperate with Wellpoint and with members in providing necessary information to resolve the appeals within the required time frames. Providers must provide the pertinent medical records and any other relevant information upon request and when initiating an appeal. In some instances, providers must provide the records and information very quickly in order to allow Wellpoint to make an expedited decision. Your participation in, along with the member's election of the Wellpoint plan, are an indication of consent to release those records as part of healthcare operations.

Wellpoint Member Liability

Wellpoint has determined that an Wellpoint member is responsible for payment as the service(s) are determined to be not covered under the plan to which they are enrolled or is considered an allowable cost-share. Any time a member liability denial letter is issued, the member appeals process should be followed and NOT the provider appeals process. Wellpoint member liability is assigned when:

- The Integrated Denial Notice (IDN) is issued as per the *Medicare Managed Care Manual* Chapter 13 appeal rights with subsequent review by the Independent Review Entity (IRE).
- Notice of Medicare Non-Coverage (NOMNC) is issued as per the *Medicare Managed Care Manual* Chapter 13 appeal rights with rights to pursue an appeal via the Quality Improvement Organization (QIO) or the plan directly.
- An *Explanation of Benefits (EOB)* indicates there is member responsibility assigned to a claim processed.
- An *Explanation of Payment (EOP)* indicates there is member responsibility assigned to a claim processed.

Note: Members that are dually eligible are protected from liability for Medicare premiums, deductible, coinsurance, and copayment amounts. This includes cost share being applied to claims. Providers may not bill a dual-eligible that has coverage for any balance left unpaid as specified in the Balanced Budget Act of 1997. Providers who balance bill the dual eligible beneficiary are in violation of these regulations and subject to sanctions. Providers also may not accept dual eligible beneficiaries as 'private pay' in order to bill the patient directly and providers identified as continuing to bill dual eligible beneficiaries inappropriately will be reported to the Centers for Medicare & Medicaid Services (CMS) for further action/investigation.

Participating Provider Liability
Wellpoint has determined that the participating provider has failed to follow the terms and conditions of their contract either administratively or by not providing the clinical information needed to substantiate the services being requested for approval of payment. Participating providers are prohibited from billing an Wellpoint member for services unless the plan has determined member liability and issued the appropriate notices as above.

Nonparticipating Provider Liability
Wellpoint has determined that the nonparticipating provider with the plan has failed to follow Wellpoint processing guidelines. Nonparticipating providers are prohibited from billing a STAR+PLUS MMP member for services unless the plan has determined member liability and issued the appropriate notices as above and has procedures for nonparticipating providers to follow.

Participating Provider Appeals and Disputes

Participating Provider Appeals follow the standard Wellpoint process for provider appeals
Wellpoint participating providers may initiate provider appeals under the Provider Complaint and Appeal Procedures. The processing of a particular provider appeal will vary depending on whether or not it involves a review of medical necessity. The Provider Complaint and Appeals Procedures contain alternative steps, based on product and state, as necessary to comply with regulatory and accreditation requirements.

The Provider Complaint and Appeal Procedures are designed to permit Wellpoint to examine issues fully and fairly before completion of the internal review process. Special processes apply to appeals that involve utilization review decisions on clinical benefits. Wellpoint typically determines provider appeals within 60 days.

Participating Provider Standard Appeal
A formal request for review of a previous Wellpoint decision where medical necessity was not established where provider liability was assigned (see original decision letter) for services already rendered.

Provider Medical Necessity Appeals Responsibility
All requests must be:

- Submitted in writing
- Include necessary attachments:
  - Copy of the original Wellpoint decision
  - All applicable medical records

Note: Wellpoint will not request additional records to support the provider's argument and expects the provider to submit the necessary information to substantiate their request for payment. Contracted provider medical necessity appeals should be mailed to:

Medicare Complaints, Appeals and Grievances (MCAG)
Attention: Contracted Provider Medical Necessity Appeals
Mailstop: OH0205-A537

4361 Irwin Simpson Road
Mason, OH 45040

Providing the above information will enable Wellpoint to properly and timely review requests within 60 days. Requests that do not follow the above may be delayed.

Participating Provider Administrative Plea/Appeal
A formal request for review of a previous Wellpoint decision where a determination was made that the participating provider failed to follow administrative rules and provider liability was assigned (see original decision letter) where services have already been rendered. The Participating Provider Administrative Plea should follow the provider "Claim Payment Dispute" process as outlined below.

Appeals for failure to provide timely notification will not be reviewed clinically until the late notification denial is resolved.

Provider Appeal Process to HHSC (Related to Claim Recoupment due to Member Disenrollment)
A provider may appeal claim recoupment by submitting the following information to HHSC:

- A letter indicating the appeal is related to a managed care disenrollment/recoupment and the provider is requesting an Exception Request.
- The Explanation of Benefits (EOB) showing the original payment. Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- The EOB showing the recoupment and/or the plan's "demand" letter for recoupment. If sending the demand letter, it must identify the client's name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
- Completed clean claim. All paper claims must include both the valid NPI and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, TX 78720-4077

Claim Payment Disputes

Provider Claim Payment Dispute Process
If you disagree with the outcome of a claim, you may begin the Wellpoint Provider Payment Dispute Process. There are two types of submissions that are handled within the dispute process:

- **Provider Payment Dispute:** The claim has been finalized but you disagree with the amount that you were paid.
- **Provider Administrative Plea/Appeal:** The claim has been finalized, but you disagree with the administrative denial that has been applied. An administrative denial is applied within the claims process when it is determined that the provider failed to follow the terms and conditions of their contract. Examples of administrative denials are as follows: denials such as no prior authorization or late notification.

Please be aware, there are two common claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, they are briefly defined below. They are:

- **Claims Inquiry:** A question about a claim, but not a request to change a claim payment.
- **Claims Correspondence:** A request from Wellpoint for further information to finalize a claim. Typically, these requests include medical records, itemized bills, or information about other insurance a subscriber may have. A full list of correspondence related materials are in the "Claim Correspondence" section of this manual.

Claims that are denied for lack of medical necessity should follow the existing provider post-service appeal process. An example of a post-service medical necessity appeal scenario would be as follows: Upon clinical review, the services related to the prior authorization request were deemed not medically necessary, but services were rendered and claim payment was denied. For more information on each of these, please refer to the appropriate section of this *Provider Manual.*

The Wellpoint Provider 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 the 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:** 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 reasons including:

- Contractual payment issues
- Disagreements over reduced claims or zero-paid claims not related to medical necessity
- Post-service authorization issues
- Other health insurance denial issues

- Claim code editing issues
- Retro-eligibility issues
- Experimental/investigational procedure issues
- Claim data issues
- Timely filing issues*

*Timely filing issues: Wellpoint will consider reimbursement of a claim which 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 Provider 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 website **provider.wellpoint.com/tx** within 120 calendar days from the date on the *Explanation of Payment* (*EOP*) (see below for further details on how to submit). Reconsiderations filed more than 120 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.

We encourage providers to use our claims payment Reconsideration process if you feel a claim was not processed correctly; however, this optional step is not required prior to filing a claim payment appeal.

If a Reconsideration requires clinical expertise, it will be reviewed by appropriate clinical professionals.

The plan will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by an additional 30 calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We will send you our decision in a determination letter, which will include:

1. A statement of the provider's Reconsideration request.
2. A statement of what action the Plan intends to take or has taken.
3. The reason for the action.
4. Support for the action including applicable statutes, regulations, policies, claims, codes, or *Provider Manual* references.
5. An explanation of the provider's right to request a Claim Payment Appeal within 60 calendar days (63 calendar days if mailed) of the date of the *Reconsideration Determination Letter*.
6. An address to submit the Claim Payment Appeal.

If any decision results in a claim adjustment, any payment due and the 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 Availity Essentials at **availity.com** or in writing within 60 calendar days (63 calendar days if mailed) of the date on the *Reconsideration Determination Letter*. Claim Payment Appeals received more than 63 calendar days after the *EOP,* or the *Claims Redetermination Letter* will be considered untimely and will be 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 finalized claim on file.

If a Claim Payment Appeal requires clinical expertise, it will be reviewed by appropriate clinical professionals.

The Plan will make every effort to resolve the Claim Payment Appeal within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

The *Claim Payment Appeal Determination Letter* will include:

1. A statement of the provider's Claim Payment Appeal request.
2. A statement of what action the Plan intends to take or has taken.
3. The reason for the action.
4. Support for the action including applicable statutes, regulations, policies, claims, codes, or *Provider Manual* references.

If any decision results in a claim adjustment, any payment due and the EOP will be sent separately.

How to Submit a Claim Payment Dispute

We have several options when filing a claim payment dispute. They are described below:

- **Verbal (Reconsideration only):** Verbal submissions may be submitted by calling Provider Services at **855-878-1785.**
- **Online (Reconsideration and Claim Payment Appeal):** Use the secure provider Availity Appeal application at **availity.com.** Through Availity, you can upload supporting documentation and receive immediate acknowledgement of your submission:
  - Locate the claim you want to dispute on Availity using **Claim Status** from the **Claims & Payments** menu. If available, select **Dispute Claim** to initiate the dispute. Go to

Request to navigate directly to the initiated dispute in the appeals dashboard add the documentation and submit.

- **Written (Reconsideration and Claim Payment Appeal):** Written Reconsiderations and Claim Payment Appeals should be mailed to:

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 ID number.
- A list of disputed claims, which should include the claim number and the date(s) of service.
- All supporting statements and documentation.

Claim Inquiry

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Provider Relations program helps with claim inquiries. Call **855-878-1785** and select the *Claims* prompt within our voice portal. We connect you with a dedicated resource team called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

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

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim Correspondence

Claim correspondence is different from a payment dispute. Correspondence is when the Plan requires more information in order 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.

Nonparticipating Provider Payment Disputes

Nonparticipating Provider Payment Disputes
If, after a claim has been adjudicated, a nonparticipating provider contends that our decision was to pay for a different service than the one originally billed or believes they would have received a different payment under Original Medicare, the Nonparticipating Provider Payment Disputes Resolution Process can be utilized. Notification will be provided to the nonparticipating provider at each step of the process.

Nonparticipating Provider Appeals Rights
If a claim is partially or fully denied for payment, the nonparticipating provider must request a reconsideration of the denial within 60 calendar days from the remittance notification. With the appeal, the nonparticipating provider agrees to hold the enrollee harmless regardless of the outcome of the appeal.

With the appeal, the nonparticipating provider should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement. **The appeal must be in writing and mailed.** Please mail the appeal to this address:

Medicare Complaints, Grievances and Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Rd
Mason, OH 45040

Member Complaints, Appeals and Grievances

Distinguishing Between Member Appeals and Member Grievances
Complaints by an enrollee, made orally or in writing, are considered an expression of dissatisfaction to a health plan, provider, facility, or Quality Improvement Organization (QIO).

There are two procedures for resolving Wellpoint member complaints: the Wellpoint member **appeals** process and Wellpoint member **grievance** process. All member concerns are resolved through one of these mechanisms. The member's specific concern dictates which process is used. Thus, it is important for the provider to be aware of the difference between appeals and grievances.

Wellpoint Member Liability Appeals
A member appeal is the type of request a member (or authorized representative) makes when the member wants Wellpoint to reconsider and change an initial coverage/organization determination (by Wellpoint or a provider) about what services, benefits or prescription drugs are necessary or covered, or whether Wellpoint will reimburse for a service, benefit or prescription drug.

An appeal refers to any of the procedures that deal with a request to review a denial of payment or services. If a member believes he or she is entitled to receive a certain service and

Wellpoint denies it, the member has the right to appeal the decision. It is important to follow the directions in the denial letter issued to ensure the proper appeals process is followed.

A member may appeal:

- An adverse initial organization determination by Wellpoint or a provider concerning authorization for or termination of coverage of a healthcare service.
- An adverse initial organization determination by Wellpoint concerning reimbursement for a healthcare service.
- An adverse initial organization determination by Wellpoint concerning a refusal to reimburse for a health service already received if the refusal would result in the member being financially liable for the service.
- An adverse coverage determination by Wellpoint or a provider concerning authorization for prescription drugs.

Member Liability Appeals should be sent to:

Medicare Complaints, Appeals and Grievances (MCAG)
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, OH 45040
Fax: 888-458-1406

All Wellpoint member concerns that do not involve an initial determination are considered grievances and are addressed through the grievance process.

Participating Provider Responsibilities in the Wellpoint Member Appeals Process:

- Physicians can request standard service or expedited appeals on behalf of their members; however, if not requested specifically by the attending physician, an *Appointment of Representative Form* to submit an appeal on behalf of an Wellpoint member may be required. The *Appointment of Representative Form* can be found online and downloaded at **cms.hhs.gov/cmsforms/downloads/cms1696.pdf**.
- When submitting an appeal, provide all medical records and/or documentation to support the appeal at that time. Please note that if additional information is requested, it will delay processing of the appeal.
- Expedited appeals should only be requested if the normal time period for an appeal could jeopardize the member's life, health, or ability to regain maximum function.
- The CMS guidelines should be utilized when requesting services and initiating the appeals process.

Appeal timeframes:

- Members or their Authorized Representatives have 60 days from the date of the denial of services to file an appeal. The 60-day filing deadline may be extended if good cause can be shown.
- For standard service appeals, service and payment issues must be resolved within 30 days from the date the request was received:
  - If the normal time period for an appeal could jeopardize the member's life, health, or ability to regain maximum function, a request for an expedited appeal may be

submitted orally or in writing. Such appeals are generally resolved within 72 hours unless it is in the member's interest to extend this time period.

- For payment appeals, payment issues must be resolved within 60 calendar days from the date the request was received. All payment appeals must be submitted in writing.

Further Appeal Rights

If Wellpoint is unable to reverse the original denial decision in whole or part, the following additional steps will be taken:

- Medicare-Covered Services:
  - Wellpoint will forward the appeal to an independent review entity (IRE) contracted with the federal government. The IRE will review the appeal and make a decision:
    - Within 72 hours if expedited (A 14-day extension may be taken if additional information is needed).
    - Within 30 days if the appeal is related to authorization for healthcare (A 14-day extension may be taken if additional information is needed).
    - Within 60 days if the appeal involves reimbursement for care).
    - Note: Prescription drug appeals are not forwarded to the IRE by Wellpoint but may be requested by the member or representative; information will be provided on this process during the Wellpoint member appeals process.
  - If the IRE issues an adverse decision and the amount at issue meets a specified dollar threshold, the member may appeal to an administrative law judge (ALJ).
  - If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council. If the Medicare Appeals Council refuses to hear the case or issues an adverse decision, the member may be able to appeal to a federal court.
- Medicaid-Covered Services:
  - Only covered under Medicaid (HHSC), including LTSS services, covered non-Part D Drugs and behavioral health:
    - The appeal may be filed externally by the member to the HHSC Appeals Division.
    - A response will be issued within 72 hours for an expedited appeal.
    - A response will be issued within 30 calendar days.
- Medicare- and Medicaid-Covered Services:
  - Any appeals that overlap Medicare and Medicaid (including but not limited to: home health, durable medical equipment, and skilled therapies, excluding Part D) will be automatically forwarded to the IRE. The member may also submit a request to the HHSC Appeals Division. Wellpoint is bound to the outcome more favorable to the member.

State Fair Hearing Information

Can a member ask for a state fair hearing?

If a member of the health plan disagrees with the health plan's decision about an appeal, the member has the right to ask for a state fair hearing. The member may name someone to represent him or her by writing a letter to the health plan telling Wellpoint the name of the person the member wants to represent him or her. A provider may be the member's representative. The member or the member's representative must ask for the state fair

hearing within 120 days of the date on the health plan's appeal decision letter. If the member does not ask for the state fair hearing within 120 days, the member may lose his or her right to a state fair hearing. To ask for a state fair hearing, the member or the member's representative should send a letter to the health plan at:

Attn: State Fair Hearing Coordinator
Wellpoint
P.O. Box 62429
Virginia Beach, VA 23466 -2429

Or call Member Services at **855-878-1784** (TTY **711**).

If the member asks for a state fair hearing within 10 days from the time the health plan sends the appeal decision letter, the member has the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If the member does not request a state fair hearing within 10 days from the time the health plan sends the appeal decision letter, the service the health plan denied will be stopped.

If the member asks for a state fair hearing, the member will get a packet of information letting the member know the date, time, and location of the hearing. Most state fair hearings are held by telephone. At that time, the member or the member's representative can tell why the member needs the service the health plan denied.

HHSC will give the member a final decision within 90 days from the date the member asked for the hearing.

Hospital discharge appeals and QIO review process

Hospital discharges are subject to the expedited member appeal process. CMS has determined that Wellpoint members wishing to appeal an inpatient hospital discharge must request an immediate review from the appropriate Quality Improvement Organization (QIO) authorized by Medicare to review the hospital care provided to Medicare patients.

When an Wellpoint member does not agree with the physician's decision of discharge from the inpatient hospital setting, then the member must request an immediate review by the QIO. The member or their authorized representative, attorney, or court-appointed guardian must contact the QIO by telephone or in writing. When the member requests a review no later than midnight of the day of discharge, the member is not financially responsible for inpatient hospital services furnished before noon of the day after the date the member receives notification of the QIO determination. The QIO will make a decision within one full working day after it receives the member's request, the appropriate medical records, and any other information it needs to make a decision. While the member remains in the hospital, Wellpoint continues to be responsible for paying the costs of the stay until noon of the calendar day following the day the QIO notifies the member of its official coverage decision.

If the QIO agrees with the physician's discharge decision, the member will be responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day

the QIO provides notification of its decision. If the QIO disagrees with the physician's discharge decision, the member is not responsible for paying the cost of additional hospital days. If the member misses the deadline to file for an immediate QIO review, then he/she may request an expedited appeal. In this case, the member does not have automatic financial protection during the course of the expedited appeal and may be financially liable for paying for the cost of the additional hospital days if the original decision to discharge is upheld on appeal.

Wellpoint Member Grievance

A member grievance is the type of complaint a member makes regarding any other type of problem with Wellpoint or a provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room, and the cleanliness of the provider's facilities are grievances.

Wellpoint must accept grievances from members orally or in writing. Wellpoint must make a decision and respond to the grievance within 30 days. A member can request an expedited grievance, in which case Wellpoint has 24 hours to respond. An expedited grievance can only be initiated if Wellpoint refuses to grant the member an expedited organization/coverage determination or an expedited reconsideration/determination, or if the member disagrees with a decision by Wellpoint to take an extension in making an organization/coverage determination or appeal decision.

Resolving Wellpoint Member Grievances

Associates will also provide assistance in completing forms or other procedural steps to support the member filing the grievance.

Members may also file a grievance with CMS by dialing **800-MEDICARE**, completing the electronic Grievance form on **Medicare.gov**, emailing CMSgrievancecontact@CMS.Gov or by mailing the grievance to:

Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

If a member has a grievance about Wellpoint, a provider or any other issue, providers should instruct the member to call Member Services at **855-878-1784** (TTY **711**) during regular business hours or send a written grievance to:

Complaints, Appeals and Grievances Department
Wellpoint
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, OH 45040
Fax: **888-458-1406**

Billing Members/Cost Sharing

Providers may ***not*** collect any additional payment for cost-sharing obligations from Wellpoint members other than those specified in a member's plan Summary of Benefits. In the MMP program, member cost-sharing obligations are limited to patient-pay amounts authorized by HHSC for some members for certain nursing home services and copays for some prescription drugs covered under Medicare Part D.

Wellpoint will process provider claims in accordance with the Wellpoint benefit package. Unless specifically noted as one of the exceptions above, our payment is payment in full, and providers may not bill members for cost sharing.

Noncovered Services

Before rendering services, providers should always inform members of the cost of services not covered under Wellpoint that will be charged to the member. A provider who chooses to provide services **not covered** under Wellpoint:

- Understands Wellpoint only reimburses for services that are medically necessary, including hospital admissions and other services.
- Understands he or she may not bill for or take recourse against a member for denied or reduced claims for services within the amount, duration, and scope of Wellpoint benefits.
- Obtains the member's signature on the Client Acknowledgment Statement, which specifies the member will be held responsible for payment of services prior to rendering services; alternatively, the provider can follow the in-office denial process.

Client Acknowledgement Statement

A provider may bill an Wellpoint member for a service that has been denied as not medically necessary or not a covered benefit **only if** both of the following conditions are met:

- The member requests the specific service or item.
- The provider obtains and keeps a written acknowledgement statement signed by the member and the provider stating:

I understand that, in the opinion of (provider's name), the services or items I have requested to be provided to me on (dates of service) may not be covered under Wellpoint as being reasonable and medically necessary for my care or are not a covered benefit. I understand Wellpoint has established the medical necessity standards for the services or items I request and receive. I also understand I am responsible for payment of the services or items I request and receive if these services or items are determined to be inconsistent with Wellpoint medically necessary standards for my care or are not a covered benefit.

Member name: _____ Member ID: _____

Type of service: _____

Cost of service: $_____

Member Signature: _____ Date: _____

IMPORTANT: Wellpoint members must NOT be balance billed for the difference between the amount paid by Wellpoint and the billed amount for covered services.

In addition, providers may **not** bill a member if any of the following occurs:

- Failure to submit a claim in a timely manner, including claims not received by Wellpoint
- Failure to submit a claim to Wellpoint for initial processing within the required filing deadline
- Failure to submit a corrected claim within the required filing resubmission period
- Failure to appeal a claim within the 120-day administrative appeal period
- Failure to appeal a utilization review determination within 60 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made in claims preparation, claims submission or the appeal process

Provider Websites and Provider Inquiry Line

To verify member eligibility and benefits, request precertification and check status, file claims, check claims status, and submit claim disputes, access **availity.com**.

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

For other functions such as looking up precertification/notification requirements and reimbursement policies, finding forms and other general information, visit **provider.wellpoint.com/tx.**

Note: Most of these functions are also available directly through Availity Essentials.

Toll-Free Automated Member Services and Provider Services
To support our providers and members, we have established MMP Customer Care to assist with questions and concerns about Wellpoint. MMP Customer Care is comprised of coordinated care subject matter experts and specializes in first-call resolution for provider and member inquires.

Our MMP Customer Care representatives can help:

- Resolve payment questions, appeals and other claims issues.
- Verify claims status, member eligibility, preauthorization requirements and the status of healthcare services.
- Identify participating Wellpoint providers for referring members to specialty services.
- Support noncompliant members (e.g., members who repeatedly miss appointments, members who are noncompliant with their treatment plans, etc.).

MMP Customer Care
Member Services: **855-878-1784** (TTY **711**), 8 a.m. to 8 p.m. local time
Provider Services: **855-878-1785**, Monday through Friday, 8 a.m. to 8 p.m. local time

Information is also available through the automated system, or you can be transferred to the appropriate department for other needs, such as seeking advice in service coordination or case management.

CHAPTER 16: MEMBER RIGHTS AND RESPONSIBILITIES

Overview

Providers are required to adhere to CMS, HHSC and Wellpoint requirements concerning issuing letters and notices.

Wellpoint Member Rights

1. Members have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
    a. Be treated fairly and with respect
    b. Know that medical records and discussions with providers will be kept private and confidential
2. Members have the right to a reasonable opportunity to choose a healthcare plan and primary care provider. This is the doctor or healthcare provider seen most of the time and who will coordinate care. Members have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
    a. Be told how to choose and change health plans and PCPs
    b. Choose any health plan that is available and choose PCP from that plan
    c. Change PCPs
    d. Change health plans without penalty
    e. Be told how to change health plans or PCPs
3. Members have the right to ask questions and get answers about anything they do not understand. That includes the right to:
    a. Have providers explain healthcare needs and talk about the different ways healthcare problems can be treated
    b. Be told why care or services were denied and not given
4. Members have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
    a. Work as part of a team with the provider in deciding what healthcare is best for themselves
    b. Say yes or no to the care recommended by the provider
5. Members have the right to use each available complaint and appeal process through the managed care organization and through Medicaid/Medicare and get a timely response to complaints appeals and fair hearings. That includes the right to:
    a. Make a complaint to the health plan or to the state Medicaid program about the healthcare, provider, or health plan
    b. Get a timely answer to complaints
    c. Use the plan's appeal process, and be told how to use it
    d. Ask for a fair hearing from the state Medicaid program and get information about how that process works
6. Members have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
    a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need that is needed

    b. Get medical care in a timely manner
    c. Be able to get in and out of a healthcare provider's office; this includes barrier-free access for people with disabilities or other conditions that limit mobility, in accordance with the *Americans with Disabilities Act*
    d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan; interpreters include people who can speak in the member's native language, help someone with a disability or help the member understand the information
    e. Be given information you can understand about your health plan rules, including the healthcare services you can get and how to get them
7. Members have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force the member to do something he or she does not want to do or is to punish the member.
8. Members have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care and treatment; the health plan cannot prevent them from giving members this information, even if the care or treatment is not a covered service.
9. Members have a right to know that they are not responsible for paying for covered services. Doctors, hospitals, and others cannot require members to pay copayments or any other amounts for covered services.

Wellpoint Member Responsibilities

1. Members must learn and understand each right under the program. That includes the responsibility to:
    a. Learn and understand rights under the Medicaid program
    b. Ask questions if they do not understand their rights
    c. Learn what choices of health plans are available in their area
2. Members must abide by the health plan's and Medicaid's/Medicare's policies and procedures. That includes the responsibility to:
    a. Learn and follow the health plan's rules and Medicaid/Medicare rules
    b. Choose the health plan and primary care provider quickly
    c. Make any changes in their health plan and PCP in ways established by Medicaid/Medicare and by the health plan
    d. Keep scheduled appointments
    e. Cancel appointments in advance when necessary
    f. Always contact the PCP first for nonemergency medical needs
    g. Be sure to have approval from your PCP before going to a specialist
    h. Understand when they should and should not go to the emergency room
3. Members must share information about their health with their PCP and learn about service and treatment options. That includes the responsibility to:
    a. Tell the PCP about their health
    b. Talk to providers about healthcare needs and ask questions about the different ways healthcare problems can be treated
    c. Help providers get your medical records

4. Members must be involved in decisions relating to service and treatment options, make personal choices and take action to maintain their health. That includes the responsibility to:
    a. Work as a team with the provider in deciding what healthcare is best
    b. Understand how the things the member does can affect health
    c. Members should do the best they can to stay healthy
    d. Treat providers and staff with respect
    e. Talk to their provider about all of their medications

Additional member responsibilities while using NEMT services:

1. When requesting NEMT services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT services to travel to and from your medical appointments.
7. If you have arranged for an NEMT service but something changes and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

Member's Right to Designate an OB/GYN

Wellpoint allows the member to pick any Wellpoint OB/GYN, whether that doctor is in the same network as the member's primary care provider or not.

ATTENTION FEMALE MEMBERS

Members have the right to pick an OB/GYN without a referral from their PCP. An OB/GYN can give the member:

- One well-woman checkup each year.
- Care related to pregnancy.
- Care for any female medical condition.
- A referral to a specialist doctor within the network.

CHAPTER 17: FRAUD AND ABUSE

General Obligations to Prevent, Detect and Deter Fraud, Waste and Abuse

As a recipient of funds from state and federally sponsored healthcare programs, Wellpoint has a duty to help prevent, detect, and deter fraud, waste, and abuse. Wellpoint is committed to detecting, mitigating, and preventing fraud, waste, and abuse as outlined in its Corporate Compliance Program.

As part of the requirements of the federal Deficit Reduction Act, each provider is required to adopt Wellpoint policies on detecting, preventing and mitigating fraud, waste and abuse in all the federally and state funded healthcare programs in which Wellpoint participates. Provider must also distribute them to any staff members or contractors who work with Wellpoint.

Wellpoint maintains several ways to report suspected fraud, waste, and abuse. As a participant in government-sponsored healthcare, you and your staff are obligated to report suspected fraud, waste, and abuse. These reports can be made anonymously at **provider.wellpoint.com/tx.** In addition to anonymous reporting, suspected fraud, waste, and abuse may also be reported by calling Provider Services at **855-878-1785**.

If you have questions or would like more details concerning the Wellpoint fraud, waste, and abuse detection, prevention, and mitigation program, please contact the Wellpoint chief compliance officer.

Importance of Detecting, Deterring and Preventing Fraud, Waste and Abuse

Healthcare fraud costs taxpayers increasingly more money every year. State and federal laws are designed to crack down on these crimes and impose strict penalties. Fraud, waste, and abuse in the healthcare industry may be perpetuated by every party involved in the healthcare process. There are several stages to inhibiting fraudulent acts, including detection, prevention, investigation, and reporting. The following is education on how to help prevent member and provider fraud by identifying the different types as the first line of defense.

- **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, Waste and Abuse (FWA):

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified 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

Providers can prevent fraud, waste, and abuse by ensuring the services rendered are medically necessary, accurately documented in the medical records and billed according to American Medical Association guidelines.

Examples of Member Fraud, Waste and Abuse

- Forging, altering, or selling prescriptions
- Letting someone else use the member's ID (identification) card
- Relocating to out-of-service plan area and not notifying us
- Using someone else's ID card

To help prevent fraud, waste and abuse, providers can educate members about these types of fraud and the penalties levied. Also, spending time with patients and reviewing their records for prescription administration will help minimize drug fraud and abuse. One of the most important steps to help prevent member fraud is as simple as reviewing the Wellpoint member ID card. Wellpoint may not accept responsibility for the costs incurred by providers rendering services to a patient who is **not** an Wellpoint member even if that patient presents a member ID card. Providers should take measures to ensure the cardholder is the person named on the card. Additionally, encourage members to protect their cards as they would a credit card or cash, carry their Wellpoint member ID card at all times, and report any lost or stolen cards to Wellpoint as soon as possible.

Learn more about healthcare fraud at **fighthealthcarefraud.com.**

Reporting Waste, Abuse or Fraud by a Provider or Member

Do you want to report waste, abuse, or fraud?
Let us know if you think a doctor, dentist, pharmacist at the drug store, other healthcare providers or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law. For example, contact us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Wellpoint ID card.
- Using someone else's Wellpoint ID card.

Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at **800-436-6184**.
- Visit **https://oig.hhs.texas.govs** and click the red **Report Fraud** box to complete the online form.
- Report directly to your health plan:

  Attn: Compliance Officer
  Wellpoint
  2505 N. Highway 360, Suite 300
  Grand Prairie, TX 75050
  800-839-6275

Other reporting options include:

- Wellpoint Provider Services: **855-878-1785**
- Special Investigations Fraud Hotline: **866-847-8247** (reporting can be anonymous)
- Visiting our **fighthealthcarefraud.com** education site; at the top of the page, select **Report it** and complete the ***Report Waste, Fraud and Abuse*** form

To report waste, abuse, or fraud, gather as much information as possible.
When reporting about a provider (a doctor, dentist, counselor, etc.), include:

- Name, address, and phone number of provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.).
- Medicaid number of the provider and facility if you have it.
- Type of provider (doctor, dentist, therapist, pharmacist, etc.).
- Names and phone numbers of other witnesses who can help in the investigation.
- Dates of events.
- Summary of what happened.

When reporting about someone who gets benefits, include:

- The person's name.
- The person's date of birth, Social Security number, or case number if you have it.
- The city where the person lives.
- Specific details about the waste, abuse, or fraud.

Investigation Process

Our Special Investigations Unit (SIU) reviews all reports of provider or member fraud, waste, and abuse for all services. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste, or abuse, which may include, but is not limited to:

- *Written warning and/or education*: We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries or may advise of further action.
- *Medical record review*: We review medical records in context to previously submitted claims and/or to substantiate allegations.
- *Prepayment Review*: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- *Recoveries*: We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment of future claims and/or further legal action.

If you are working with the SIU, all checks and correspondence should be sent to:

Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Paper medical records and/or claims are a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator. An opportunity to submit claims and/or supporting medical records electronically is an option if you register for Availity Essentials. 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 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 the 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 appropriate state agency.

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 State requirements
- 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 or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily disenrolled from our healthcare plan, with HHSC approval.

Health Insurance Portability and Accountability Act

The *Health Insurance Portability and Accountability Act* (*HIPAA*, also known as the Kennedy-Kassebaum Bill) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of healthcare fraud, and simplifies the administration of health insurance.

We strive to ensure both Wellpoint and contracted participating providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to HIPAA. Providers must have the following procedures in effect to demonstrate compliance with the HIPAA privacy regulations.

Wellpoint recognizes its responsibility under HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting Wellpoint. However, please note the privacy regulations allow the transfer or sharing of member information, which may be requested by Wellpoint to conduct business and make decisions about care such as a member's medical record, to make an authorization determination, or resolve a payment appeal. Such requests are considered part of the HIPAA definition of treatment, payment or healthcare operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to Wellpoint, verify the receiving fax number is correct, notify the appropriate staff at Wellpoint and verify the fax was appropriately received.

Internet email (unless encrypted) should not be used to transfer files containing member information to Wellpoint (e.g., Excel spreadsheets with claim information). Such information should be mailed or faxed.

Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, P.O. Box, or department at Wellpoint.

The Wellpoint voicemail system is secure and password-protected. When leaving messages for Wellpoint associates, providers should only leave the minimum amount of member information required to accomplish the intended purpose.
When contacting Wellpoint, providers should be prepared to verify their name, address and Tax Identification Number or National Provider Identifier.

CHAPTER 18: GLOSSARY OF TERMS

AAPSF: Accreditation Association for Podiatric Surgical Facilities

AAAHC: Accreditation Association for Ambulatory Health Care

AAAASF: American Association for Accreditation of Ambulatory Surgery Facilities

ABMS: American Board of Medical Specialties

ABCN: American Board of Clinical Neuropsychology

ABPN: American Board of Professional Neuropsychology

ACHC: Accreditation Commission for Health Care

AOA: American Osteopathic Association

APA: American Psychological Association

Appeal: Appeals are any of the procedures that deal with the review of adverse organization or coverage determinations on the healthcare services or prescription drug benefits a member is entitled to receive or any amounts the member must pay for a covered service. These procedures include reconsiderations by Wellpoint, the Part D Quality Improvement Council, hearings before an administrative law judge, reviews by the Medical Appeals Council and federal judicial reviews. This process is separate from the provider administrative appeals/payment appeal process.

Attestation: A signed statement indicating that a practitioner or HDO designee personally confirmed the validity, correctness, and completeness of his, her or its credentialing application at the time that he, she or it applied for participation.

CACREP: Council for Accreditation of Counseling and Related Educational Programs

CARF: Commission on Accreditation of Rehabilitation Facilities

CASWE: Canadian Association for Social Work Education

Certification: Board Certification as recognized by the American Board of Medical Specialties, the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, the American Board of Orthopedic and Primary Podiatric Medicine, the American Board of Podiatric Surgery or the American Board of Oral and Maxillofacial Surgery

CHAMPUS: The Civilian Health and Medical Program of the Uniformed Services (in the United States). CHAMPUS is a federally funded health program that provides beneficiaries with medical care supplemental to that available in military and Public Health Service (PHS) facilities.

CHAP: Community Health Accreditation Program

CHEA: Council for Higher Education Accreditation, an agency recognized by the Company which publishes a reference used to verify the status of educational programs

CMS: Centers for Medicare & Medicaid Services; the federal agency under the Department of Health and Human Services responsible for administering the Medicare and Medicaid programs

COAMFTE: Committee on Accreditation for Marriage and Family Therapy Education

Company Credentials Committee (CC): A local credentialing and peer review body authorized to make decisions regarding the credentials of all practitioners and HDOs initially applying for and those requesting continued participation in the Wellpoint network

Company Medical Directors: Those medical directors with responsibility for medical operations and quality management activities

Covered services: Those benefits, services or supplies that are:

- Provided or furnished by providers or authorized by Wellpoint or its providers.
- Emergency services and urgently needed services that may be provided by nonproviders.
- Renal dialysis services provided while members are temporarily outside the service area.
- Basic and supplemental benefits.

Credentialing staff: Any associate in the Credentialing department

CSWE: Council on Social Work Education

Elderly or Disabled with Consumer Direction (EDCD) Waiver: The CMS-approved 1.27.§1915(c) waiver that covers a range of community support services offered to members who are elderly or who have a disability who would otherwise require a nursing facility (NF) level of care.

Emergency medical condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: 1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; and/or 3) serious dysfunction of any bodily organ or part; or 4) with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe

transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency services: Covered Inpatient and outpatient services that are furnished by a provider qualified to furnish such services and that are needed to evaluate or stabilize a member's emergency medical condition.

Experimental procedures and items: Procedures and items determined by Wellpoint and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, Wellpoint will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or CMS guidance already made by Medicare and Medicaid.

Exceptions: An exception request is a type of coverage determination request. Through the exception process, the member can request an off-formulary drug, an exception to the Wellpoint tiered cost-sharing structure or an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction or precertification requirement).

Fee-for-service Medicare: A payment system by which doctors, hospitals and other providers are reimbursed on a fee-for-service basis

Formal appeal: The process by which an Wellpoint adverse credentialing decision is challenged.

Grievance: A complaint or dispute other than one involving an organization determination expressing dissatisfaction with the manner in which the health plan or delegated entity provides healthcare services. Examples of issues involving a complaint that is resolved through the grievance rather than the appeal process are waiting times in physician offices and rudeness or unresponsiveness of customer service staff.

Healthcare Integrity and Protection Data Bank (HIPDB): The national databank maintained by the U.S. Department of Health and Human Services or its designated contractor, created pursuant to the Health Insurance Portability and Accountability Act (HIPAA) to combat fraud and abuse in the health insurance and healthcare delivery system

Health Delivery Organization (HDO): A facility, institution or entity that is licensed in accordance with all applicable state and/or federal laws and provides or delivers healthcare services

HFAP: Healthcare Facilities Accreditation Program (a program of the American Osteopathic Association formerly referred to as AOACHA - American Osteopathic Association Committee on Hospital Accreditation)

Home health agency: A Medicare-certified home health agency is one that provides intermittent skilled nursing care and other therapeutic services in a member's home when

medically necessary, when members are confined to their home and when authorized by their primary care physician.

Hospice: A Medicare-certified organization or agency primarily engaged in providing pain relief, symptom management and support services to terminally ill people and their families

Hospital: A Medicare-certified institution licensed by the state that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term hospital does not include a convalescent nursing home, rest facility or facility for the aged that furnishes primarily custodial care, including training in routines of daily living.

Immediate termination: A termination of network participation, which is effective immediately. It occurs prior to review by the committee and prior to the provider/HDO being allowed an appeal. It is used when determined necessary by Wellpoint to protect against imminent danger to the health or welfare of its members.

IMQ: Institute for Medical Quality

Independent practice association: A group of physicians that function as a contracting medical provider/group but in which the individual member physicians operate their respective independent medical offices

Informal review/reconsideration: A process through which a practitioner or HDO is given the opportunity to submit additional information to Wellpoint for its consideration. Reviewer(s) may be the same person(s) who were part of the original decision. As part of the informal review/reconsideration, Wellpoint at its discretion may afford additional privileges to the practitioner or HDO, such as by way of example only, an opportunity to discuss the decision with an Wellpoint representative telephonically. In any event, an informal review/reconsideration shall not include privileges equal to or greater than those offered in a formal appeal.

Initial applicant: Any person or organization that provides healthcare services that has applied for participation with Wellpoint to provide healthcare services to Wellpoint members.

Medicaid: The federal health insurance program established by Title XIX of the Social Security Act and administered by states for low-income individuals.

Medically necessary: Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member or otherwise medically necessary under 42 U.S.C. 1395y.

We make determinations of medical necessity based on peer-reviewed medical literature, publications, reports, and evaluations; regulations and other types of policies issued by federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by Wellpoint.

Medicare: The federal health insurance program established by Title XVIII of the Social Security Act and administered by the federal government for elderly and disabled individuals.

Member: A Medicare and Medicaid beneficiary entitled to receive covered services who is enrolled in the Wellpoint plan and whose enrollment has been confirmed by CMS.

National Credentials Committee: A committee composed of Wellpoint medical directors, medical director of medical policy and credentialing and chaired by the VP medical policy, technology assessment and credentialing. It is responsible for the development and maintenance of a consistent national credentialing policy. This committee shall establish policy governing all aspects of credentialing of network practitioners and HDOs, including but not limited to scope, criteria, confidentiality, delegation, and appeals.

National Credentialing Policy: Policy defined by the National Credentials Committee and set forth in this document

NIAHO: National Integrated Accreditation for Healthcare Organizations

National Practitioner Data Bank (NPDB): A federal data bank maintained by the U.S. Department of Health & Human Services or its authorized contractor that houses information regarding providers and any state or federal sanctions, closed malpractice cases where findings are for the plaintiff, settlements, and hospital privilege actions.

National Register of Health Service Providers in Psychology (a.k.a. The Register): An organization providing primary source verification for education and training and board certification of psychologists. This entity has a deemed status from the NCQA.

Participating provider: Any person or organization, including practitioners and facilities, that provides healthcare services and has entered into an agreement with Wellpoint to provide healthcare services to Wellpoint members

Patient pay: When a member's income exceeds an allowable amount, he or she must contribute toward the cost of their LTC services. This contribution, known as the patient pay or applied income amount, is required for members residing in an NF and for those receiving services. Patient pay is required to be calculated for every member receiving NF or waiver services, although not every eligible member will end up having to pay each month.

Peer review: Evaluation or review of the professional competency and conduct of colleagues by professionals with similar types and degrees of expertise (e.g., the evaluation of one physician's practice by another physician)

Practitioner: An individual person who is licensed in accordance with all applicable state and federal laws to deliver healthcare services

Primary care providers and/or primary care physicians (PCPs): Physicians who elect and are selected as PCPs and who practice in the following specialties: pediatrics, internal medicine, family practice, geriatricians, general practice

Professional review action: A decision to terminate or reject a provider from network participation that is based on the competence or professional conduct of a provider, which affects or could adversely affect the health or welfare of a patient.

Provider: Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the state and/or Medicare to deliver or furnish healthcare services. This individual or organization has a contract directly or indirectly with Wellpoint to provide services directly or indirectly to MMP members pursuant to the terms of the participating Provider Agreement.

Provider payment dispute: A formal request from a provider contesting the paid amount on a claim which does not include a medical necessity or administrative denial.

Service area: A geographic area approved by CMS and HHSC within which an eligible individual may enroll in a Medicare-Medicaid Plan. Wellpoint geographic areas are located in the Summary of Benefits document.

Specialty: Those fields of clinical practice recognized by the Wellpoint Credentialing program

TJC: The Joint Commission

Urgently needed services: Those covered services provided when the member is temporarily absent from the MMP service area or under unusual and extraordinary circumstances, services provided when the member is in the service area but the member's PCP is temporarily unavailable or inaccessible, when such services are medically necessary and immediately required as a result of an unforeseen illness, injury or condition; and it is not reasonable given the circumstances to obtain the services through the PCP.

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

CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of the health plan.


Wellpoint