Wellpoint • Washington | Apple Health

Provider Manual

Wellpoint

Washington Apple Health

833-731-2274
provider.wellpoint.com/wa

WAWP-CD-PM-080791-25

Providers must acknowledge this provider manual and any other written materials provided by Wellpoint as proprietary and confidential.

Interested in participating in the Wellpoint network? Visit **provider.wellpoint.com/wa** > Our Network > Join Our Network or call our Provider Services team at **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT.**

INTRODUCTION

Welcome to our network. We're glad you've decided to join us. This *Wellpoint Apple Health (Medicaid) Provider Manual outlines information for providers serving our Integrated Managed Care (IMC) members and Behavioral Health Services Only (BHSO) members.*

We recognize hospitals, physicians, behavioral health practitioners and other providers play a pivotal role in integrated managed care. Earning your respect and gaining your loyalty are essential to a successful collaboration in the delivery of quality healthcare. Our manual contains information you need to know about us, our programs and how we work with you.

And we want to hear from you! Participate in one of our quality improvement committees or call our Provider Services team at **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT** with any suggestions, comments or questions. Together, we can make a difference in the lives of our members — your patients.

1.1 Who We Are

As a leader in integrated managed healthcare services for the public sector, Wellpoint helps adults, low income families, children, pregnant women, those with disabilities and special needs plans get the healthcare they need.

We help coordinate physical and Behavioral Health Care and offer education, access to care and condition care programs. As a result, we lower costs, improve quality and encourage better health status for our members. Wellpoint:

- Improves access to preventive primary care services.
- Ensures selection of a primary care provider who will serve as provider, care manager and coordinator for all basic medical services.
- Improves health status outcomes for members.
- Educates members about their benefits, responsibilities, and appropriate use of care.
- Utilizes community-based enterprises and community outreach.
- Integrates physical and Behavioral Health Care.

Encourage:

- Stable relationships between our providers and members.
- Appropriate use of specialists and emergency rooms.
- Member and provider satisfaction.

In a world of escalating healthcare costs, we work to educate our members about the appropriate use of our managed care system and their involvement in all aspects of their healthcare.

1.2 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 and 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 does 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.

Enrollees who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when a Wellpoint representative working with a member identifies a potential act of discrimination, we advise the member to submit a verbal or written account of the incident and is assisted in doing so if he or she 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 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/TDD**: **800-537-7697**).

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

Wellpoint provides tools and services at no cost to those with disabilities to communicate effectively with us. Wellpoint also provides no-cost language services to people whose primary language is not English (**for example,** qualified interpreters and information written in other languages). These services can be obtained by calling the customer service number on the member's ID card.

If you or your patient believe that Wellpoint has failed to provide 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 grievance coordinator via:

- Mail: 705 Fifth Ave. S., Suite 300, Seattle, WA 98104
- Phone: (**TTY 800-855-2880)**
- Fax: **877-271-2409**

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 (in other words, 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.

1.3 Updates and Changes

This provider manual, as part of your provider agreement and related addendums, may be updated at any time and is subject to change. The most updated version is available online at **provider.wellpoint.com/wa.** To request a printed copy of this manual at no-cost, call Provider Services at **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT.**

If there is an inconsistency between information contained in this manual and the agreement between you or your facility and Wellpoint, the agreement governs. In the event of a material change to the information contained in this manual, we will make all reasonable efforts to notify you through web-posted newsletters, provider bulletins and other communications. In such cases, the most recently published information supersedes all previous information and is considered the current directive.

This manual is not intended to be a complete statement of all policies and procedures. We may publish other policies and procedures not included in this manual on our website or in specially targeted communications, including but not limited to bulletins and newsletters.

CONTACT US

2.1 Quick Reference Contact Information

Our Provider Self-Service Website

Our provider website, provider.wellpoint.com/wa, offers a full array of information and resources, such as:

- Downloadable forms.
- Access to drug coverage information.
- News and updates.
- Current and archived newsletters.
- Exchange data information.
- Maternal Child Services program.
- Quality management tools.
- Reimbursement Policies
- Clinical Practice Guidelines
- Medical Policies
- Tutorials
- Vendor/Partner Links & Information
- Precertification Lookup Tool

Our Washington Office
Address: Wellpoint
705 Fifth Ave. S., Suite 300
Seattle, WA 98104
Phone: **206-695-7081**

Important Contact Information

Department	Details
Provider Services	Phone**: 833-731-2274** Monday through Friday, 8 a.m. to 5 p.m. PT Live agents are available Monday to Friday from 8 a.m. to 5 p.m. Pacific time. The interactive voice response (IVR) system is available 24 hours a day, 7 days a week. **Interpreter Services** For interpretation help for outpatient visits and hearings, contact Universal Language Services at **888-462-0500** or

Department	Details
	interpretersvcs@hca.wa.gov. For sign language, the HCA collaborates with the Office of the Deaf and Hard of Hearing (ODH). For interpretation help for any other services, call Provider Services. **Referral Services** For assistance in referring members to Wellpoint network providers or specialists, including mental health and substance use disorder treatment, call Provider Services. You can also find a list of in-network providers online: provider.wellpoint.com/wa > Resources > Referrals
Member Services	Phone: **833-731-2167** (**TTY 711**) Monday through Friday, 8 a.m. to 5 p.m. PT Live agents are available **Monday-Friday from 8 a.m.-5 p.m. Pacific time.** The IVR system is available 24 hours a day, 7 days a week. Interpreter services are available.
24-hour Nurse HelpLine	Phone: **866-864-2544** (**TTY** 711; Spanish **866-864-2545**) Live agents are available 24 hours a day, 7 days a week.
Electronic Data Interchange (EDI)	Availity Client Services at **800-282-4548**. Availity Client Services is available Monday to Friday 8 a.m. to 8 p.m. ET.
HCA-contracted interpreter services: Universal Language Services	Phone: **888-462-0500**; **425-454-8072** Address: 929 108th Avenue NE, Suite 710, Bellevue, WA 98004 Online: universallanguageservice.com
Behavioral Health Crisis Lines	If there is a life-threatening emergency, call **988**. For the Suicide Prevention Life Line, call **800-273-8255** (TALK) (**TTY 800-799-4889**). For substance use concerns, call the Washington Recovery Help Line at **866-789-1511**.

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	Regional behavioral health crisis line numbers are available at hca.wa.gov/assets/program/county-crisis-line-phone-numbers.pdf
Washington Mental Health Referral Services for Children and Teens	Phone: **833-303-5437** Website link **seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/washingtons-mental-health-referral-service-children-teens**
WISE (Wraparound with Intensive Services) for children and youth	HCA Website Link **Wraparound with Intensive Services (WISe) | Washington State Health Care Authority**
Wellpoint ABA Line	Phone: **833-324-2088** Assistance with accessing ABA services for members
Washington Justice Support Team	Support and connection to services for Wellpoint members (adults and youth) experiencing or who have experienced any type of incarceration. CJTeam_wa@wellpoint.com
Claims Information	**Submit claims online at** Availity.com. Check claims status online (access from the Claims & Payments tab) or through our IVR system • Submit Electronic Data Interchange (EDI) claims using your vendor or Clearinghouse. Electronic claims payer ID for clearinghouse: • Availity: WLPNT Paper claims can cause payment delays. To file your claim online, log onto **Availity.com** and select the Claims & Payments tab. Mailing address: Washington Claims

Department	Details
	Wellpoint P.O. Box 61010 Virginia Beach, VA 23466-1010 Timely filing is defined in your provider contract; please refer to your contract for timely filing standards for both original and adjusted claims.
Critical Incident Reporting	Critical incidents must be reported to Wellpoint within one business day of occurrence or provider awareness. Reporting forms and instructions are available online at provider.wellpoint.com/wa > Resources > Forms
Member Eligibility	Phone: **833-731-2274** Monday through Friday, 8 a.m. to 5 p.m. PT Using Availity Essentials Eligibility and Benefits application accessed under the Patient Registration tab located at Availity.com. provider.wellpoint.com/wa or waproviderone.org
Medical Necessity Appeals	A medical necessity denial appeal must be filed within 60 calendar days from the date of the denial notification and prior to claim submission. If a claim has been submitted, see the claim payment dispute section for more details. You may appeal on behalf of a member with written authorization from that member. Members/providers should submit medical necessity appeals by mail or fax: Mail: Attn: Appeal Department Wellpoint 705 Fifth Ave. S., Suite 300 Seattle, WA 98104 Fax: **844-759-5953**
Administrative Appeals	Appeals of administrative denials (for untimely notification of inpatient admissions or for untimely

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	submission of clinical information) must be filed within 60 days of the date of denial letter, unless extension clauses apply. Refer to your provider contract for information on extensions. Providers should submit administrative denial appeals to: Attn: Appeal Department Wellpoint 705 Fifth Ave. S., Suite 300 Seattle, WA 98104
Provider Data Solutions Intake — Contract and Credentialing	Nonparticipating providers needing to contract and initial credentialing for a provider on an existing contract can submit their request via Availity Essentials. Log on to the Availity Essentials Portal and select Payer Spaces > Wellpoint > Applications > Provider Enrollment and Network Management to begin the enrollment process. If your organization is not currently registered for the Availity Essentials, the person in your organization designated as the Availity Essentials administrator should go to Availity.com and select Register. For organizations already using Availity Essentials, your organization's Availity Essentials administrator should go to My Account Dashboard from the Availity Essentials homepage to register new users and update or unlock accounts for existing users. Staff who need access to the provider enrollment tool need to be granted the role of provider enrollment. Availity Essentials administrators and user administrators will automatically be granted access to provider enrollment. If you are using Availity Essentials today and need access to provider enrollment, work with your organization’s administrator to update your Availity Essentials role. To determine who your administrator is, you can go to My Account Dashboard > My

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	Administrators. Need assistance with registering for Availity Essentials? Contact Availity Essentials Client Services at **800-282-4548.**
Provider Data Solutions Intake — Provider Rosters	**Facility-Based Rosters** Submit facility-based rosters to Availity.com >Payer Spaced> My Providers> Provider Data Management> select the TIN/Business you are managing> under the menu select Upload Roster. Standalone facilities and federally qualified health center/rural health clinic/Tribal groups. Rosters must be submitted on the appropriate template for hospital-based and facility-based providers. This roster template is located on our provider website: Provider.wellpoint.com/wa> Resources>forms>demographic updates> WA standard template file. * Tribal groups- We highly encourage roster submission to Wellpoint. Rosters are not required but highly recommended for accurate provider data in our system, which supports clean claim reimbursement. **Delegated Provider Groups** Submit facility-based rosters to Availity.com >Payer Spaced> My Providers> Provider Data Management> select the TIN/Business you are managing> under the menu select Upload Roster.
Provider Data Solutions Intake — TIN Changes	See Provider Data Solutions Intake — Demographic Updates below
Provider Data Solutions Intake — Demographic Updates	Use the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all professional and facility care providers.* The PDM application is now the intake tool for care providers to submit demographic change requests, including submitting roster uploads. If preferred, providers may continue to utilize the Provider

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	Enrollment application in Availity Essentials to submit requests to add new practitioners under existing groups for available provider types. Within the PDM application, providers have the choice and flexibility to request data updates via the standard PDM experience or by submitting a spreadsheet via a roster upload. Roster Upload is our new technology solution designed to streamline and automate provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel document. Any provider, whether an Individual provider/practitioner, group, or facility, can use Roster Upload today.** The resources for this process are listed below and available on our website. Visit provider.wellpoint.com/wa, then under For *Providers*, select **Forms and Guides**. The Roster Automation Rules of Engagement and Roster Automation Standard Template appear under the Digital Tools category: • **Roster Automation Rules of Engagement:** Is a reference document, available to ensure error-free submissions, driving accurate and more timely updates through automation. • **Roster Automation Standard Template:** Use this template to submit your information. More detailed instructions on formatting and submission requirements can also be found on the first tab of the Roster Automation Standard Template (*User Reference Guide*). • Upload your completed roster via the Availity PDM application. Accessing PDM Application: • Log onto Availity.com 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

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	option on the right side of the window, and select Upload Rosters (see screen shot below) and follow the prompts. • Availity Administrators will automatically be granted access to PDM. Additional staff may be given access to Provider Data Management by an administrator. To find your administrator, go to My Account Dashboard > My Account > Organization(s) > Administrator Information. * Exclusions: Any specific state mandates or requirements For Provider demographic updates ** If any roster data updates require credentialing, Your submission will be routed appropriately for further action.
Provider Grievance	Provider grievances may be filed at any time by mail to: Attn: Appeal Department Wellpoint 705 Fifth Ave. S., Suite 300 Seattle, WA 98104 • Note: Providers may not file a grievance on behalf of a member without written authorization.
Physical Health Prior Authorizations and Notifications	Online: • provider.wellpoint.com/wa • Availity.com Fax: **855-231-8664** Phone: **833-731-2274** Monday through Friday, 8 a.m. to 5 p.m. PT Please provide the following: • Member or Apple Health ID • Member's date of birth • Legible name of referring provider • Legible name of person referred to provider • Number of visits/services • Date(s) of service • Diagnosis

Department	Details
	• CPT/HCPCS codes • Clinical information
Pharmacy Prior Authorizations	Online: covermymeds.com Phone: **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT** Fax: **844-493-9207**
Behavioral Health and Substance Use Disorder Prior Authorizations/Notifications	Phone: **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT** Online requests: Availity.com. Honor Authorization request fax: **844-430-6806** If you prefer to paper fax, fax forms can be located at provider.wellpoint.com/wa
Claim Payment Disputes	We have several options to file claim payment disputes: • Online (for reconsiderations and claim payment appeals): Use the secure Provider Availity Essentials Claim Status application to locate the claim and initiate a claim payment dispute or appeal at Availity.com. Through Availity, you can upload supporting documentation and receive immediate acknowledgement of your submission. • Verbally (for reconsiderations only): Call Provider Services at **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT**. If you need to include supporting documentation (in other words, EOB, Consent Form, Medical Records, etc.), —Please do not use this option. • Written (for reconsiderations and claim payment appeals): Mail all required and supporting documentation to: Payment Dispute Unit Wellpoint P.O. Box 61599 Virginia Beach, VA 23466-1599 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 number or TIN

<table>
<tr><th>Department</th><th>Details</th></tr>
<tr><td></td><td>The member's name and his or her Wellpoint or Apple Health ID number
A listing of disputed claims including the Wellpoint claim number and the date(s) of service(s)
All supporting statements and documentation</td></tr>
<tr><td>Electronic remittance advices (ERA) & Electronic funds transfers (EFT)</td><td>Electronic claims payment through EFT is a secure and fastest way to receive payment reducing administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

These enhancements offer providers streamlined reimbursement registration tools.

The following chart summarizes information about the new processes to enroll in EFT or ERA or to update EFT and ERA transaction information

<table>
<tr><th>Type of trans-action</th><th>How to enroll, update, change or cancel</th><th>Contact to resolve issues</th></tr>
<tr><td>EFT only</td><td>enrollsafe.payeehub.org</td><td>877-882-0384
support@payeehub.org</td></tr>
<tr><td>ERA only</td><td>Register for ERAs at Availity.com.
Availity 800-282-4548</td><td>Availity 800-282-4548</td></tr>
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</td></tr>
</table>

Most questions and issues can be resolved by using the Wellpoint provider self-service tools. Please use Availity Essentials for inquiries like payment disputes, provider data updates, claims status, member eligibility, etc. You can also live chat with a Wellpoint associate from within Availity Essentials.

For other issues, you can message Provider Relations and your Provider Relations representative will respond – usually within two business days. You can utilize this feature by visiting the contact us page at the Wellpoint website.

CREDENTIALING SERVICES

3.1 Credentialing

Wellpoint Discretion

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

Credentialing Scope

Credentialing requirements apply to the following:

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

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

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

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

- Medical Doctors (MD)

Doctors of Osteopathic Medicine (DO)

- Doctors 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 Health Care specialists who provide treatment services under the Health Benefit Plan
- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (for example, physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dietitians

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

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Use Disorder Practitioners

Wellpoint credentials the following Health Delivery Organizations (HDOs):

- Hospitals
- Home Health agencies

- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance use disorder treatment in inpatient, residential or ambulatory settings, including:
  - Adult Family Care/Foster Care Homes
  - Ambulatory Detox
  - Community Mental Health Centers (CMHC)
  - Crisis Stabilization Units
  - Intensive Family Intervention Services
  - Intensive Outpatient – Mental Health and/or Substance Use Disorder
  - Methadone Maintenance Clinics
  - Outpatient Mental Health Clinics
  - Outpatient Substance Use Disorder Clinics
  - Partial Hospitalization – Mental Health and/or Substance Use Disorder
  - Residential Treatment Centers (RTC) – Psychiatric and/or Substance Use Disorder
    - Birthing Centers
    - Home Infusion Therapy when not associated with another currently credentialed HDO

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

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

Credentials Committee

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

The CC will meet at least once every 45 calendar days. The presence of a majority of voting

CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated. In states or regions where a Wellpoint affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or a Wellpoint medical director designee and the vice-chair must be a lead medical officer or a Wellpoint medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (for example, nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (for example, Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels 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 Wellpoint networks

or plan programs. For practitioners, the Council for Affordable Quality Healthcare (CAQH) ProView system is utilized. To learn more about CAQH, visit their web site at caqh.org.

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

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

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, NIAHO, CIHQ or HFAP accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state-controlled substance registrations • 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 Wellpoint 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 Wellpoint 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 Wellpoint intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of the Wellpoint 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 the Wellpoint determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

Reporting Requirements

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

Wellpoint Credentialing Program Standards

Eligibility Criteria

A. Healthcare practitioners:

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

- Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;
- Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to members;
- Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to 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
- Meet the education, training and certification criteria as required by Wellpoint.

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

- For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American

Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.

- If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
- If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
- Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:

1. 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;
2. 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
3. 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 Wellpoint network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

Practitioners meeting one of these three alternative criteria (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.

- 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.

- 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):

- Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
- Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
- Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
- No evidence of potential material omission(s) on application.
- Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members.
- No current license action.
- No history of licensing board action in any state.
- No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
- Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to 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.
- 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:
  - It can be verified that this application is pending.
  - The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the

alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber;
- The applicant agrees to notify Wellpoint upon receipt of the required DEA/CDS registration.
- Wellpoint will verify the appropriate DEA/CDS registration via standard sources.
- The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day timeframe will result in termination from the Network.

Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing the 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:

1. It can be verified that the applicant's application is pending; and
2. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
3. The applicant agrees to notify Wellpoint upon receipt of the required DEA registration; and
4. Wellpoint will verify the appropriate DEA/CDS registration via standard sources; and
5. 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:

1. 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
2. he or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber; and
3. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.
    a. 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.

b. No history of or current use of illegal drugs or history of or current substance use disorder.
c. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
d. 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.
e. 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.
f. A minimum of the past 10 years of malpractice claims history is reviewed.
g. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in the Wellpoint 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;
h. No involuntary terminations from an HMO or PPO.
i. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
    i. Investment or business interest in ancillary services, equipment or supplies;
    ii. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    iii. Voluntary surrender of state license related to relocation or nonuse of said license;
        a. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
        b. 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);
        c. 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.
        d. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
        e. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

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

Participation Criteria and Exceptions for Non-Physician Credentialing.

The following participation criteria and exceptions are for non-MD practitioners. It is not additional or more stringent requirements, but instead the criteria and exceptions that apply for these specific provider types to permit a review of education and training.

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

2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC) or other master level license type:
    a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
    b. Master or doctoral degrees in divinity, masters in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
    c. Practitioners with PhD training as a clinical psychologist can be reviewed.
    d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
    e. Licensure to practice independently or in states without licensure or certification:
        i. Marriage & Family Therapists with a master's degree or higher:
            a. Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).
        ii. Mental Health Counselors with a master's degree or higher:
            a. Provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) (proof of NBCC certification required) or meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).

3. Pastoral Counselors:
    a. Master's or doctoral degree in a mental health discipline.

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

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

4. Clinical Psychologists:
   a. Valid state clinical psychologist license.
   b. Doctoral degree in clinical or counseling, psychology or other applicable field of study.
   c. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

5. Clinical Neuropsychologist:
   a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
   b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
   c. Clinical neuropsychologists who are not board certified, nor listed in the National

Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:

i. Transcript of applicable pre-doctoral training;
ii. Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
iii. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
iv. Minimum of five years' experience practicing neuropsychology at least ten hours per week.

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

7. Process, requirements and Verification – Nurse Practitioners:
   a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
   b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
   c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
   d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be

requested and primary source verified via normal Wellpoint procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.

e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
   i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
   ii. American Academy of Nurse Practitioners – Certification Program;
   iii. National Certification Corporation;
   iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner);
   v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
   vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

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

f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP

g. The NP applicant will undergo the standard credentialing processes outlined in the Wellpoint Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

h. Upon completion of the credentialing process, the NP may be listed in the 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. NPs will be clearly identified:
   I. On the credentialing file;
   II. At presentation to the CC; and
   III. Upon notification to network services and to the provider database.

8. Process, Requirements and Verifications – Certified Nurse Midwives:
   a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.

b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Wellpoint procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
e. All CNM applicants will be certified by either:
    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 committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
g. The CNM applicant will undergo the standard credentialing process outlined in the 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.

i. Upon completion of the credentialing process, the CNM may be listed in the 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.
ii. CNMs will be clearly identified:
    1. On the credentialing file;
    2. At presentation to the CC; and
    3. Upon notification to network services and to the provider database.

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

committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.

g. The PA applicant will undergo the standard credentialing process outlined in the 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:
j. On the credentialing file;
k. At presentation to the CC; and
l. 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 Wellpoint Plan programs or provider Networks, federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Networks as well as the Wellpoint other credentialed provider Networks.
4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;

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

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

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

B. HDO Eligibility Criteria

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

- General Criteria for HDOs:
- Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
- Valid and current Medicare certification.
- Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in the Wellpoint Plan programs or provider Networks, exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Networks as well as the Wellpoint other credentialed provider Networks.
- Liability insurance acceptable to Wellpoint.
- If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if the Wellpoint quality and certification criteria standards have been met.

Additional Participation Criteria for HDO by Provider Type:

HDO Type and Wellpoint Approved Accrediting Agent(s)

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

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Skilled Nursing Facilities/Nursing Homes	CARF, TJC

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

Facility Type (Behavioral Health Care -Rehabilitation)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	TCT, DNV/NIAHO, HFAP, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Use Disorder Clinics	CARF, TJC, COA,

3.2 Delegated Credentialing

Provider groups with strong credentialing programs that meet Wellpoint credentialing standards may be evaluated for delegation. As part of this process, Wellpoint will conduct a pre-delegation assessment of a group's credentialing policy and program as well as an onsite evaluation of credentialing files. A passing score is considered to be an overall average of 95-percent compliance. If deficiencies are identified, the group is expected to submit an acceptable corrective action plan within 30 days of receipt of the audit results. If there are serious deficiencies, we will deny the delegation or will restrict the level of delegation.

We may waive the need for the pre-delegation onsite audit if the group's credentialing program is NCQA-certified for all credentialing and recredentialing elements.

Wellpoint is responsible for ongoing oversight of any delegated credentialing arrangement and will schedule appropriate reviews. The reviews are held at least annually.

3.3 Digital Provider Enrollment

Digital provider enrollment (DPE) is currently only available for professional practitioners.

Note: Enrollment for providers in a hospital, Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Behavioral Health Agency (BHA), Tribal Health Clinic should submit an email here: provider.wellpoint.com/washington-provider/contact-us.

Updates to any existing Wellpoint participating providers should be submitted through Provider Data Management at Availity.com.

With DPE, you can:

- Apply to add new practitioners to an already existing group
- Apply and request a contract to enroll a new group of practitioners
- Monitor submitted applications statuses real-time with a digital dashboard

How the online enrollment application works

Your professional and practice details from Council for Affordable Quality Healthcare (CAQH) ProView is populated with the information Wellpoint needs to complete the enrollment process — including credentialing, claims, and directory administration. Please ensure your provider information on CAQH is updated and in *complete* or *re-attested* status.

The online enrollment application will guide you through the process, and a dashboard will display real-time application statuses. You will know where each provider is in the process without having to call or email for a status.

Accessing the provider enrollment application

Log onto Availity.com and select **Payer Spaces > Wellpoint > Applications > Provider Enrollment** to begin the enrollment process.

If your organization is not currently registered for Availity Essentials, the person in your organization designated as the Availity Essentials administrator should go to Availity.com and select **Register.** For organizations already using Availity Essentials, your administrator(s) will automatically be granted access to the provider enrollment tool.

Staff using the provider enrollment tool need to be granted the user role **Provider Enrollment** by an administrator. To find yours, go to **My Account Dashboard > My Account > Organization(s) > Administrator Information.**

The following provider types may be submitted as Primary Care Providers *or* Specialty Care Providers depending on their clinical role:

- Advanced Registered Nurse Practitioners
- Naturopathic Physicians
- Osteopathic Physicians
- Osteopathic Physician Assistants
- Physicians
- Physician Assistants

The following provider types should be submitted as Specialty Care Providers:

- Anesthesiologists
- Behavior Analysts (including ABA, LABA, and CBT)
- Chemical Dependency
- Chiropractors
- Marriage and Family Therapists
- Mental Health Counselors
- Midwives
- Nurse Anesthetist
- Pharmacists
- Podiatric Physicians
- Psychiatrists

- Psychologists
- Radiologists
- Social Workers
- Substance Use Disorder Professionals

The following provider types should be submitted as Specialty Care Providers if joining an existing group however as Ancillary if requesting a new contract:

- Audiologists
- Dietitians or Nutritionists
- Hearing Aid Fitters/Dispensers
- Occupational Therapists
- Physical Therapists
- Speech/Language Pathologists

The following provider types are Ancillary Providers:

- Ambulance
- Cardiac Event Monitoring
- Dialysis Facilities
- Durable Medical Equipment
- Hearing Aid Distributor
- Home Health Agencies
- Hospice Facilities
- Infusion Therapy
- Laboratory
- Orthotic Supplier
- Prosthetic Supplier
- Skilled Nursing Facilities

3.4 Peer Review

We continuously monitor the quality and appropriateness of care of our practitioner and provider network through peer review.

Peer review responsibilities are to:

- Participate in the established peer review system.
- Review and make recommendations regarding individual provider peer review cases.
- Work in accordance with the executive medical director.

If an investigation of a member grievance results in concerns regarding your compliance with community standards of care or service, all elements of peer review will be followed.

We apply dissatisfaction severity codes and levels of severity to quality issues. Peer review includes investigation of physician actions by the medical director.

The medical director:

- Assigns a level of severity to the grievance.
- Invites the cooperation of the physician.
- Consults with and informs the MAC.
- Informs the physician of the committee's decision, recommendations, follow-up actions and/or
- disciplinary actions to be taken.

We report outcomes to the appropriate internal and external entities, including the quality management committee.

The peer review process is a major component of the MAC monthly agenda. The peer review policy is available upon request.

ENROLLMENT

4.1 Provider Roster

To support with proper claims reimbursement, it is essential to notify Wellpoint about any demographic and/or roster changes prior to 30 days of the specified change. Please see Provider Data Solutions Intake — Demographic Updates.

In order to ensure accurate provider loading:

- Confirm all columns are populated
- Do not change the layout of the columns
- If a provider has multiple practicing locations, please add the locations on separate lines

PROVIDER RIGHTS & RESPONSIBILITIES

5.1 Marketing: Prohibited Provider Activities

Wellpoint and its subcontractors, including healthcare providers, are prohibited from engaging in the following, which are considered to be member marketing activities:

- Distributing plans and materials or making any statement (written or verbal) that the Washington State Health Care Authority (HCA) determines to be inaccurate, false, confusing, misleading or intended to defraud members or HCA; this includes statements which mislead or falsely describe covered services, membership, availability of providers, qualifications and skills of providers or assertions the recipient of the communication must enroll in a specific health plan in order to obtain or not lose benefits.
- Distributing marketing materials (written or verbal) that have not been reviewed and approved in advance by the HCA.
- Asserting that Wellpoint or any other HCA participating managed care organization (MCO) is endorsed by the Centers for Medicare & Medicaid Services, the federal or state government, or similar entity.
- Influencing enrollment in conjunction with the sale or offer of any private insurance.
- Assisting with enrollment or improperly influencing HCA participating selection.
- Inducing or accepting a member's enrollment or disenrollment.
- Using the seal of the state of Washington or the HCA name, logo or other identifying marks on any materials produced or issued without the prior written consent of HCA.
- Distributing marketing information (written or verbal) that implies joining HCA MCO networks or a particular HCA MCO network is the only means of preserving Apple Health coverage, that HCA MCO networks or a particular HCA MCO network is the only provider of Apple Health services and the potential enrollee must enroll in the HCA MCO network or networks to obtain benefits or not lose benefits.
- Offering gifts or material (either provided by Wellpoint or a third-party source) with financial value or financial gain as incentive to or conditional upon enrollment; promotional items having no substantial resale value (for example, $10 or less) are not considered things of financial value; cash gifts of any amount, including contributions made on behalf of people attending a marketing event, gift certificates or gift cards are not permitted to be given to enrollees or the general public.
- Charging members a fee for accessing the Wellpoint or HCA website.

5.2 Records Standards: Member Medical Records

Wellpoint requires 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 must be permanently maintained at the primary care site.

Members are entitled to one copy of their medical record each year, and the copy is provided at no cost to the member. Members or their representatives should have access to these records. Members are entitled to request their medical records be amended or corrected.

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 ten years from the date of service. Upon request, providers shall provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the premises to reasonable accommodate HCA, MFCD, or other state or federal agency. Medical Records shall be kept in accordance with all applicable WACS and federal guidelines.

Behavioral Health Clinical Record Set

Behavioral health agencies and practitioners must maintain current records at the primary location of service. Records must be maintained in accordance with practitioner or agency licensure, per state and federal guidelines.

Our medical and behavioral health clinical records standards include:

- Patient identification information (in other words, patient name or ID number): must be shown on each page or electronic file
- Personal/biographical data: age, sex, address, employer, home and work phone 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
- Medical information: include medication and instruction to patient
- Identification of current problems:
  - Serious illnesses
  - Medical and behavioral conditions
  - Health maintenance concerns
- Instructions: include 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.
- Evidence of completion of the GAIN-SS screening and indicated referrals

- 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 directive: must document whether the patient has executed an advance directive, such as a living will, durable power of attorney or mental health advance directive

Documentation Standards for an Episode of Care

Refer to the standard data elements to be included for specific episodes of care as established by applicable WACs, your accrediting body such as The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities, etc. 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:
- 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 (for example, handwritten signatures, unique electronic identifiers or initials)

When we request clinical documentation from you to support claim payments for services, you must ensure the information provided to us:
- Identifies the member.
- Is legible.
- Reflects all aspects of care.

Wellpoint may request that you submit additional documentation, including medical records, patient visit 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.

5.3 Rights of our providers

Each network provider who contracts with Wellpoint to furnish services to members has the right to:

- While acting within the lawful scope of practice, advise or advocate on behalf of a member who is his or her patient regarding:
  - The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered.
  - Any information the member needs in order to decide among all relevant treatment options.
  - The risks, benefits and consequences of treatment or non-treatment.
  - The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment and express preferences about future treatment decisions.
- Receive information on the grievance, appeal and state fair hearing procedures.
- Have access to Wellpoint policies and procedures covering the authorization of services.
- Be notified of any decision by Wellpoint to deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested.
- Challenge on the member's behalf, at the request of the Apple Health/CHIP member, the denial of coverage or payment for medical assistance.
- Be free from discrimination where Wellpoint selection policies and procedures govern
- particular providers that serve high-risk populations or specialize in conditions that require
- costly treatment.
- Be free from discrimination for the participation, reimbursement or indemnification of any
- provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

5.4 Support & Training for Providers

Support

We support our providers by offering meaningful online tools and telephonic access to Provider Services and local Provider Relations.

- Providers Services supports provider inquiries about member benefits and eligibility, authorizations, and claims..
- Provider Relations are assigned to participating providers; they facilitate provider orientations and education programs that address Wellpoint policies and programs.

Wellpoint also provides communications to providers through newsletters, alerts and updates. These communications are posted to our provider website and may also be sent to providers via email, fax or regular mail.

Training

Wellpoint ensures contracted providers are procedures and other guidelines relevant to their services. Providers receive ongoing education on a weekly, monthly, quarterly and yearly basis on topics identified by the health plan. In addition, training is developed and provided annually in collaboration with other managed care or administrative service organizations. These topics are derived from the following:

- State and federal laws and regulations pertaining to Apple Health and/or Medicare
- State contracts
- HCA expectations
- NCQA standards
- Health plan policies and procedures
- Provider requests
- Other relevant sources

Changes to relevant requirements — including contract, state and federal regulations, and company policies — are carefully monitored and communicated to providers.

Wellpoint, in partnership with other MCOs, makes every effort to simplify mandated annual providers training requirements through partnership and collaboration with the Health Care Authority. These trainings may be offered by one MCO but be sufficient to meet all MCOs requirements for annual training. Trainings may be offered in person, electronically or in written form. Providers are required to track completion of all mandatory training requirements per federal and state rules for all applicable employees. Requests for training to meet mandated requirements can be made to Wellpoint or any other MCO.

Newly contracted providers complete their initial training through the provider onboarding process within 30 days of participating status date or contract effective date. New and existing providers can enroll in the Wellpoint Provider Pathways digital provider orientation, a 24/7 educational resource for doing business with Wellpoint. Provider Pathways is a self-paced, individualized orientation. Providers can enroll on the Wellpoint provider website at provider.wellpoint.com/wa > Resources > Training Academy.

Ongoing training requirements and opportunities are communicated to providers in a variety of ways including the following:

- Provider website (both public and secure)
- Provider visits by Provider Relations or other staff
- Workshops and in-service presentations by health plan associates
- Broadcast faxing
- Provider mailings
- Customer care representatives from our Provider Services team

- Provider web demonstrations and web tutorials
- Emails from Provider Relations or other associates

Our comprehensive training plan outlines essential topics, timelines and methods for provider training. It is available at provider.wellpoint.com/wa.

5.5 Missed Appointments

At times, members may cancel or not attend necessary appointments and fail to reschedule, which can be detrimental to their health. You should attempt to contact any member who has not shown up for or canceled an appointment without rescheduling. Contact the member by phone to:

- Educate the members about the importance of keeping appointments.
- Encourage the member to reschedule the appointment.

For members who frequently cancel or fail to show up for appointments, please call Provider Services at **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT** to address the situation. 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 PCPs.

We have a comprehensive program to meet our members' physical and behavioral health needs . The case management team consists of adult, pediatric, NICU and OB, substance use disorder, and behavioral health case managers. Once we have identified a member's need, an appropriate nurse or mental health professional will work with that member and the member's providers to address issues such as:

- Gaps in care
- Barriers to care
- Understanding diagnosis(es), medication, or treatment interventions
- Appropriate level of care
- Needed healthcare services
- Medical equipment and/or supplies
- Community-based services.
- Communication between the member and their PCP or specialty provider

Wellpoint provides comprehensive case management and support for all members transitioning in and out of incarceration. This includes transitions from city, county and Tribal jails, juvenile detention, Juvenile Rehabilitation and Department of Corrections facilities. Referrals can be made to CJTeam_wa@Wellpoint.com

For members who are hospitalized, our case managers will also work with the member, utilization review team, PCP or hospital, and any follow-up providers to develop a safe discharge plan of care and link the member to:

- Community resources
- Needed follow-up appointments
- New medication access and education
- Our internal and external outpatient programs
- Our Condition Care programs
- Behavioral Health Services including mental health services and substance use disorder treatment services

5.6 Member Assessment

Our case manager conducts a comprehensive assessment to determine members' needs, evaluating their:

- Medical condition
- Social determinants of health
- Functional status
- Healthcare Goals
- Life environment
- Support systems
- Behavioral health status
- Ability for self-care
- Current treatment plan

Through communication with members or members' representatives and information from PCPs and specialists, our case manager will coordinate current physical and behavioral health needs and develop a plan of care. A member or member's representative must provide consent to participate in the case management program.

Plan of Care

After assessing a member's needs, our case manager:

- Determines the appropriate level of case management services
- Guides, develops and implements an individualized plan of care or treatment plan
- Works with the member, the member's representative and his or her family and provider as appropriate

Research has shown that our members comply with their treatment plans more when they can make their own healthcare decisions.

Case managers consider our members' needs for:

- Social services
- Educational services
- Therapeutic services
- Other nonmedical support services (personal care, WIC, transportation)

Case managers also consider the strengths and needs of our members' families.

Our case manager nurses and social workers collaborate and coordinate with member advocates or outreach associates to define ways to coordinate physical health, behavioral health, pregnancy and social services. We then make sure we forward all written care plans to you by fax or mail.

We welcome your referrals of patients who can benefit from our case management support. Please call Wellpoint Provider Services **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT**, visit provider.wellpoint.com/wa or email cmrefwash@Wellpoint.com with any referrals or for more information. For BH specific referrals please send directly to wabhreferrals@Wellpoint.com.

5.7 Out of Network Providers

Out-of-network providers must obtain prior authorization for all non-emergent services and ensure any cost to the member is no greater than it would be if services were furnished as a participating provider.

5.8 Satisfaction Surveys

Wellpoint will conduct an annual survey to assess provider satisfaction with provider enrollment, communications, education, complaints resolution, claims processing, claims reimbursement and utilization management processes, including medical reviews and support toward patient-centered medical home implementation.

Our provider satisfaction survey tool and methodology will be submitted to the Washington State Health Care Authority (HCA) for approval prior to administration. A results report summarizing the survey methods, findings and analysis of opportunities for improvement will be provided to HCA for review within 120 days after the end of the plan year.

5.9 Condition Care

Our Condition Care (CNDC) program is based on a system of coordinated care management interventions and communications designed to help physicians and other healthcare professionals manage members with chronic conditions. CNDC services include a holistic, focusing on the needs of the member through telephonic and community-based resources. Motivational interviewing techniques used in conjunction with member self-empowerment. The ability to manage more than one condition to meet the changing healthcare needs of our member population. Our condition care programs include the following:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disorder (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder – adult
- Major depressive disorder – child/adolescent
- Schizophrenia
- Substance abuse disorder addition to our condition-specific condition care programs, our member-centric, holistic approach also allows us to manage members with smoking cessation and weight management education.

Program Features

- Proactive population identification process
- Evidence-based clinical practice guidelines from recognized sources
- Collaborative practice models that include the physician and support providers in treatment planning
- Continuous self-management education
- Ongoing communication with primary and ancillary providers regarding patient status
- Nine of our Condition Care programs are National Committee for Quality Assurance accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care.

Additionally, all our programs are based on nationally approved clinical practice guidelines are located at provider.wellpoint.com/wa. A copy of the guidelines can be printed from the website.

Who Is Eligible?

Members diagnosed with one or more the above conditions are eligible for CNDC services.

As a valued provider, we welcome provider referrals for patients who can benefit from additional education and care management support. Our case managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk-stratified based on the severity of their condition. They are provided with continuous education on self-management concepts, which include primary prevention, coaching related by healthy behaviors and compliance/monitoring as well as case/care management for high-risk members. Providers are given telephonic and/or written updates regarding patient status and progress.

Condition Care Rights and Responsibilities

You have the right to:

- Obtain information about the organization's services, staff qualifications and any contractual relations.
- Decline to participate in or work with any of our programs and services for your patients.
- Be informed of how we coordinate our interventions with your patients' treatment plans.
- Know how to contact the case manager responsible for managing and communicating with your patients.
- Be supported by our organization when interacting with members to make decisions about their healthcare.
- Receive courteous and respectful treatment from our staff.
- Communicate complaints to the organization.

Hours of Operation

Our CNDC case managers are registered nurses. They are available Monday-Friday from 8:30 a.m.-5:30 p.m. local time. Confidential voice mail is available 24 hours a day. The Nurse Helpline is available for our member 24 hours a day, 7 days a week.

Contact

You can call a CNDC team member at 888-830-4300. Additional information about CNDC program content is located at provider.wellpoint.com/wa. Members can obtain information about CNDC program by visiting wellpoint.com/wa/medicaid or calling **888-830-4300** (**TTY 711**).

Health Management: Healthy Families

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

5.10 Provider Directories

Wellpoint makes provider directories available to members in online searchable and hard-copy formats. Since use of these directories is how members identify healthcare providers near them, it is important that your practice address/addresses, doctors' names and contact information are promptly updated when changes occur. You can update your practice information by:

- Can be update via a Provider Roster Submission
- Utilize the Chat function through the Availity Essentials portal. Select Payer Spaces > Applications > Chat with Payer to start a live chat.
- Calling Provider Services.

5.11 Urgent Care/After Hours Care

We require our members to contact their PCPs or treating provider if they need urgent care. If you are unable to see the member, you can refer him or her to one of our participating urgent care centers or another provider who offers after-hours care. Prior authorization is not required.

We strongly encourage PCPs and behavioral health providers to provide evening and Saturday appointment access. To learn more about participating in the after-hours care program, call your local Provider Relations.

5.12 Culturally & 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. Wellpoint encourages 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 LGBTIA+ patients often feel about seeking medical care, learn key health concerns of LGBTIA+ patients, & develop strategies for providing effective healthcare to LGBTIA+ 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 & 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 Healthcare Stereotype Threat (HCST): Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

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

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients.

Please see section 5.22 Interpreter Services for the language supports available to our members.

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

5.13 Research, Evidence-Based and Promising Practices

We support the use of research, evidence-based and promising practices (R/EBPs) in all healthcare services. We participate in state initiatives focused on increasing the use of R/EBPs in mental health services provided to youth through:

- Monitoring provider network training and certification in R/EBPs, particularly TF-CBT and CBT+.
- Reporting additional coding on eligible services; these services can occur within the primary care setting or be provided by a qualified mental health practitioner.

Reporting expectations for the use of R/EBPs in youth mental health treatment are outlined in policy and developed in accordance with HCA reporting guidelines and the University of Washington's *Evidence-Based Practice Institute Reporting Guidelines*.

Reporting guidelines and R/EBPs resources for mental health practitioners are located at hca.wa.gov/assets/program/ebp-reporting-guides.pdf. We encourage providers to access

available training on CBT+, TF-CBT and other modalities as offered and coordinated by the University of Washington's Evidence-Based Practice Institute (go to depts.washington.edu/uwhatc/training/ or call **206-744-1679** for more information).

Guidelines focused on mental health services occurring in the primary care setting and provided by PCPs are available on the HCA website at hca.wa.gov/about-hca/behavioral-health-recovery/evidence-based-and-research-based-practices.

Additional instructions for both medical and behavioral health providers on R/EBP reporting are available at provider.wellpoint.com/wa.

5.14 Quality Management Program

We have a comprehensive Quality Management Program (QMP) to monitor the demographic and epidemiological needs of the population served. You have opportunities to make recommendations for areas of improvement.

We evaluate the needs of the health plan's specific population annually so we can define high volume, high-risk and problem-prone conditions. Examples include:

- Members' demographic distribution
- Inpatient, emergent/urgent care
- Office visits by type, cost and volume

Practitioners and providers must allow Wellpoint to use performance data in cooperation with our QMP and activities. Interpretation of data from the Quality Improvement program is available by calling **206-695-7081,** ext. **106-103-5172**.

5.15 Quality of Care

We evaluate all physicians, advanced registered nurse practitioners and physician assistants for compliance with:

- Medical community standards;
- External regulatory and accrediting agencies' requirements;
- Contractual compliance.

We share these reviews to enable you to increase individual and collaborative rates for members. Our QMP includes a review of quality of care issues for all care settings using:

- Member grievances
- Reported adverse events
- Critical incidents
- Other information, such as members' gaps in care data

The results submitted to our Quality Management department are incorporated into a profile.

5.16 Quality Management Committee

The Wellpoint quality management committee's (QMC) responsibilities are to:

- Establish strategic direction and monitor and support implementation of the QMP;
- Establish processes and structure that ensure compliance with Washington State Health Care Authority (HCA) contract and NCQA standards;
- Review planning, implementation, measurement and outcomes of clinical/service quality improvement studies;
- Coordinate communication of quality management activities among health plans;
- Review HEDIS® data and action plans for improvement
- Review and approve the annual QMP *Program Description*;
- Review and approve the annual work plans for each service delivery area;
- Provide oversight and review of delegated services;
- Provide oversight and review of subordinate committees;
- Receive and review reports of utilization review decisions and take action when appropriate;
- Analyze member and provider satisfaction survey responses;
- Monitor the plan's operational indicators through the plan's senior staff.

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

5.17 Medical Necessity and Clinical Review Criteria

Wellpoint has its own nationally recognized *Medical Policy* process.

These *Medical Policies* are publicly accessible at provider.wellpoint.com/wa > Medical Policies and Clinical UM Guidelines and are the primary benefit plan policies for determining whether services are considered to be a) investigational/experimental, b) medically necessary and c) cosmetic or reconstructive. Paper copies of *Medical Policies* may be requested by calling **206-695-7081**, ext. **106-103-5172**.

- We review for medical necessity using the Apple Health clinical criteria hierarchy. If the criteria do not address the requested service or level of specificity, we move to the next level in the hierarchy:
  - State manuals/state contracts/state policies
  - Federal Medicaid mandates
  - Medical Policies

- Carelon Medical Benefits Management, Inc.
- *Clinical Utilization Management (UM) Guidelines*
- MCG
- Delegated vendor criteria when approved

If and when Wellpoint uses non-licensed review criteria, the following standards apply to the development of the Wellpoint clinical criteria:

- Criteria are developed with involvement from appropriate providers with current knowledge relevant to the content of treatment guidelines under development.
- Criteria are based on review of market practice and national standards/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 development, and the timing and frequency at which the criteria will be evaluated and updated.

Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and utilization management criteria. We also work with network providers to develop clinical practice guidelines of care for our membership. Review criteria are objective and based on medical evidence and nationally recognized standards of care. The medical advisory committee helps us formalize and monitor the clinical practice guidelines and adopt the review criteria.

Wellpoint as a corporation and as individuals involved in UM decisions is governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Wellpoint does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.
- MCG Health or American Society of Addiction Medicine criteria, appropriate to the health need and service provided, will be used when no specific medical policies exist. In the absence of licensed criteria, Wellpoint may use *Clinical UM Guidelines*. A list of the specific *Clinical UM Guidelines* used is posted and maintained on the Wellpoint website and can be obtained in hard copy. The policies described above will support prior

authorization requirements, clinical-appropriateness claims, edits and retrospective review.

Copies of the criteria used in a case to make a clinical determination may be obtained by calling Provider Services or the local Washington health plan offices. Providers may also submit their requests in writing to:

Medical Management
Wellpoint
705 Fifth Ave. S., Suite 300
Seattle, WA 98104

Peer-to-Peer Discussion

If the medical director denies coverage of the request, the appropriate notice of proposed action, including the member's appeal rights, will be mailed to the requesting provider, the member's PCP and/or attending physician, and the member.

If the request does not meet criteria for approval, the requesting provider will be afforded the opportunity to discuss the case with the medical director prior to issuing the denial letter, within the time limits listed below.

- Inpatient/outpatient preauthorization: 2 business days
- Inpatient concurrent stay: 2 business days

Call the Washington medical director at **206-695-7081**, ext. **106-124-5230**.

Medical Advisory Committee

Wellpoint has established a medical advisory committee (MAC) to:

- Assess levels and quality of care provided to members.
- Recommend, evaluate and monitor standards of care.
- Identify opportunities to improve services and clinical performance by establishing, reviewing
- and updating clinical practice guidelines based on review of demographics and epidemiologic information to target high volume, high-risk and problem-prone conditions.
- Oversee the peer review process.
- Conduct network maintenance through the credentialing/recredentialing process.
- Advise the health plan administration in any aspect of the health plan policy or operation
- affecting network providers or members.
- Approve and provide oversight of the peer review process and the Utilization Review Program.
- Approve and make recommendations of the clinical aspects of the QMP.

- Oversee and make recommendations regarding health promotion activities.
- Use an ongoing peer review system to:
- Monitor practice patterns.
- Identify appropriateness of care.
- Improve risk prevention activities.
- Approve clinical protocols/guidelines.
- Review clinical study design and results.
- Develop action plans/recommendations regarding clinical quality improvement studies.
- Consider/act in response to provider sanctions.
- Provide oversight of credentialing committee decisions to credential/recredential providers.
- Approve credentialing/recredentialing policies and procedures.
- Oversee member access to care.
- Review and provide feedback regarding new technologies.
- Approve recommendations from subordinate committees.

5.18 Availity Essentials

The Availity Essentials helps reduce costs and administrative burden. Whether you work with one managed care organization (MCO) or hundreds, Availity Essentials can help you easily submit claims, check eligibility, process payments, submit claim payment disputes and more.

To initiate the registration process, select someone in your organization to be the Availity Essentials administrator for the account to complete the registration process at Availity.com. This individual will be responsible for maintaining users and organization information. After completing registration the Availity Essentials administrator will receive a temporary password to gain access, and then can begin to add users to your organization.

For training, visit Availity.com and select Help & Training > Get Trained to access the Availity Essentials Learning Center. From here, you can sign up for informative webinars and even receive credit from the American Academy of Professional Coders for many sessions.

For any questions or additional registration assistance, contact Availity Essentials Client Services at **800-282-4548, Monday-Friday from 5 a.m.-4 p.m. Pacific time**.

5.19 Provider and Facility Digital Guidelines

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

Wellpoint expects Providers and Facilities will utilize digital tools, unless otherwise prohibited by law or other legal requirements.

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

The Digital Guidelines outline the digital/electronic platforms Wellpoint has available to participating and nonparticipating Providers and Facilities who serve its Members. The expectation of Wellpoint is based on our contractual agreement that Providers and Facilities will use these digital platforms and applications, unless otherwise mandated by law or other legal requirements.
Digital and/or electronic transaction applications are accessed through these platforms:

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

Digital guidelines available through Availity Essentials include:

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

Additional digital applications available to Providers and Facilities include:

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

Wellpoint expects Providers and Facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual

channels (paper, mail, fax, call, chat, etc.). All channels are consistent with industry standards. All EDI transactions use version 5010.

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

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

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

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

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

Section 3: Prior authorization submission, attachment, status, and clinical appeals.

Providers and Facilities should leverage these channels for prior authorization submission, status inquiries and to submit electronic attachments related to prior authorization submissions:

- EDI transaction: X12 278 – prior authorization and referral:
  - Wellpoint supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per *HIPAA*.
- EDI transaction: X12 275 – patient information, including HL7 payload for authorization attachments:
  - Wellpoint supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
- Availity Essentials:
  - Authorization applications include the Availity Essentials multi-payer Authorization and Referral application and the Interactive Care Reviewer (ICR) for authorization submissions not accepted through Availity Essentials' multi-payer application.
    - Both applications enable prior authorization submission, authorization status inquiry and the ability to review previously submitted authorizations.
- Provider desktop integration via B2B APIs:
  - Wellpoint has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Section 4: Claims: submissions, claims payment disputes, attachments, and status

Claim submissions status and claims payment disputes

Providers and Facilities should leverage these channels for electronic Claim submission, attachments (for both pre- and post-payment) and status:

- EDI transaction: X12 837 – Professional, institutional, and dental Claim submission (version 5010):
  - Wellpoint supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per *HIPAA*.
  - 837 Claim batch upload through EDI allows a provider to upload a batch/file of Claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – Claim status inquiry and response:

  - Wellpoint supports the industry standard X12 276/277 transaction set for Claim status inquiry and response as mandated by *HIPAA*.

- Availity Essentials: The Claims & Payments application enables a provider to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.
  - Claim Status application enables a provider to access online Claim status. Access the Claim payment dispute tool from Claim Status. Claims Status also enables online claim payment disputes in most markets and for most claims. It is the expectation of Wellpoint that electronic Claim payment disputes are adopted when and where it is integrated.
- Provider desktop integration via B2B APIs:
  - Wellpoint has also enabled real-time access to Claim Status via APIs, which can be directly integrated within participating vendor's practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Claim attachments

Providers and Facilities should leverage these channels for electronic Claim attachments from Availity.com:

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

Section 5: Electronic remittance advice and electronic claims payment

Electronic remittance advice

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

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

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

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

Electronic claims payment

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

- Electronic Funds Transfer (EFT)

  Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a Provider's or Facility's bank account at no charge for the deposit. Health plans can use a Provider's or Facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.

  To enroll in EFT: Providers and Facilities can register, enroll, and manage account changes for EFT through EnrollSafe at enrollsafe.payeehub.org. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. For help with enrollment, use this convenient EnrollSafe User Reference Manual.

  To disenroll from EFT: Providers and Facilities are entitled to disenroll from EFT. Disenroll from EFT payments through EnrollSafe at enrollsafe.payeehub.org.

- Virtual Credit Card (VCC)

  For Providers and Facilities who don't enroll in EFT, and in lieu of paper checks, Wellpoint is shifting some reimbursements to virtual credit card (VCC). VCC allow Providers and Facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply.
  Note that Wellpoint may receive revenue for issuing a VCC.

Opting out of virtual credit card payment. Providers and Facilities are entitled to opt out of electronic payment. To opt out of virtual credit card payment, there are two options:

- Enrolling for EFT payments automatically opts you out of virtual credit card payments. To receive EFT payments instead of virtual credit cards payments, enroll for EFT through EnrollSafe at enrollsafe.payeehub.org.

  OR

- To opt out of virtual credit card payments, contact Comdata at **800-833-7130** and provide your taxpayer identification number.

- Zelis Payment Network (ZPN) electronic payment and remittance combination

  The Zelis Payment Network (ZPN) is an option for Providers and Facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to **Zelis.com**. Zelis may charge fees for their services. Note that Wellpoint may receive revenue for issuing ZPN.

  ERA through Availity is not available for Providers and Facilities using ZPN.

  To disenroll from ZPN payment, there are two (2) options:

  - Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at enrollsafe.payeehub.org.

    OR

  - To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at **877-828-8770**.

Not being enrolled for EFT, VCC, or ZPN will result in paper checks being mailed.

5.20 Core Provider Agreement Requirements

The Washington State Health Care Authority (HCA) requires all providers who serve Apple Health enrollees through a managed care organization to also hold a Washington State Apple Health *Core Provider Agreement* (*CPA*) with the HCA. If you do not currently have an agreement, you must apply with HCA online at:

hca.wa.gov/billers-providers-partners/become-apple-health-provider/enroll-nonbilling-provider

Providers are not required to accept Medicaid fee-for-service members but must have an active *CPA*. This allows the HCA to ensure specific communications reach all Apple Health providers and all providers specifically adhere to state and federal requirements, which are

also parts of providers' agreements with managed care plans. Instructions on how to become a non-billing provider are available on the HCA website at:

hca.wa.gov/billers-providers-partners/become-apple-health-provider/enroll-nonbilling-provider

As explained by the HCA, if a provider who already has a *CPA* submits a non-billing application, the *CPA* is replaced by the agreement given in the non-billing application.

5.21 24-Hour Nurse Helpline

The 24-hour Nurse HelpLine is a phone, 24-hour triage service Wellpoint members can call to speak with a registered nurse who can help them:

- Find doctors when your office is closed, whether after hours or weekends.
- Schedule appointments with you or other network doctors.
- Get to urgent care centers or walk-in clinics.
- Speak directly with a doctor or a member of the doctor's staff to talk about their healthcare needs.

We encourage you to tell your Wellpoint patients about this service and share about the advantages of avoiding the emergency room when a trip there isn't necessary or the best alternative.

Members can reach the 24-hour Nurse HelpLine at **866-864-2544** (Spanish **866-864-2545**). **TTY** services are available for the hearing impaired by dialing 711, and language translation services are also available.

5.22 Critical Incidents

Critical incidents are unexpected events or situations with significant impact on the health and safety of our members or contracted agencies and facilities. We monitor our network of providers and members for critical incidents and report them to the HCA. We ensure adequate follow-up to events, identify trends in incidents, and develop strategies to mitigate risk and prevent future occurrences.

Providers who become aware of a critical incident involving a Wellpoint member must report the incident within one business day of the occurrence or the provider's awareness. Critical incident categories, forms and reporting instructions are available at provider.wellpoint.com/wa > Resources > Forms.

5.23 Interpreter Services

No-cost interpreter services are available to members when they call Wellpoint Member Services for a question about our program, when they call the 24-hour Nurse HelpLine, during appointments with healthcare providers, and during grievance or appeals processes.

Outpatient visits and hearings: The HCA is responsible for payment of interpreter services provided by interpreter agencies contracted with the state.

HCA contracted interpreter services:
Translation Services:

Mail:	Universal Language Services 929 108th Avenue NE, Suite 710 Bellevue, WA 98004
Online:	universallanguageservice.com
Phone:	**888-462-0500** or **425-454-8072**

Sign Language Services:

Online: dshs.wa.gov/altsa/odhh/sign-language-interpreter-contracts-and-resources-program

Inpatient hospital and residential stays: Hospitals and Residential Treatment Facilities are responsible for interpreter services during member inpatient stays.

Services provided at or by public health departments or public entities: Public entities, such as public health departments, are responsible for payment for interpreter services provided at their facilities or affiliated sites.

PRIMARY CARE PROVIDERS & SPECIALISTS

6.1 Primary Care Providers

PCPs are responsible for the complete care of their patients, including:

- Providing primary care.
- Providing the level of care and range of services necessary to meet the medical needs of members, including those with special needs and chronic conditions.
- Coordinating and monitoring referrals to specialist care.
- Coordinating and monitoring referrals to specialized behavioral health in accordance with state requirements.

- Referring patients to subspecialists and subspecialty groups and hospitals for consultation and diagnostics, according to evidence-based criteria for such referrals as it is available.
- Authorizing hospital services.
- Maintaining the continuity of care.
- Assuring all medically necessary services are made available in a timely manner.
- Providing services ethically and legally and in a culturally competent manner.
- Monitoring and following up on care provided by other medical service providers for diagnosis and treatment.
- Maintaining a medical record of all services rendered by you and other referral providers.
- Communicating with members about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.
- Providing a minimum of 32 office hours per week of appointment availability as a PCP.
- Providing hours of operation for members that are no less than those offered to any other patient.
- Arranging for coverage of services to assigned members 24 hours a day, 7 days a week in person or by an on-call physician.
- Offering evening and Saturday appointments for members (strongly encouraged for all PCPs).
- Continuing care in progress during and after termination of your contract for up to 60 days (up to 90 days if the member is receiving inpatient services), until a continuity of care plan is in place to transition the member to another provider, or through postpartum care for pregnant members, in accordance with applicable state laws and regulations.
- Coordinating care for members with mental health issues and substance use disorders.

6.2 PCP Responsibilities

PCPs also have the responsibility to:

Communicate with Members:

- Make provisions to communicate in the language or fashion primarily used by the member and contact Provider Services for help with oral translation services if needed. The Washington State Health Care Authority will help with and is responsible for payment for interpreter services provided by interpreter agencies contracted with the state for outpatient medical visits and hearings.
- Freely communicate with members about their treatment, regardless of benefit coverage limitations.

- Provide complete information concerning their diagnoses, evaluations, treatments and prognoses and give members the opportunity to participate in decisions involving their healthcare.
- Advise members about their health status, medical care and treatment options, regardless of whether benefits for such care are provided under the program.
- Advise members on treatments that may be self-administered.
- Contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.

Maintain Medical Records:

- Treat all members with respect and dignity.
- Provide members with appropriate privacy.
- Treat members' disclosures and records confidentially, giving members the opportunity to approve or refuse their release.
- Maintain the confidentiality of family planning information and records for each individual member, including those of minor patients.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research shall be clearly contrasted with entries regarding the provision of non-research related care.
- Share records subject to applicable confidentiality and *Health Insurance Portability and Accountability Act* (*HIPAA*) requirements.
- Obtain/store medical records from any specialty referrals in members' medical records.
- Manage the medical and healthcare needs of members to assure all medically necessary services are made available in a timely manner.

Cooperate and Communicate with Wellpoint:

- Internal and external quality assurance.
- Participation and resolution of critical incidents
- Utilization review.
- Continuing education.
- Other similar programs.
- Complaint and grievance procedures (when notified of a member grievance).
- Inform Wellpoint if a member objects to provision of any counseling, treatments or referral services for religious reasons.
- Identify children or adult members with special healthcare needs during the course of any contact or member-initiated healthcare visit and report these members to us so we can help them with additional services.

- Identify members who would benefit from our Case Management/Condition Care programs.
- Comply with our Quality Improvement Program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner.

Cooperate and Communicate with Other Providers:

- Monitor and follow up on care provided by other medical service providers for diagnosis and treatment, including services available under Medicaid fee-for-service.
- Provide the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through Apple Health.
- As a part of Integrated Managed Care Coordination with behavioral health providers.
- Provide case management services to include but not be limited to screening and assessing, developing a plan of care to address risks, medical/behavioral health needs, and other responsibilities as defined in the state's program.
- Coordinate the services Wellpoint furnishes to the member with the services the member receives from any other managed care organization (MCO) network program during member transition.
- Share with other healthcare providers serving the member the results of your identification and assessment of any member with special healthcare needs (as defined by the state) so those activities are not duplicated.

Cooperate and Communicate with Other Agencies:

- Maintain communication with the appropriate agencies, such as:
  - Local police.
  - Social services agencies.
  - Poison control centers.
  - Women, Infants and Children (WIC) program.
- Develop and maintain 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*.
- Coordinate the services Wellpoint furnishes to the member with the services the member receives from any other MCO during ongoing care and transitions of care.

6.3 Who Can Be a PCP?

Physicians with the following specialties can apply for enrollment with Wellpoint as a PCP:

- Advanced registered nurse practitioner (ARNP): Nurse practitioners are advanced registered nurses who have achieved additional certification after becoming a registered nurse.

- Family practitioner: Doctors who are trained to practice preventive medicine and diagnose and treat illness or diseases. These doctors are known as family practitioners but are also called family doctors or primary physicians.
- General practitioner: A general practitioner (GP) is a medical practitioner who treats acute and chronic illnesses and provides preventive care and health education to patients. GPs intend to practice a holistic approach that takes into consideration the biological, psychological and social factors relevant to the care of their patients.
- General pediatrician: General pediatricians are doctors who work with babies, children and adolescents. Pediatric physicians must have general medical knowledge and an understanding of how treatments affect different developmental growth stages.
- General internist: General internists treat, diagnose and manage the health and well-being of individuals who are ill with a condition or disease that is not easily treatable through surgery or medication.
- Obstetrics and gynecology (OB-GYN, often abbreviated as OB/GYN, OBG, O&G or Obs & Gynae): This is the medical specialty dealing with fields of obstetrics and gynecology through only one postgraduate training program. This combined training prepares the practicing OB/GYN to be adept at the care of female reproductive organs health and at the management of obstetric complications, even through surgery.
- Federally qualified health center (FQHC)/rural health clinic (RHC): FQHCs include all organizations receiving grants under Section 330 of the Public Health Service (PHS) Act. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.
- Internist: An internist, also called a general internist or doctor of internal medicine, is a medical doctor that specializes in the diagnosis and medical (nonsurgical) treatment of adults. Internists provide long-term, comprehensive care and manage both common and complex diseases. An internist can serve as a primary care physician or as a consultant to other medical specialists. Many internists also are involved in research and teaching.
- Pediatrician: A pediatrician is a doctor who specializes in the care of children. Pediatrics is a very broad medical specialty encompassing everything from general practice to children's oncology.
- Physician Assistant (PA): Physician assistants provide medical care services to patients under the supervision and responsibility of a Doctor of Medicine or Osteopathy.
- Naturopathic doctors: Naturopathic doctors (NDs) are trained as primary care physicians with an emphasis in natural medicine in ambulatory settings. Their scope of practice varies by state and territory but generally consists of the diagnosis, prevention and treatment of disease by stimulation and support of the body's natural healing mechanisms. Standard diagnostic and preventive techniques utilized include physical examination, laboratory testing and diagnostic imaging. NDs may employ additional laboratory tests and examination procedures for further evaluation of nutritional status,

metabolic functioning and toxicities. Treatment modalities utilized by NDs include diet and clinical nutrition, behavioral change, hydrotherapy, homeopathy, botanical medicine, and physical medicine. Depending on the state, NDs may also be licensed to perform minor office procedures and surgery, administer vaccinations, and prescribe many prescriptive drugs.

- Specialist providers: If a specialist provider is the PCP for a member with special health needs, the specialist is responsible for ensuring that child receives Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

As a PCP, you may practice in any of the following:

- Solo or group setting
- Clinic (for example, an FQHC or RHC)
- Outpatient clinic

6.4 PCP Onsite Availability

PCPs are required to abide by the following standards to ensure access to care for our members:

- Offer 24-hour-a-day, 7-day-a-week phone access for members. A 24-hour phone service may be used.
- Follow the referral/prior authorization guidelines. This is a requirement for covering physicians.
- Be available to provide medically necessary services. You or another physician must offer this service.
- The service may be answered by a designee such as:
- An on-call physician.
- A nurse practitioner with physician backup.

Additionally, we encourage PCPs to offer after-hours office care in the evenings and on Saturdays.

It is **not** acceptable to automatically direct the member to the emergency room when the PCP is not available.

6.5 Screenings for Behavioral Health Conditions & Developmental Disabilities in Primary Care

PCPs play an important role in the recognition, diagnosis, referral, and treatment of behavioral health disorders and developmental disabilities. Wellpoint encourages the use of established screening tools to assist care providers in this process. Screening tools are

included in our *Clinical Practice Guidelines* available at provider.wellpoint.com/wa > Patient Care > Early and Periodic Screening Diagnostic Treatment

Wellpoint supports the use of screening tools as recommended by the Washington State Health Care Authority, including those for children and youth, available in the Early Periodic Screening, Diagnosis and Treatment Billing Guide hca.wa.gov/assets/billers-and-providers/EPSDT-bg-20220701.pdf

6.6 Specialty Care Providers

A specialty care provider is a network physician responsible for providing specialized care for members, usually upon appropriate referral from members' PCPs. To access a searchable online directory, members can go to wellpoint.com/wa/medicaid > Member Support > Search providers and providers can go to provider.wellpoint.com/wa > Resources > Referrals. To assist PCPs in meeting the needs of children with mental health diagnosis, Wellpoint provides PCPs access to consultations with child psychiatrists. For more information on how to arrange for these consultations, call Provider Services at **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT**.

PCPs who wish to obtain consultations from child and adolescent behavioral health specialists regarding mental health issues can call the state's Partnership Access Line (PAL) at **866-599-7257**. This no-cost service is available to any PCP throughout Washington. For more information, visit palforkids.org.

Access to Women's Health Specialists

Female members may directly access women's health specialists within the Wellpoint network for covered routine and preventive healthcare services. Services include but are not limited to: maternity care, reproductive health services, gynecological care, general examination and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. General examinations, preventive care and medically appropriate follow-up care are limited to services related to maternity, reproductive health services, gynecological care or other health services that are particular to women, such as breast examinations. Women's healthcare services also include any appropriate healthcare service for other health problems discovered and treated during the course of a visit to a women's healthcare practitioner for a women's healthcare service, which is within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health and preventive services include contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and complications of pregnancy.

Additionally, Wellpoint will:

- Ensure the confidentiality of all information related to women's health services is maintained.
- Not exclude or limit access to covered women's health services.
- Not impose notification/authorizations upon women's healthcare practitioners that are not imposed on providers offering similar types of service.
- Include coverage for medically appropriate laboratory, imaging and diagnostic services as well as prescriptions and medical supplies ordered by a directly accessed participating women's healthcare practitioner within the provider's scope of practice.

6.7 Role & Responsibilities of Specialty Care Providers

Specialists treat members who are referred by network PCPs or self-referred.

Specialists are responsible for:

- Complying with all applicable statutory and regulatory requirements of the Apple Health
- program.
- Accepting all members referred to them.
- Rendering covered services only to the extent and duration indicated on the referral.
- Submitting required claims information, including source of referral and referral number.
- Arranging for coverage with network providers while off duty or on vacation.
- Verifying member eligibility and prior authorization or notification requirements of services at each visit.
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis.
- Notifying the member's PCP when scheduling a hospital admission or scheduling any procedure requiring the PCP's approval.
- Coordinating care with other providers for:
- Physical and behavioral health comorbidities.
- Co-occurring behavioral health disorders.
- Adhering to the same responsibilities as the PCP.

6.8 Specialty Care Access & Availability

Note: In-office wait time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room.

Each patient should be notified immediately if the provider is delayed for any period of time. If the appointment wait time is anticipated to be more than 45 minutes, the patient should

be offered a new appointment. Walk-in patients with nonurgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

6.9 Access & Availability Appointment Standards

Our ability to provide quality care depends on your accessibility and availability. PCP referral is not required for members to access behavioral health services, though if a PCP believes these services are necessary they may refer the member or request referral assistance at any time.

Type of care	Standard
Emergency	Immediately treat or refer to ED
Urgent care	Within 24 hours
Nonurgent sick care	Within 10 calendar days
Routine or preventive care	Within 30 calendar days
Transitional healthcare by a PCP	Shall be available for clinical assessment and care planning within seven calendar days of discharge from inpatient or institutional care for physical or BH disorders or discharge from a substance use disorder treatment program

Note: In-office wait time for scheduled appointments should not routinely exceed 30 minutes, including time in the waiting room and examining room.

Walk-in patients with request for non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. We encourage providers to maintain office hours outside of traditional business hours, including into the evening and on Saturdays, to best accommodate member needs. Providers are required to offer service hours to Wellpoint members no less than those offered to other patients or clients.

As part of our commitment to providing the best quality provider networks for our members, we conduct annual phone surveys to verify provider appointment availability and after-hours access. If found non-compliant your organization will have 30 business days to complete the form mailed to your address on file with how you will become compliant.

Providers may not use discriminatory practices such as:

- Showing preference to other insured or private-pay patients.
- Maintaining separate waiting rooms.
- Maintaining separate appointment days.
- Denying or not providing to a member any covered service or availability of a facility.

- Condition the provision of care or otherwise discriminate against our members based on whether the members.
- Have executed advance directives.
- Providing to a member any covered service that is different or is provided in a different manner
- or at a different time from that provided to other members, other public or private patients or the public at large.

We will routinely monitor providers' adherence to access standards and appointment wait times. You are expected to meet federal and state accessibility standards and those standards defined in the *Americans with Disabilities Act of 1990*. Healthcare services provided through Wellpoint must be accessible to all members.

For urgent care and additional after-hours care information, see the **Urgent Care/After-Hours Care** section of this manual.

6.10 *Clinical Practice Guidelines*

We work with providers to develop clinical policies and guidelines. A comprehensive list of the Wellpoint identified practice guidelines for various medical and behavioral health conditions is available at **provider.wellpoint.com/wa** > Resources > Medical Policies And Clinical UM Guidelines. These guidelines include recommendations for screening and identification of conditions and ongoing treatment recommendations. Guidelines are considered for updates at least every two years. Paper copies of *Clinical Practice Guidelines* may be requested by calling Provider Services at **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT**.

6.11 Covering Physicians

During your absence or unavailability, you must arrange for coverage for your members assigned to your panel. You will be responsible for making arrangements with either:

- One or more network providers to provide care for your members.
- Another similarly licensed and qualified participating provider who has appropriate medical staff privileges at the same network hospital or medical group 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.

You will be solely responsible for:

- A non-network provider's adherence to our network provider agreement.

- Any fees or monies due and owed to any non-network provider providing substitute coverage to a member on the provider's behalf.

6.12 Lab Requirements: Clinical Laboratory Improvement Amendments

Wellpoint is bound by the *Clinical Laboratory Improvement Amendments (CLIA) of 1988*. The purpose of the *CLIA* program is to ensure laboratories that test specimens in interstate commerce consistently provide accurate procedures and services.

As a result of *CLIA*, any laboratory that solicits or accepts specimens in interstate commerce for laboratory testing is required to hold a valid license or letter of exemption from licensure issued by the Secretary of the Department of Health and Human Services. Since 1992, carriers have been instructed to deny clinical laboratory services billed by independent laboratories that do not meet *CLIA* requirements.

The *CLIA* number must be included on each *CMS-1500* claim form for laboratory services by any laboratory performing tests covered by *CLIA*.

The *CLIA certification* must be effective for the claim date of service. The address registered with CMS for the CLIA certificate billed on the claim must also match either the billing or servicing address submitted on the claim. Providers that have applied and been approved by CMS as multi-site providers are excluded from address validations.

The CLIA Certification level must be a high enough level for the laboratory procedure being performed.

The CMS CLIA Certification types can be found on the CMS website here:

qcor.cms.gov/advanced_find_provider.jsp?which=4&backReport=active_CLIA.jsp

A CLIA Certificate of Waiver does not mean the provider is Waived or Excluded from CLIA validations. A Certificate of Waiver is just a lower level of certification issued to laboratories to perform only waived tests specified by CMS.

6.13 Health Home Programs

We offer a Health Home program to high cost, high need members enrolled in Apple Health. To be eligible for the program, a member must have at least one chronic condition, be at risk for another, have a PRISM predictive risk score of 1.5 or above, and have probable cause to admit to the emergency department or inpatient setting.

Members enroll voluntarily, sign a consent form and are assigned a care coordinator in the community that provides face-to-face visits to:

- Develop a person-centered health action plan with long term goals, short term goals and action steps.
- Improve self-management of chronic conditions and engagement of the member in their own healthcare.
- Ensure care coordination and care transitions are completed.

The Health Home program provides the following specific services to the member:

- Comprehensive care management.
- Care coordination.
- Health promotion.
- Comprehensive transitional care, including follow-up from inpatient settings to another.
- Individual and family support.
- Referrals to community and social support services.

If you'd like to check whether a member is currently enrolled in the Health Home program or you'd like to refer a member, send an email AMG_WAHealthHomes@elevancehealth.com.

6.14 Automatic Assignment of PCPs

During enrollment, a member can choose their PCP. When a member does not choose a PCP at the time of enrollment or is automatically assigned to Wellpoint, he or she is auto-assigned to a PCP within one business day from the date Wellpoint processes the daily eligibility file from the state.

PCP auto-assignments are based on proximity to members' home addresses as well as ages, genders and primary spoken languages. If a member loses coverage for a period of time and is reinstated with Wellpoint, he or she will be assigned to the most recent provider that was previously assigned to him or her.

Members receive a Wellpoint-issued identification card that displays the PCP name and phone number in addition to other important plan contact information.

Procedure for Changing PCPs or Other Providers

Members have the right to change their PCP at any time. The member may select a PCP from the provider directory myWellpoint.com/wa/care/find-a-doctor.html or call Member Services at **833-731-2167 (TTY 711) Monday through Friday, 8 a.m. to 5 p.m. PT.** The member handbook includes a description of how to choose a PCP. PCP change requests will be

processed generally on the same day or by the next business day, and a new ID card will be issued.

This ID card is separate from any ID card issued to the member by the state.

Please note:

- We list within each report the specific service each member needs.
- You must render the services on or after the due date in accordance with federal EPSDT and state Department of Health guidelines.
- We base our list on claims data we receive before the date shown on each list. Please check to see if you have provided the services after the report run date.
- Please submit a completed claim form for those dates of services to the Wellpoint Claims department at:

  Washington Claims
  Wellpoint
  P.O. Box 61010
  Virginia Beach, VA 23466-1010

6.15 Locum Tenen

Physicians may bill under certain circumstances for services provided on a temporary basis (in other words, locum tenens) to their patients by another physician...Any provider that will perform as a locum tenens provider that will treat a Medicaid client must be enrolled as a Washington Apple Health (Medicaid) provider for claims to be paid." Please refer to the Physician Related Services/Healthcare Professional Services billing guide for more information.

BEHAVIORAL HEALTH PROVIDERS

7.1 Behavioral Health Providers

Behavioral health providers are responsible for the assessment, diagnosis, and treatment of mental health and substance use conditions. Essential duties include:

- Assessment and diagnosis of a behavioral health or substance disorder condition in accordance with the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5), *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC: 0-5) and the *International Classification of Diseases, Version 10* (ICD-10) or subsequent updates

Assessment and diagnosis include accurate diagnoses of condition including assessment of condition severity

- Assessing appropriate levels of care to reflect the medical necessity and intensity of services to treat the diagnosed condition(s) utilizing MCG Health (mcg.com/) and/or the American Society of Addiction Medicine (ASAM) guidelines (asam.org/quality-care/clinical-guidelines)
- Ensuring services are delivered with consideration for evidence-based practices for the diagnoses assessed and the level of need
- Referring patients to sub-specialists for consultation and assessment as appropriate
- Referring to specialty programming as appropriate according to evidence-based criteria as available
- Ensuring all medically necessary services are made available in a timely manner
- Providing services ethically, legally, and in a culturally competent manner with respect for member rights and autonomy
- Providing services that are accessible to all members according to the American Disabilities Act guidelines
- Providing accurate and timely documentation of services rendered
- Ensuring continued care is in progress during and after termination of your contract for up to 60 days (up to 90 days if the member is receiving inpatient services), until a continuity of care plan is in place to transition the member to another provider in accordance with applicable state laws and regulations

Transition to another provider may include a different behavioral health provider or an accepting primary care physician as appropriate

7.2 Responsibilities of the Behavioral Health Provider

Behavioral health providers also have the responsibility to:

- VBP contracted providers related to the Well child visits for the WCV and W30 measure: Make provisions to communicate in the language or fashion primarily used by the member and contact Provider Services for help with oral translation services if needed. The Washington State Health Care Authority will help with and is responsible for payment for interpreter services provided by interpreter agencies contracted with the state for outpatient medical visits and hearings.
- Provide complete information concerning their diagnoses, evaluations, treatments and prognoses, and give members the opportunity to participate in decisions involving their healthcare.
- Advise members about their health status and treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.
- Provide members with appropriate privacy.

Maintain Medical Records and Confidentiality:

1. Treat all members with respect and dignity.

2. Provide members with appropriate privacy.
3. Treat members' disclosures and records confidentially, giving members the opportunity to approve or refuse their release.
4. Maintain the confidentiality of family planning information and records for each individual member, including those of minor patients.
5. Comply with all applicable federal and state laws regarding the confidentiality of patient records.
6. Share records subject to applicable confidentiality and Health Insurance Portability and Accountability Act (*HIPAA*) requirements.
7. Obtain/store medical records from any specialty referrals in members' medical records.
8. Maintain a record of all services provided, including a narrative description of each service encounter in accordance with federal and state regulations.
9. Maintain a clinical record set inclusive of components as required by federal and state regulations appropriate to the services rendered and licensure of the provider and/or agency.
10. Ensure any notation in a member's clinical record indicating a diagnostic or therapeutic intervention as part of a clinical research trial is clearly contrasted compared to treatment that is not part of a clinical research trial (in other words. treatment as usual)

Cooperate and Communicate with Wellpoint:

Participate in:

1. Internal and external quality assurance.
2. Addressing and participation in resolution of critical incidents.
3. Utilization review(s).
4. Communication for the purposes of continuity of care with Wellpoint as needed. A release of information is not required to exchange clinical information with Wellpoint Utilization Management and Case Management teams.
5. Identify members who could benefit from our Case Management/Condition Care programs and refer to Wellpoint Case Management.
6. Continuing medical education.
8. Complaint and Grievance procedures (when notified of a member grievance).
    a. Inform Wellpoint if a member objects to provision of any counseling, treatments or referral services for religious reasons.
    b. Identify pediatric or adult members with special healthcare needs during any contact or member-initiated healthcare visit and report these members to us so we can help them with additional services.
    c. Identify members who could benefit from our Case Management/Condition Care programs.
    d. Comply with our Quality Improvement Program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner.

e. Maintain policies and procedures in compliance with HCA contractual requirements.

Cooperate and Communicate with Other Providers:

1. For members without an identified PCP refer to Wellpoint member services for assistance in selecting and accessing a PCP.
2. Provide the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through Apple Health.
3. Coordinate with member PCPs and specialists for integrated care, particularly when members experience comorbidity of physical health and behavioral health conditions.
4. Coordinate and monitor the outcome of referrals for psychiatric medication management as needs are identified.
5. Provide case management services when needs are identified, including, but not limited to, screening, assessing, and developing a plan of care to address risks, behavioral health needs, and coordination with other healthcare or social service needs.
6. Coordinate the services Wellpoint furnishes to the member with the services the member receives from any other managed care organization network program during member transition.
7. Share the results of your identification and assessment of any member with special healthcare needs (as defined by the state) with other healthcare providers serving the member so those activities are not duplicated.

Cooperate and Communicate with Other Agencies:

- Maintain communication and service coordination with appropriate agencies, such as:
- Local law enforcement and corrections.
- Social services and community support agencies.
- Tribal service providers.
- Washington State Department of Social and Health Services, including Home-and Community Services, Behavioral Health Administration and Aging and Long-Term Support Administration.
- Washington State Department of Children, Youth and Families.
- Establish an appropriate mechanism to fulfill obligations under the *Americans with Disabilities Act*.

7.3 Who Can Be a Behavioral Health Provider?

Behavioral health providers may apply for enrollment with Wellpoint in 2 ways: as an independent provider or affiliated with a behavioral health agency/large group practice.

To be considered an independent practitioner, you must be licensed (MD, ARNP, LICSW, LMHC) by the Washington State Department of Health (WA DOH) to provide behavioral

health services. Practitioners with associate level licensure will be expected to follow Department of Health rules and regulations regarding supervised practiced.

Providers affiliated with Behavioral Health Agencies may have other credentials, qualifications, and skills that support Wellpoint members. The individual agencies are responsible for practitioner credentialing with Wellpoint and ensuring all credentialling is up to date.

7.4 Required Behavioral Health Screenings

All behavioral health service providers are required to use the Global Appraisal on Individual Need – Short Screener (GAIN-SS) for members ages 13 and above consistent with expectations established by the Washington State Department of Health and Health Care Authority. Agencies are expected to screen members for co-occurring disorders and stratifies risk through the use of a quadrant placement methodology. If the result of the assessment are consistent with the presence of a co-occurring disorder, this information must be considered in the development of the treatment plan including appropriate referrals.

Providers must keep documentation of completion of GAIN-SS in member records and submit necessary data through required Behavioral Health Supplemental Data submissions.

7.5 Behavioral Health Supplemental Transaction Data

Behavioral Health Supplemental Transaction Data are non-encounter data submissions to the Behavioral Health Data System (BHDS) as outlined in the Behavioral Health Supplemental Transaction Data Guide (hca.wa.gov/assets/billers-and-providers/Behavioral-Health-Data-Guide.pdf). This Guide is published by HCA and defines that the transactions include supplemental data, including additional demographic and social determinant data, as well as service episode and outcome data necessary for federal Substance Abuse and Mental Services Administration (SAMHSA) block grant reporting and other state reporting needs.

Managed care organizations (MCOs) and Behavioral Health Administrative Service Organizations (BH-ASOs) serve as a bridge between providers and HCA by collecting the data from the providers via a standardized format and submitting the data to HCA via BHDS. MCOs have selected Carelon Behavioral Health, Inc. to develop the platform and standardized format for submitting these data transactions. Additional information regarding data collection can be found at wa.carelonbehavioralhealth.com/providers/bhsd

Mental health and substance use disorder providers/organizations licensed as behavioral health agencies (BHAs) are required to collect and submit the BH supplemental transactions. This requirement to collect and report this data is not dependent on the type or

level of service or type of contract the BHA has with an MCO – therefore, this requirement also applies to encounters occurring under a single case agreement.

Individual treatment practitioners practicing outside of a BHA, including prescribers [in other words. buprenorphine providers] are excluded from this requirement.

7.6 Wraparound with Intensive Services (WISe)

Program Overview
Wraparound with Intensive Services, known as WISe, is a service targeting Medicaid eligible youth and their families with intensive mental health services. WISe services are meant to support individuals with mental health difficulties by providing services in the youth's home and community. The goal of this program is for youth to live and thrive in their homes and communities, avoid delinquency, and avoid disruptive out-of-home placements. WISe promotes youth development, maximizing their potential to grow into healthy and independent adults.

Population Served
WISe services are available to all Medicaid-eligible youth from birth to age 21 who experience mental health symptoms that disrupt or interfere with their functioning at home, school and/or with peers.

WISe-Specific Agency Requirements
WISe agencies will comply with all requirements of the most current Washington State WISe Program Policy and Procedure Manual, including but not limited to, team staffing requirements, notification of change, and crisis services.

Referrals:
Anyone can make a referral to WISe including the youth, a family member, or a licensed provider by telephone or in writing. Once Medicaid eligibility is verified by the agency, a trained staff member completes the Child & Adolescent Strengths and Needs (CANS) assessment to determine eligibility. The CANS must be completed within calendar 14 days of a referral being sent to a WISe organization and entered into the BHAS portal (wa-bhas.org). If the CANS screen is completed and the member is deemed ineligible for WISe services, a written notification must be sent to the youth/family explaining the denial.

Services:
WISe services include an intake evaluation, intensive care coordination (including in-home supports, family support, and community supports), 24/7 crisis management support, and peer support. WISe programs are required to maintain an average of 10.5 hours of service per member enrolled in WISe services per month (known as service intensity). An updated CANS assessment must be completed every 90 days thereafter while the member is in WISe

services, and a discharge CANS assessment must be completed upon completion of WISe services.

The Health Care Authority (HCA) utilizes Research and Data Analysis (RDA) to validate WISe performance measures on a quarterly and annual basis. WISe services must meet 85% of the Wellpoint caseload target.

Service Changes:
Wellpoint must be notified within 1 business day if WISe services are decreased, suspended, terminated, or youth is not considered eligible for WISe from a CANS screen by utilizing the Notification for Change in WISe Services Form: provider.wellpoint.com/docs/gpp/WA_WLP_CAID_NotificationforchangeinWISe.pdf?v=202401311731. This ensures Wellpoint will meet the Adverse Authorization Decision notification within HCA mandated timeframes.

Tracking and Payment:
WISe service providers must supply a monthly invoice tracking report for all WISe-enrolled youth by the 5th of the month. Providers must participate in a review of WISe services using the WISe Quality Improvement Review Tool, known as QIRT (as needed by HCA or Wellpoint). Providers are required to complete the WISe QIRT tool annually and a full review of each WISe program occurs at least once every 3 years. Additionally, there is a semi-annual review of WISe service encounters to ensure service quality and integrity which includes:

- Individual chart reviews (quarterly by WISe supervisors and annually by HCA)
- Annual review to obtain feedback on service effectiveness
- Quarterly review of Notices of Adverse Benefit determinations
- Quarterly review of Grievances and Appeals
- Annual Quality Improvement Review (QIRT)
- Any other elements as detailed in Carelon Medical Benefits Management of the WISe quality management plan (QMP)

The monthly report template can be found at provider.wellpoint.com/washington-provider/resources/forms > Behavioral health > WA 2024 WISe payment template here:

Wellpoint will train all WISe providers on the correct process to submit all forms and reports. Providers may contact Wellpoint directly through their Provider Relations for any assistance regarding WISe requirements, reporting, and billing.

Please note, failure to meet expectations in assessment, service intensity and quality, reporting requirements, or other aspects of the WISe program requirements may result in a Corrective Action Plan (CAP) and further action up to and including termination of contract with Wellpoint.

Communication and requests related to WISe services can be sent to WLPWISe@Wellpoint.com

7.7 Access & Availability Appointment Standards

Behavioral health services must be available in each region 24 hours per day, 7 days per week. In conjunction and coordination with regional behavioral health crisis service providers, you are required to adhere to the following access standards:

Type of care	Standard
Emergency	Immediately treat or refer to ED
Non-life-threatening emergency	Treat within six hours or refer to ED
Urgent care	Within 24 hours of referral
Nonurgent sick care (routine)	Within 10 calendar days
Routine or preventive care	Within 30 calendar days

As part of our commitment to providing the best quality provider networks for our members, we conduct annual phone surveys to verify provider appointment availability and after-hours access. If found non-compliant your organization will have 30 business days to complete the form mailed to your address on file with how you will become compliant.

We will routinely monitor providers' adherence to access standards and appointment wait times. You are expected to meet federal and state accessibility standards and those standards defined in the *Americans with Disabilities Act of 1990*. Healthcare services provided through Wellpoint must be accessible to all members.

For urgent care and additional after-hours care information, see the Urgent Care/After-Hours Care section of this manual.

Infant and Early Childhood Mental Health (DC 0-5):
The Washington state Health Care Authority (HCA) contracts with Washington Association for Infant Mental Health (WA-AIMH) to support the Infant-Early Childhood Mental Health Workforce Collaborative (IECMH-WC). This is to support the implementation of House Bill 1325 (HB1325) which work to coordinate the delivery of Clinical and Overview DC: 0-5 trainings as well as providing related professional development supports.

The aim of this program is to empower providers to feel comfortable seeking out or completing assessments for very young children who may have mental health concerns with the goal of developing and enacting interventions at earlier ages to prevent more serious and long-standing mental health issues. For program information and information on

trainings, please refer to the Mental Health Assessment for Young Children page through the HCA or the Billers, Providers, and Partners page.

Behavioral Health Facility Transitional Care Planning
All behavioral health treatment agencies are expected to develop policies and procedures that enhance care coordination, including transitions between all levels of care. Behavioral health treatment agencies are responsible for ensuring there is adequate coordination for Members transitioning between various levels of treatment services to ensure continuity of care.

To ensure quality of care and sufficient communication from one level of care to another, all behavioral health treatment agencies are expected to have policies and practices that support the following occurring when a member is discharged or transitioned to a lower or higher level of care:

- Screen for and identify members that are currently homeless or at risk of homelessness; provide resources and referrals as part of a comprehensive discharge plan.
- Appropriate referrals are made to a behavioral health provider
- Follow up appointments scheduled within 7 calendar days of member's discharge. Discharge plans must include:
  - Release of information between behavioral health treatment agencies or other entities to ensure quality continuity of care
  - Date and time of follow up care appointment
  - Current medications at the time of discharge and
  - If appropriate, the member should be provided with a sufficient supply of medication and a plan for compliance documented
- Any planned steps or necessary actions taken to reduce the likelihood of readmission, address the reason for admission and address any safety concerns
- The agency must have a plan for the member's assigned counselor or a designated outreach coordinator to follow up via telephone, text message, or email with the Enrollee within 72-hours post-discharge.
- Provide notification of a member's discharge at least 24 hours prior to discharge, or on the day of discharge for patients leaving against medical advice.
- Communication for the purposes of continuity of care with Wellpoint as needed. A release of information is not required to exchange clinical information with Wellpoint Utilization Management and Case Management teams.

For Utilization Management needs or questions please call: **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT**
For Case Management needs or questions please email: WABHReferrals@Wellpoint.com

Specific Requirements for Members Receiving Medications for Substance Use Disorders
The Behavioral Health Agency must provide coordination for members receiving FDA approved medication for opioid use disorders requesting transfer out their current region. The Agency must ensure the following:

- An intake appointment with 7 calendar days of discharge from the previous facility
- Sufficient medication until the member's scheduled appointment with a community provider behavioral health treatment agency
- Sufficient notification and request for assistance from Wellpoint prior to discharge, when available, for Wellpoint to assist with discharge planning if needed.

Inpatient and Residential SUD Behavioral Health Agency:

Availability of Medication for Opioid Use Disorders:

Inpatient and Residential behavioral health facilities treating SUD must have policies and policies and practices that ensure the following

- All members who are prescribed any of the FDA approved medication to treat all substance use disorders are not denied services.
- Decision concerning medication and medication adjustments are based on the medical necessity and in coordination with the prescribing provider. There may not be mandates to titrate any prescribed FDA approved medications to treat any SUD as a condition of received treatment or continuing to receive behavioral health treatment.
- The agency will provide or facilitate the induction of any prescribed FDA approved medications for any SUD throughout the course of a member's treatment. This may be done by:
  - Having an appropriately credentialed prescriber on-site available through telemedicine
  - who can prescribe FDA approved medications for SUD; or
  - Facilitating off-stie transportation of members to medication or behavior health
  - treatment agencies that offer medications for SUD
- The agency will provide or facilitate the continuation of any prescribed FDA approved medications for any substance use disorder. Decisions concerning medication adjustments must be done on medical necessity and in concern with the prescribing provider.

Transitional Care Planning:
Facilities that provide inpatient services for substance use disorders are expected to have policies and practices in place that meet the following requirements at the time of a member's discharge from care:

- Provide scheduled immediate appointments with community healthcare providers, to include, but not limited to the following:

- **Intensive Outpatient/Outpatient Services**: Documentation of and appointment referral for next level of treatment upon completion of residential services.
- **Medication Assisted Treatment**: If the Enrollee was inducted or continued FDA approved medications for SUD during their stay in an Inpatient Behavioral Health facility, the agency will coordinate a same day appointment with an outpatient provider to coincide with the individual's discharge date.
- **Peer Support and Recovery Based Services**: The Inpatient Behavioral Health facility will document and provide the Enrollee with addresses and phone numbers at discharge for community-based Peer Support and Recovery Support resources.
- **Housing:** Enrollee's housing status must be verified through the Enrollee or authorized representative and documented within the electronic health record system. When necessary, the Behavioral Health facility will refer Enrollee to housing and community support services; documentation of any referrals must be placed in the electronic health record. When the Enrollee is prescribed FDA approved medications for SUD, the provider must document efforts to obtain housing to fit the individual's needs
- **Transportation**: Arrange for transportation for the individual, as needed, to scheduled appointments and recovery-based housing

If a member discontinues services, the facility must properly document the reason for discharge in the electronic health record and the attempts and offerings to facilitate a transition back into the community.
If the facility discontinues treatment of a member, the facility is responsible for meeting all the discharge requirements noted above.

Outpatient Substance Use Disorder Treatment Facilities

Outpatient behavioral health treatment facilities providing Federal Drug Administration (FDA) approved medication to treat substance use disorders must have policies and practices that ensure the following:

- Members who are prescribed any of the prescribed FDA approved medications to treat all substance use disorders will not be denied services.
- Decision concerning medication and medication adjustments are based on the medical necessity and in coordination with the prescribing provider. There may not be mandates to titrate any prescribed FDA approved medications to treat any SUD as a condition of received treatment or continuing to receive behavioral health treatment.
- Availability of peer support services for members

Behavioral Health Authorization and Concurrent Review (CCR) Documentation

To ensure timely and accurate processing of authorization decisions, Wellpoint Washington recommends submission of authorization requests via electronic portal or fax the forms available on our Provider website.

Providers may choose to submit authorizations via fax without the Wellpoint coversheet. It is recommended that these authorizations include a coversheet clearly indicating the requested level of care, whether this is an initial or concurrent review and with a point of contact identified for questions. Additionally, the following clinical documentation should be included:

- Member demographic information
- Facility information, including NPI
- Attending Provider Information, including NPI
- Diagnosis
- Reason for Admission including summary of symptoms present at admission
- Indications of risk to harm to self or others at admission
- Indication of risk to harm to self or others within the last 24-48 hours (concurrent review)
- Current ASAM Assessment, if applicable
- Labs and current vitals
- Current Medications
- Psychiatric Assessment or 2 most recent notes by psychiatric provider
- Treatment Plan (most recent update for concurrent review)
- Discharge plan

Request for Behavioral Health Administrative Days

In the event a member on a voluntary, inpatient hospital stay does not meet criteria for acute inpatient level of care but is not discharged because appropriate placement is not available, the Wellpoint will approval of administrative day rate in lieu of denial.

Request of administrative day rates must be coordinated with the assigned UM Care Manager while the member remains inpatient. The authorization will be updated to reflect the administrative rate. Any consideration to return to full payment rate will require documentation that the member meets medical necessity.

Approvals for administrative days will be reviewed every 7 days, or more frequently as needed, and facilities will be expected to provide documentation of on-going efforts to secure appropriate placement and aftercare. Facilities may coordinate with their Utilization Care Manager for additional Wellpoint assistance with discharge coordination.

TRIBAL

8.1 Tribal Taxonomies

Wellpoint treats Tribal Providers as an in-network regardless of contracting status with Wellpoint. Tribal providers must bill with the appropriate billing taxonomy and the appropriate assigned American Indian/Alaskan Native (AI/AN) or non-AI/AN tribal modifier.

Acceptable Taxonomies for Tribal Providers

Medical claims:
- 208D00000X
- 225100000X
- 225X00000X
- 235Z00000X
- 152W00000X
- 171M00000X

Mental health claims:
- 2083P0901X

Substance use disorder claims:
- 261QR0405X

Residential treatment facilities:
- 324500000X
- 3245S0500X

8.2 Tribal Encounter Payment

Wellpoint pays Tribal Providers the applicable encounter rate published annually in the Federal Register by the Indian Health Service and outlined in the Tribal Health Billing Fee Schedules.

Encounter payments are identified by the submission of the appropriate Current Procedural Treatment (CPT) code T1015 with the accompanying Tribal Health Billing Guidelines.
When billing for services eligible for an encounter payment the following I is required on claims submissions:

- Appropriate billing taxonomy in box 33b

- Servicing taxonomy in box 24i.

For details and applicable fee schedules. Please refer to the HCA Tribal Health Billing Guide at:

hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules

8.3 Tribal Timely Filing

Timely filing limitation for claims, regardless of PAR status, are listed below:

- New day and/or Clean claims: 365 days from date of service*
- Corrected claims: 365 days from date of service*
- Rejected claim: 365 days from date of service*

* Exception: In the case of coordination of benefits with another carrier, claims will need to be submitted with 365 days of the date of Primary (or Secondary) Payor's Explanation of Benefits/Explanation of Payment.

8.4 Claim Dispute/Appeal

Should a Tribal Provider want to dispute the processing of a claim, there are 2 levels in which the review requested:

Reconsiderations:

- Must be received within 12 months from the date of the original explanation of payment or denial. A Reconsideration can be filed by one of the following:
- Verbally with Provider Call Center
- In writing by Paper Dispute, or
- In writing via Availity Essentials

Claim Payment Appeals (The Reconsideration determination is upheld all or in part):

Must be received within 60 days months from the date of the Reconsideration Outcome letter. A Claim Payment Appeal can be filed by one of the following:

- In writing by Paper Dispute, or
- In writing via Availity Essentials

INDEPENDENT CLINICS OF WASHINGTON

9.1 Claims

All claims payment and medical management services for Independent Clinics of Washington (ICW) RISK members are delegated to ICW under the terms of the agreement between ICW and Wellpoint.

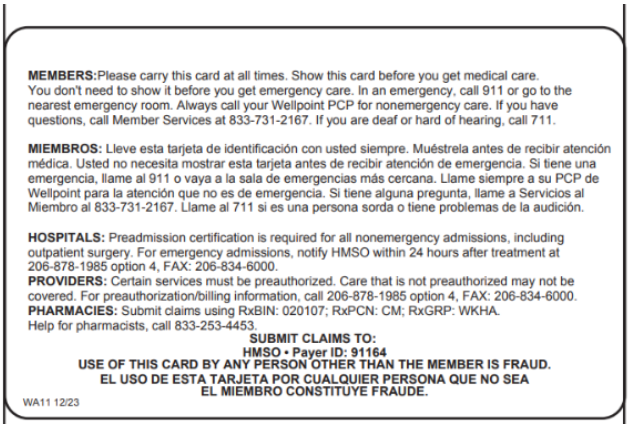
Wellpoint members assigned to an ICW PCP will be governed by the terms of the provider's agreement with ICW.

Providers will be required to submit claims directly to ICW and obtain any authorizations as required.

The provider RISK ID can only be found in the Directory and Availity Essentials.

9.2 Identification card

The member ID card will look like:



MEMBER RIGHTS & RESPONSIBILITIES

Our Member Services representatives serve as member advocates. Outlined below are our members' rights and responsibilities.

10.1 General Member Rights

Members have the right to:

- Get understandable notices or have program materials explained or interpreted.
- Receive timely information about the health plan.

- Get courteous, prompt answers from the health plan and the Washington State Health Care Authority (HCA).
- Be treated with respect and with consideration for their dignity and privacy.
- Have their privacy protected by HCA, the health plan and its providers.
- Get information about all physical and behavioral health services covered by Apple Health.
- Choose their health plans and primary care providers from among available health plans and contracted networks.
- Receive information about the organization, its services, its practitioners, and providers and member rights and responsibilities.
- Receive proper physical and Behavioral Health Care consistent with the Apple Health member handbook and without discrimination regarding health status or conditions, gender, ethnicity, race, marital status or religion.
- Get all medically necessary covered services and supplies listed in the Apple Health handbook and a schedule of benefits, subject to the limits, exclusions and cost-sharing described in the Apple Health member handbook.
- Take part in decisions about their healthcare and their children's healthcare, including having candid discussions of appropriate or medically necessary treatment options, regardless of cost or coverage. This includes the right to refuse treatment.
- Get physical and Behavioral Health Care without long delays.
- Refuse treatments and be told of the possible results of refusing treatments, including whether refusals may result in disenrollment from Apple Health.
- Expect their records and their children's records and conversations with providers be kept confidential.
- Get second opinions by other providers in their health plans when they disagree with the initial providers' recommended treatment plans.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Make complaints or grievances about the health plans or providers and receive timely answers.
- File appeals with their health plans or HCA if they are not satisfied with their decisions.
- Receive reviews of appeals decisions.
- Change primary care providers.
- Make recommendations regarding the organization's member rights and responsibilities policy

Informed Consent

Members also have the right to:

- Give consent to treatment or care.
- Ask providers about the side effects of care for themselves or their children.
- Know about side effects of care and give consent before getting care for themselves or their children.

Advance Directives

We respect the right of the member to control decisions relating to his or her own medical and Behavioral Health Care. This includes the decision to have the medical or surgical means or procedures calculated to prolong life provided, withheld or withdrawn as well as decisions about mental health treatment that members prefer when they become impaired by mental illness that affect their judgment and communication about mental healthcare. 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.

We adhere to the *Patient Self-Determination Act* and maintain written policies and procedures regarding advance directives. Advance directives or physician orders for life-sustaining treatment (POLST) are documents signed by a competent person giving direction to medical and mental healthcare providers about treatment choices in certain circumstances. Wellpoint recognizes and supports the following advance directives:

- Durable power of attorney
- Living will
- Mental health advance directive

We understand a facility, physician or mental health provider may conscientiously object to an advance directive. However, we also recognize the member's right to determine his or her own care.

Please note that a Wellpoint associate cannot act as a witness to an advance directive nor serve as a member's advocate or representative.

A sample living will/durable power of attorney is located on our provider website at provider.wellpoint.com/wa.

Advance Directive vs. Mental Health Advance Directive

An advance directive (living will) protects members' right to refuse medical treatment they do not want or to request treatment they do want if they lose the ability to make decisions. A durable power of attorney lets a member name a patient advocate to act on his or her behalf. A living will lets a member state his or her wishes on medical and mental health treatment in writing. Providers and Wellpoint have the requirement to assist the member in completing any advance directive if the member requests assistance.

A mental health advance directive is a written document that describes directions and preferences for treatment and care during times when members are having difficulty communicating and making decisions about mental healthcare. It can inform others about what treatment is wanted or not wanted, and it can identify an agent who is trusted to make decisions and act on their behalf.

We encourage members age 18 and older to ask you for an advance directive, mental health advance directive, or POLST form and education at their first appointment. Please document their forms in your medical records. For mental health advance directives, go to hca.wa.gov/health-care-services-supports/behavioral-health-recovery/mental-health-advance-directives.

A POLST form is located at Washington State Medical Association website at wsma.org/POLST.

Privacy

Members also have the right to:

- Be treated with respect and with due consideration for their dignity and privacy.
- Expect that we will treat their records (including medical and personal information) and communications confidentially.
- Request and receive a copy of their medical records at no cost to the member and request that the records be amended or corrected.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation as specified in federal regulations.

Per RCW 40.24, Washington's Address Confidentiality Program (ACP) is designed to help people maintain a confidential address who fear for their safety. Passed by legislature in 1991, ACP is used as part of an overall safety plan to prevent perpetrators from locating Medicaid members through public records. Washington's ACP is available to state residents who are targets of stalking, domestic violence, trafficking, or sexual assault. In 2011, the program expanded to include criminal justice employees who have been threatened or harassed because of their work.

Grievances, Appeals and Administrative Hearings

Enrollees also have the right to:

- Pursue resolution of grievances and appeals about the health plan or care provided.
- Freely exercise filing a grievance or an appeal without adversely affecting the way they are treated.

- Continue to receive benefits pending the outcome of an appeal or a fair hearing under certain circumstances.
- File a grievance with Wellpoint and/or the HCA if dissatisfied with our advance directive policy and procedure or our administration of our policy and procedure.
- Access assistance with grievance procedures from the regional behavioral health ombudsman office.

Wellpoint Information

Members also have the right to:

- Receive the necessary information to be a Wellpoint member in a manner and format they can understand easily.
- Receive a current member handbook and a provider directory wellpoint.com/wa/medicaid > Member Support > Search providers.
- Receive assistance from Wellpoint in understanding the requirements and benefits of the
- plan.
- Receive notice of any significant changes in the benefit package at least 30 days before the intended effective date of the change.
- Make recommendations about our rights and responsibilities policies.
- Know how we pay our providers.

Healthcare

Members also have the right to:

- Choose their PCPs from our network of providers.
- Choose their Behavioral Health Care provider from our network of providers.
- Choose any Wellpoint network specialist after getting a referral from their PCPs, if
- appropriate.
- Be referred to healthcare providers for ongoing treatment of chronic disabilities.
- Have access to their PCPs or backups 24 hours a day, 365 days a year for urgent or emergency care.
- Get care right away from any hospital when their symptoms meet the definition of an emergency medical condition.
- Get post-stabilization services following an emergency medical condition in certain
- circumstances.
- Be free from discrimination and receive covered services without regard to race, color, creed, gender, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, physical or behavioral disability, or whether advance directives have been issued except where medically indicated.

10.2 Member Responsibilities

Members and/or their enrolled dependents have the responsibility to:

- Understand their Apple Health benefits.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Supply information, to the extent possible, that the organization and its practitioners and providers need in order to provide care.
- Accurately and promptly report changes that may affect premiums or eligibility, such as address changes or changes in family status or income, and submit the required forms and documents.
- Choose a primary care provider before receiving services.
- Work with Wellpoint to help get any third-party payments for medical care.
- Tell Wellpoint about any outside sources of healthcare coverage or payments, such as insurance coverage for accidents.
- Tell all your providers about medical problems and ask questions about things they do not understand.
- Decide whether to receive treatments, procedures or services.
- Get medical services from (or coordinated by) primary care providers, except in emergencies or in the cases of referrals.
- Get referrals from PCPs before going to specialists, if referral is required.
- Pay applicable copays in full at the times of service.
- Pay deductibles and coinsurance in full when they are due.
- Not engage in fraud or abuse in dealing with Apple Health, the Maternity Benefits program, the health plan, primary care providers or other providers.
- Keep appointments and be on time or call the providers' offices when late or cancelling appointments.
- Keep medical ID cards with themselves at all times.
- Notify the health plan or PCPs within 24 hours or as soon as reasonably possible regarding any emergency services provided outside the health plan.
- Use only the selected health plan and PCPs to coordinate services for medical needs.
- Comply with requests for information, including requests for medical records or information about other coverage by the date requested.
- Cooperate with PCPs and referred providers by following recommended procedures or treatments, and plans and instructions for care they have agreed with their practitioners.
- Work with the health plan and providers to learn how to stay healthy.

Respect and Cooperation

Members and/or their enrolled dependents also have the responsibility to:

- Treat their doctors, their doctors' staff and Wellpoint employees with respect and dignity.
- Not be disruptive in the doctor's office.
- Make and keep appointments and be on time.
- Call if they need to cancel an appointment or change the appointment time or call if they will be late.
- Respect the rights and property of all providers.
- Tell their providers about their symptoms and problems and ask questions.
- Supply information providers need in order to provide care.
- Understand the specific health problems and participate in developing mutually agreed upon treatment goals as much as they are able.
- Discuss problems they may have with following their providers' directions.
- Follow plans and instructions for the care they have agreed to with their practitioners.
- Consider the outcome of refusing treatment recommended by a provider.
- Discuss grievances, concerns and opinions in an appropriate and courteous way.
- Help their providers obtain medical records from their previous providers, and help their providers complete new medical records as necessary.
- Secure referrals from their PCPs when specifically required before going to another healthcare provider, unless they have a medical emergency.
- Know the correct way to take medications.
- Go to the emergency room when they have an emergency.
- Notify their PCPs as soon as possible after they receive emergency services.
- Tell their doctor who they want to receive their health information.

Wellpoint Policies

Members and/or their enrolled dependents also have the responsibility to:

- Provide us with proper identification during enrollment.
- Carry their Wellpoint and Apple Health ID cards at all times and report any lost or stolen
- cards.
- Contact us if information on their ID cards is wrong or if there are changes to their name, address or marital status.
- Call us and change their PCP before seeing the new PCP.
- Tell us about any providers they are currently seeing.
- Notify us if a member or family member who is enrolled in Wellpoint has died.
- Report suspected fraud and abuse.

10.3 Members with Special Needs

Adults with special needs are those members with complex/chronic medical conditions requiring specialized healthcare services, including persons with physical, behavioral and/or

developmental disabilities. Children with special healthcare needs are those members who have or are at an increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required generally by children.

Wellpoint, through an intensive care management program, has processes in place to assist with the following:

- Well-child care
- Health promotion and disease prevention
- Specialty care for those who require such care
- Diagnostic and intervention strategies
- Therapies
- Ongoing ancillary services
- Long-term management of ongoing medical complications
- Care management systems for assuring children with serious, chronic and rare disorders receive appropriate diagnostic workups on a timely basis

We coordinate with qualified community health homes and long-term care agencies to provide a full range of health home services for members with special needs. See the **Wellpoint as the Member Health Home** section of this manual for more details.

We have policies and procedures to allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member.

Wellpoint, with the assistance of network providers, will identify members who are at risk of or have special needs. The identification will include the application of screening procedures for new members. These will include a review of hospital and pharmacy utilization. We will develop care plans with the member and his or her representatives that address the member's service requirements with respect to specialist physician care, durable medical equipment, home health services, transportation, etc. The care management system is designed to ensure that all required services are furnished on a timely basis and that communication occurs between network and non-network providers if applicable.

We work to ensure a new member with complex/chronic conditions receives immediate transition planning. The transition plan will include the following:

- Review of existing care plans
- Preparation of a transition plan that ensures continual care during the transfer to the plan

If a new member upon enrollment or a member upon diagnosis requires very complex, highly specialized healthcare services over a prolonged period of time, the member may

receive care from a participating specialist or a participating specialty care center with expertise in treating the life-threatening disease or specialized condition.

Training sessions/materials and after-hours protocols for provider's staff will address members with special needs. Protocols must recognize that a nonurgent condition for an otherwise healthy member may indicate an urgent care need for a member with special needs.

Case/care managers, providers and Member Services staff are able to serve members with behavior problems associated with developmental disabilities, including the extent to which these problems affect the member's level of compliance.

10.4 Noncompliant Members

Contact Provider Services if you have an issue with a member regarding:

- Behavior.
- Treatment cooperation.
- Completion of treatment.
- Continuously missed or rescheduled appointments.

We will contact the member to provide the education and counseling to address the situation and will report to you the outcome of any counseling efforts.

10.5 Second Opinions

A member, parent and/or legally appointed representative, or the member's PCP may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. The second opinion will be provided at no cost to the member.

The second opinion must be obtained from a network provider (see wellpoint.com/wa/medicaid > Member support > Search providers or a non-network provider if there is not a network provider with the expertise required for the condition. Authorization is required for a second opinion from a non-network provider.

Once approved, you will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. You will notify the member of the outcome of the second opinion.

To prescribe a psychotropic medication for a child less than 5 years of age, a second opinion from an expert in child psychiatry is required.

We may also request a second opinion at our own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by the member or the provider
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during our regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

When we request a second opinion, we will make the necessary arrangements for the appointment, payment and reporting. We will inform you and the member of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

10.6 Member Grievances

Our members have the right to say they are dissatisfied with Wellpoint or a provider's service and operations. A member or member's representative may file a grievance at any time. Members have the right to access Ombudsman services for assistance in the grievance process when the grievance is regarding behavioral health.

Only a member or a member's authorized representative may file a grievance. A provider may not file a grievance on behalf of a member unless the provider is acting with the member's written consent. The member's authorized representative must submit the member's written consent in order to file a grievance on behalf of a member. A member can file a grievance orally by calling Member Services at **833-731-2167 (TTY 711).** Monday through Friday, 8 a.m. to 5 p.m. PT He or she can also file a grievance by mail. Any supporting documents must be included. Grievances should be sent to:

Wellpoint
Attention: Quality Management
705 Fifth Ave. S., Suite 300
Seattle, WA 98104
Fax: **855-292-3770**

Member grievances do not involve:

- Medical management decisions.
- Interpretation of medically necessary benefits.
- Adverse benefit determinations.

These concerns are appeals and are addressed in the Provider Procedures, Tools and Support chapter of this manual.

We will acknowledge receipt of each grievance, either orally or in writing, within two business days of receipt of the grievance. An acknowledgement letter is mailed within two business days of receiving a grievance to the member or the member's authorized representative.

We investigate each grievance and all of its clinical aspects and ensure decision-makers on grievances:

- Have not been involved in previous levels of review or decision-making.
- Are not subordinates or direct reports of staff involved in previous levels of review or decision-making.
- Have clinical expertise in treating the member's condition or disease if the grievance involves any clinical issues.
- That a physician, doctoral level psychologist, certified addiction medicine specialist, or pharmacist, as appropriate, shall review any behavioral health quality of care grievances.

Grievances will be resolved as expeditiously as the member's medical condition requires. We investigate the grievance and for non-urgent grievances, will resolve it within 45 calendar days from the date we received the grievance. We will provide a written disposition of the grievance within five business days of determination. The notification may be oral or in writing for grievances not involving clinical (quality of care) issues. Notices of disposition for all clinical issues are sent in writing in an easily understood language.

Wellpoint plan may extend the timeframe for processing a grievance by up to fourteen (14) calendar days if the enrollee requests the extension. If the enrollee did not request the extension, the health plan must:

- Document that there is need for additional information and that the delay is in the enrollee's best interest.
- Give the enrollee prompt oral notice of the delay.

If Wellpoint extends the timeline for a grievance not at the request of the enrollee, Wellpoint must give the enrollee written notice, within two (2) calendar days of the reason for the decision to extend the time frame.

Wellpoint will inform the enrollee of their right to file a grievance is the enrollee does not agree with the decision to extend the grievance timeframe.

Enrollees do not have the right to hearings in regard to the dispositions of grievances, except to address the plan's failure to adhere to the notice and timing requirements for grievances.

Enrollee's do not have the right to appeal an adverse grievance decision to Wellpoint for non-coverage benefits.

No enrollee nor provider will be penalized for filing a grievance. At no time will Wellpoint cease medically necessary care pending a grievance investigation.
Enrollee grievances must be filed with Wellpoint and not with HCA. HCA will forward any grievance received by HCA to Wellpoint for resolution.

We will notify the member of the resolution in writing of the following:

- The names(s), titles(s) and, in the case of a grievance with a clinical issue, qualifying credentials of the person or persons completing the review of the grievance.
- Our decision.
- The reason for the decision.

10.7 Member Self-Referrals

Members may self-refer for family planning services, sexually transmitted disease screenings and treatment services provided by participating and nonparticipating providers, including but not limited to family planning agencies and local health departments. Wellpoint is contracted with all Planned Parenthood agencies in the state of Washington.

Note: In accordance with *Section 5006(d)* of the *American Recovery and Reinvestment Act of 2009*, American Indians and Alaska Natives have free access to any participating and nonparticipating Indian healthcare providers for contracted services provided to American Indian and Alaska Native enrollees.

10.8 Member Enrollment

Apple Health recipients who meet the state's eligibility requirements for participation in managed care are eligible to join Wellpoint. Members are enrolled without regard to their health status. Our members:

- Are free to switch from managed care organization (MCO) to MCO each month.
- Can choose their PCPs and will be auto-assigned to a PCP if they don't select one.
- Are encouraged to make appointments with their PCPs within 90 calendar days of their effective dates of enrollment.

Eligible newborns born to members are automatically enrolled with Wellpoint on the date of birth if the mother of the newborn was enrolled with Wellpoint before the birth and has not made an alternative MCO or PCP selection. We are responsible for all covered medically necessary services to the qualified newborn.

If the mother's enrollment ends before the newborn receives a separate client identifier from the Washington State Health Care Authority (HCA), the newborn's enrollment shall end the

last day of the month in which the 21st day of life occurs or when the mother's enrollment ends, whichever is sooner, except for members hospitalized at the time of their eligibility termination.

BENEFITS & COVERED SERVICES

11.1 Health Care Authority & Integrated Managed Care

Most individuals eligible for Apple Health in Washington are covered through managed care – a prepaid, comprehensive system of medical and healthcare delivery. Integrated managed care is administered through managed care organizations, or health plans. It includes preventive, primary, specialty and ancillary health services; the same basic services are covered by all health plans.

Managed care programs include Integrated Managed Care, Behavioral Health Services Only. Wellpoint is an available health plan for Apple Health enrollees across the state for the Integrated Managed Care and Behavioral Health Services Only programs. Descriptions of managed care programs, including availability by region, are available at hca.wa.gov/billers-providers-partners/program-information-providers/managed-care.

American Indian and Alaska Native enrollees can select an Integrated Managed Care plan or receive Apple Health coverage without a managed care plan. Information on these options is available at hca.wa.gov/free-or-low-cost-health-care/i-need-medical-dental-or-vision-care/apple-health-coverage-without-managed-care.

Apple Health enrollees in regions offering Integrated Managed Care who are not eligible for managed care enrollment may be eligible for Behavioral Health Services Only (BHSO). This includes enrollees who are:

- Dual eligible for both Medicare and Apple Health.
- American Indian/Alaska Native (by choice).
- Medically needy.
- Have met their spend-down.
- Noncitizen pregnant women.
- Admitted to an institution of mental disease (IMD).
- Long-term care residents.
- Enrolled in other health insurance (by choice).

Their behavioral health services are covered by the BHSO health plan, one of the plans administering Integrated Managed Care. Physical health services are covered separately by another plan or the state on fee-for-service. A BHSO fact sheet is available at hca.wa.gov/assets/program/bhso-fact-sheet.pdf.

11.2 Services Covered under the State Plan or Fee-For-Service Medicaid

While Wellpoint manages most of our members' healthcare services, the Washington State Health Care Authority (HCA) also directly manages a multitude of services available to our members. We encourage providers to be aware of these services so you can refer members. These services include:

- Inpatient services at certified public expenditure hospitals for categorically needy — blind and disabled identified by the HCA.
- School-based healthcare services for children in special education with an individualized education plan or individualized family service plan who have a disability, developmental delay or are diagnosed with a physical or mental condition.
- Eyeglass frames, lenses and fabrication services covered under the HCA's selective contract for these services, and associated dispensing services.
- Voluntary termination of pregnancy.
- Court-ordered transportation services, including ambulance services.
- Transportation services including but not limited to: taxi, ambulance, voluntary transportation, public transportation and common carriers, and ground and air ambulance services.
- HCA's First Steps Program maternity support services.*
- Sterilizations for enrollees under age 21 or those that do not meet other federal requirements.
- Services provided by a health department when a client self-refers for care (if the health department is not contracted with Wellpoint).
- Long-term private duty nursing for enrollees 18 and over. These services are covered by the Department of Social and Health Services Aging and Long-Term Services Administration.
- HIV case management.
- Prenatal diagnosis genetic counseling provided to members to allow them and their PCPs to make informed decisions regarding current genetic practices. (Please note, testing is covered by Wellpoint.)
- Long-term private duty nursing for members 18 and over (covered by the Aging and Long-Term Support Administration).
- Community-based services (for example, Community Options Program entry system and Personal Care Services) covered through the Aging and Long-Term Services Administration.
- Nursing facility stays that do not meet rehabilitative or skilled criteria.
- Vaccines covered under the Vaccines for Children program.
- Healthcare services covered through the Developmental Disabilities Administration for institutionalized clients.

- Infant formula for oral feeding provided by the Women, Infants and Children program in the Department of Health.
- Any service provided to a member while incarcerated with the Washington State Department of Corrections.
- Hemophiliac blood product-blood factors VII, VIII and IX and the anti-inhibitor indicated for use in treatment for hemophilia and von Willebrand disease distributed for administration in the enrollee's home or other outpatient setting.
- Immune modulators and anti-viral medications to treat hepatitis C. This exclusion does not apply to services covered by Wellpoint related to the diagnosis or treatment of hepatitis C.
- Sexual reassignment surgery as described in *WAC 182-531-1675(6)(d) and (e)* as well as hospitalizations, physician and ancillary services required to treat postoperative complications of these procedures (case management services and medication are covered by Wellpoint).
- Chemical-Using Pregnant (CUP) Women program as described in *WAC 182-533-0730* when provided by an HCA-approved CUP provider.
- Professional services provided by a dentist, dental surgeon, dental hygienist, denturist, dental anesthesiologist, endodontist, periodontist, or other dental specialist for care and treatment of a dental condition, including anesthesia for dental care.

For details on how and where members can access these services, call HCA's Apple Health Customer Service line at **800-562-3022** (**TTY 711**).

* A note about HCA's First Steps Program maternity support services (MSS): All pregnant women covered under HCA Apple Health programs are eligible to receive maternity support services (MSS) through the First Steps program, a preventive health program designed to ensure healthy birth outcomes. MSS are voluntary and offer a variety of services, including nutritional counseling, targeted case management, referrals to community resources, family training and counseling. We recommend that all pregnant women covered under Apple Health are referred to the First Steps program.

The First Steps program is part of the Department of Social and Health Services. Interested members should call **800-322-2588** (**TTY 711**) for additional information.

11.3 Services covered under Wellpoint

Note: We do not cover experimental procedures or medications unless specifically noted in the chart below. Some services may require prior authorization; visit our provider self-service website by logging in at provider.wellpoint.com/wa for additional information and requirements prior to performing services. Services may vary by region based on availability of Integrated Managed Care.

Service	Descriptions/Notes	Covered for Wellpoint Members?
Ambulatory Surgical Services	Covered services include medically necessary diagnostic, preventive, therapeutic, rehabilitative or palliative items, or services furnished to an outpatient.	Yes
Anesthesia	General anesthesia is covered for: • Radiological procedures for children. • Patients when medically necessary procedures cannot be performed unless patients are given anesthesia. • Dental anesthesia is covered through fee-for-service Medicaid.	Yes
Assistive/ Augmentative Communication Devices	• Communication devices/speech generating devices are covered. • Communication devices/speech generating devices (SGD) requested for the purpose of education are not covered. • Back-up batteries for SGDs are not covered, but replacement batteries are covered. • Interpreter services for medical visits are covered through Medicaid fee-for-service.	Yes Certain limits apply. Prior approval is required.
Audiology Services	A referral must be made by a licensed physician for these services. Covered services include: • Speech/audiology services for medically known diseases and defects when given by a licensed or registered audiologist. • Osseo-integrated bone-anchored hearing aids (BAHA) are covered for members age 20 and younger. • Requests to remove or repair BAHA and cochlear devices that were implanted in the past when medically needed for members age 21 and older; prior approval is required.	Yes Certain limits apply. Prior approval is required.
Bariatrics	Prior authorization is required for: • Bariatric surgery program/bariatric surgery.	Yes Prior authorizati

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• Insertion, removal, and/or replacement of adjustable gastric restrictive devices and subcutaneous port components	on may be required
Behavioral Health Services	All Wellpoint members are allowed an assessment for behavioral health service needs at any of our contracted behavioral health providers. Ongoing services vary by provider. Crisis services do not require an assessment prior to receiving the service. Covered behavioral health services in Integrated Managed Care and BHSO include: • Applied behavior analysis • Brief intervention treatment • Case Management • Behavioral health outpatient services • Crisis Services • Day support* • Family treatment • Freestanding evaluation and treatment* • Group treatment services • High-intensity treatment • Individual treatment services • Inpatient withdrawal management services* • Inpatient/residential substance use treatment services* • Inpatient psychiatric services (voluntary and involuntary) • Intake evaluation • Intensive outpatient* • Medication management • Medication monitoring • Opiate substitution treatment • PACT services and monitoring • Intensive Residential Treatment (IRT)*	Yes Prior approval or notification may be required. Required for some services.

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• Peer support services • Psychological assessment* • Rehabilitative case management • Residential mental health services* • Stabilization services* • Special population evaluation • Therapeutic psychoeducation • Psychiatric and psychological testing, evaluation, and diagnosis* • WISe Services and monitoring • Withdrawal management* * Prior authorization or notification only required. Screening, brief intervention and referral for treatment (SBIRT) Services will be covered when certain criteria are met by eligible providers who have participated in specific training. These services are covered in all regions. SBIRT services are covered for: • Determining risk factors related to alcohol and other drug use disorders. • Providing interventions for determined risk factors that motivate patients to change. • Making appropriate referrals as needed. A brief intervention may be provided on the same day as a full screen or on subsequent days. SBIRT services will be covered when all of the following are met: • The billing provider and servicing provider are SBIRT-certified. The client is age 18 or older. • The diagnosis code is Z71.41 or Z71.51. • The screening is done during an evaluation and management examination.	Required for some services.

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• The treatment or brief intervention does not exceed the limit of four encounters per client, per provider, per year. • The place of service is appropriate for the SBIRT assessment, intervention or treatment. • The provider has an appropriate taxonomy to bill for SBIRT; chemical dependency professionals is a subspecialty of counselor: Addiction (Substance Use Disorder) — 101YA0400X.	
Blood Administration and Other Blood Products	Covered services include blood, blood components, human blood products and their administration when provided in the inpatient setting.	Yes
Botox Injections	These injections are used for various medically necessary treatments, including the following: • Stroke rehabilitation • Surgical procedures • Eye conditions to help stop twitching • Relief from migraine headaches, excessive sweating and muscle spasms in the neck and eyes Facial cosmetic enhancements are not covered.	Yes Certain limits apply. Prior approval is required
Outpatient Cardiac Rehabilitation Services	Covered services include the following: • Up to 24 sessions (three sessions a week for 4-6 weeks) of cardiac rehab exercise per event, including continuous electrocardiogram monitoring • Continued participation in cardiac rehab exercise programs beyond 24 sessions on a case-by-case basis with prior authorization. • Cardiac rehabilitation is covered for the following diagnosis codes, per the Health Care Authority: acute myocardial infarction, angina pectoris, aortocoronary bypass status and	Yes Certain limits apply. Prior approval is required.

Service	Descriptions/Notes	Covered for Wellpoint Members?
	percutaneous transluminal coronary angioplasty status	
Cardiac Rehabilitation	Covered in a hospital outpatient setting when: • Referred by a physician • Have Coronary artery disease • Do not have specific contraindications to exercise training have: – A recent documented history of acute myocardial infarction (MI) within the preceding 12 months. – Had coronary angioplasty (coronary artery bypass grafting [CABG]. – Percutaneous transluminal coronary angioplasty [PTCA]). – Stable angina. Bill physician services with CPT code 93797 or 93798 or HCPCS G0422 or G0423 (per session) with one of the following diagnoses: • Acute myocardial infarction • Angina pectoris • Aortocoronary bypass status • Percutaneous transluminal coronary angioplasty status • Coverage is limited to up to 24 sessions of cardiac rehabilitation sessions (phase II) per event. • Visits beyond 24 sessions is covered on a case by case basis.	
Chemotherapy (place of service)	Prior authorization is not required for procedures performed in the following outpatient settings: • Office • Outpatient hospital • Ambulatory surgery center Prior authorization is required for inpatient chemotherapy and other drugs as part of the inpatient admission.	

Service	Descriptions/Notes	Covered for Wellpoint Members?
	Check the coverage and prior authorization requirement status for oncology drugs and adjunctive agents. Please refer to the Prior Authorization Lookup Tool Online on our provider website under Quick Tools or Medical Oncology Injectables for prior authorization information	
Chiropractic Services	Covered services include medically needed spinal manipulations for Apple Health members age 20 and younger to a chiropractor as part of an EPSDT checkup.	Yes Certain limits apply. Prior approval is required.
Circumcision	Circumcisions are covered when billed with one of the following diagnoses: • Phimosis, N47.3-N47.8 • Balanoposthitis, N47.0-N47.8, N48.1 • Balanitis Xerotica, N48.0 • Use CPT codes: 54150; 54160; 54161	Yes
Clinical Trials	Routine Cost: Any item or service provided to the member under the qualifying clinical trial including covered physician services or laboratory or medical imaging services that assist with prevention, diagnosis, monitoring or treatment of complications arising from clinical trial participation. To determine if the service falls under the definition of a "qualifying clinical trial", please consult the health plan and/or HCA. A Qualifying Clinical Trial Attestation Form is required to be submitted by the provider to Wellpoint prior to the start of the Qualifying Clinical Trial. Forms can be found on the CMS website. HCA's Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial can be found on HCA's Forms and Publications website. For members participating in a qualifying clinical trial, requests must be submitted to the health plan	Certain limits apply

Service	Descriptions/Notes	Covered for Wellpoint Members?
	with an expedited request and be made without regard to the geographic locations of network affiliation of the healthcare provider treating member or the principal investigator of the qualifying clinical trial.	
Cochlear Implants	For members 20 years and under: Monaural and binaural hearing aids, bilateral cochlear implants and bone-anchored hearing aids (BAHA) Covered services include: • Cochlear implantation for post-lingual hearing loss and members with prelingual hearing loss when all of the following are true: • When performed in an inpatient or outpatient hospital setting. • Has a diagnosis of profound to severe bilateral, sensorineural hearing loss. • Has stimulable auditory nerves but limited benefit from appropriately fitted hearing aids. • Has the cognitive ability to use auditory clues. • Is willing to undergo an extensive rehabilitation program. • Has an accessible cochlear canal that is structurally suited for a cochlear implant. • Does not have lesions in the auditory nerve and/or acoustic areas of the central nervous system. • Has no other factors to prevent surgery. • Replacement of parts for cochlear implants and BAHA. For members age 21 and older: • Non-refurbished, monaural hearing aids includes one new non-refurbished monaural hearing aid, which includes the ear mold, every 5 years.	Yes Certain limits apply. Prior approval is required.

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• The member must have an average decibel loss of 45 or greater in the better ear, based on a pure-tone audiometric evaluation by a licensed audiologist or a licensed hearing aid specialist at 1000, 2000, 3000 and 4000 Hertz (Hz) with effective masking as indicated. • The hearing aid must meet the client's specific hearing needs and carry a manufacturer's warranty for a minimum of 1 year.	
Cosmetic/ Plastic/ Reconstructive Procedures	Covered services include the surgery and related services and supplies to: • Correct physical defects from birth, an illness or physical trauma. • Perform mastectomy reconstruction for post-cancer treatment.	Yes
Clinic Services (Other Than Hospitals)	Covered services include diagnostic, preventive, therapeutic, rehabilitative or palliative items or services furnished to an outpatient by or under the direction of a physician in a facility that is not part of a hospital. For example, mental health clinics, prenatal healthcare clinics, family planning clinics, end-stage renal disease facilities and radiation therapy centers). A maximum of one procedure per day per recipient for mental health clinic services is permitted. Recreational therapy, music therapy and art therapy are not provided. Prenatal care provided in a prenatal healthcare clinic is subject to limitations.	Yes Certain limits apply.
Clinical Lab Services, Diagnostic Testing and Radiology Services	Covered services include: • Inpatient and outpatient lab services (see coverage limits for hospital outpatient facilities). • Diagnostic testing and radiology services. • Portable (mobile) services for members who cannot leave their homes without special transport.	Yes

Service	Descriptions/Notes	Covered for Wellpoint Members?
	To ensure outpatient diagnostic laboratory services are directed to the most appropriate setting, laboratory services should be sent to a Wellpoint-preferred laboratory vendor. Contact LabCorp at the numbers below to receive a LabCorp specimen drop box. Visit our website for further details in the accordion titled Vendor/Partner Links & Information at provider.wellpoint.com/wa For more information, testing solutions and services or to set up an account, contact one of the following: • LabCorp: **800-345-4363** • PACLAB/PAML/TriCities Lab: **800-541-7891**	
Dental	Professional services provided by a dentist, dental surgeon, dental hygienist, denturist, dental anesthesiologist, endodontist, periodontist, or other dental specialist for care and treatment of a dental condition, including anesthesia for dental care.	Certain limits apply. Prior approval may be required.
Dermatology	Prior authorization is not required for a network provider for evaluation and management testing or procedures. Cosmetic services or services related to previous cosmetic procedures are not covered. For code-specific requirements, visit our provider website.	Yes
Diabetes Services	Covered services include: • Up to six hours (or 12 half-hour units) of diabetes education and management per calendar year per person.	Yes

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• Education in a group or individual setting or both, based on a person's needs. Diabetic supplies, including syringes and needles, diabetic test strips, lancets, and insulin are covered under the pharmacy benefit.	
Diabetic Testing Supplies	Diabetic testing supplies are covered and include glucose monitors, test strips, lancets, alcohol pads, ketostix and continuous personal glucose monitors (CGM).	Yes Certain limits apply. Prior approval may be required.
Dialysis (End-Stage Renal Disease)	Covered services for persons with end-stage renal disease (ESRD) or acute renal failure include: • Dialysis in a Medicare-certified ESRD facility. • Kidney transplant treatment in a Medicare-certified ESRD facility when medically needed. • Treatment for conditions directly related to ESRD. • Training and supervision of personnel and clients for home dialysis, medical care and treatment, including home dialysis helpers. • Supplies and equipment for home dialysis. • Diagnostic lab work. • Treatment for anemia. • Intravenous drugs.	Yes Certain limits apply. Prior approval may be required.
Diagnostic Testing	Prior authorization is not required for routine diagnostic testing. For code-specific requirements, visit our provider website Prior authorization is required for: • MRAs • MRIs • CAT scans • Nuclear cardiac • Inpatient Video EEGs.	

Service	Descriptions/Notes	Covered for Wellpoint Members?
	Carelon Medical Benefits Management manages prior authorization for computerized tomography, computerized axial tomography, nuclear cardiology, magnetic resonance imaging, magnetic resonance angiogram and positron emission tomography scans. They can be contacted at **800-714-0040.**	
Drugs/ Injectables/ Pharmaceuticals	Covered services include: • All home health/home infusion services (including drugs dispensed). • Prescription drug products, according to the *Preferred Drug List* (formulary).	Yes Certain limits apply. Prior approval may be required.
Durable Medical Equipment (DME)	Services include medically needed medical supplies, appliances and assistive devices for members, including disposable incontinence supplies. Prior authorization may be required for certain rental and purchased medical equipment and supplies. For code-specific requirements, visit our provider website at **provider.wellpoint.com/wa**. Request prior authorization with a Certificate of Medical Necessity (CMN) — available on our website — or by submitting a physician order and Wellpoint Referral and Authorization Request form. Clinical information to substantiate the request must be included. You must send a complete CMN with each claim for the following: • Hospital bed • Support surface • Motorized wheelchair • Manual wheelchair • Continuous positive airway pressure (CPAP)	Yes

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• Lymphedema pump • Osteogenesis stimulator • Seat-lift mechanism • Power-operated vehicle (POV) • External infusion pump • Parenteral nutrition • Enteral nutrition and oxygen We must agree on HCPCS and/or other codes for billing, and we require you to use appropriate modifiers (NU for new equipment, RR for rental equipment).	
Early Periodic Screening, Diagnosis and Treatment (EPSDT)/ Well-Child Visits	The EPSDT service is a complete and preventive child health program for Apple Health members ages birth-20 years of age per the nationally recognized pediatric periodicity schedule. Benefits cover: • a health and development history • complete physical exam • proper immunizations, screenings and diagnostic services, including lead blood level assessment • Vision • Hearing • Dental • Screenings to decide healthcare needs and other measures to identify, correct or improve physical or mental defects or chronic conditions. Prior authorization is not required. Members may self-refer for services. Use the EPSDT schedule and document all visits. Vaccine serum must be received under the Vaccines for Children program.	Yes

Service	Descriptions/Notes	Covered for Wellpoint Members?
	Wellpoint will pay for both a sick visit and an EPSDT visit performed on the same day. To receive payment, be sure to include modifier 25 on claims. Non-covered services may be approved under EPSDT rules if determined to be medically necessary.	
Emergency Medical Services	Includes emergency care in-network, out-of-network and post-stabilization care. Prior authorization is not required. Coverage includes emergency services given by an in-network or out-of-network provider under these conditions: • The member has an emergency medical condition; this includes cases in which the absence of getting medical care right away would not have had the outcome defined as an emergency medical condition. • Wellpoint tells the member to get emergency services. We will cover these services and the screening exam even if the member's condition does not qualify as an emergency. For inpatient services to be covered beyond the ER, notification is required within 24 hours or by the next business day when a member is admitted to the hospital through the ER.	Yes
End-Stage Renal Disease (ESRD) Services	ESRD services are covered for eligible child and adult members. Certain limits apply. Prior approval may be required. See also the Dialysis section in this grid.	Yes
ENT Services (Otolaryngology)	Prior authorization is not required for a network provider for: • Evaluation and management testing • Certain procedures Prior authorization may be required for:	

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• Tonsillectomy and/or adenoidectomy	
Eye Care and Vision Services	Includes vision services from a licensed ophthalmologist or optometrist. EyeQuest Phone: **855-225-2640** Online: **eye-quest.com** EyeQuest manages all vision and medical eye services provided by an ophthalmologist or optometrist in a clinic or ambulatory surgery center. Providers should reach out to EyeQuest directly to contract for service rendered within the above scenarios. Services provided in other settings are covered by Wellpoint and should be billed to Wellpoint directly. Eyeglass frames, lenses, fabrication services, and associated dispensing services are covered under the Washington State Health Care Authority's fee-for-service program through Correctional Industries Optical. Orders should be placed by the member's optical provider. Eye examinations, refractions and fitting services are covered with the following limitations: • Once every 24 months for asymptomatic members 21 years of age or older • Once every 12 months for asymptomatic members 20 years of age or younger Fitting of contact lenses for treatment of ocular surface diseases (92071) is limited to: • Once every 24 months for members ages 21 and older. • Once every 12 months for members ages 20 and younger.	Yes

Service	Descriptions/Notes	Covered for Wellpoint Members?
	Fitting of contact lenses for management of keratoconus: the initial fitting (92072) is limited to ICD-10 codes H18.60x, H18.61x, or H18.62x, and is limited to: • Two every 24 months for members ages 21 and older. • Two every 12 months for members ages 20 and younger. Repair and adjustment of spectacles (92370 and 92371) is limited to clients 20 years of age and younger. Scanning, computerized ophthalmic diagnostic imaging, posterior segment with interpretation and report, unilateral or bilateral, for the optic nerve (92133) is limited to one per calendar year. Scanning, computerized ophthalmic diagnostic imaging, posterior segment with interpretation and report, unilateral or bilateral, for the retina (92134) is limited to two times per calendar year but may be expanded to up to 12 times per calendar year with prior authorization.	
Family Planning Services	Family planning services include counseling, information, education and communication activities, and delivery of contraceptives/birth control. Reproductive health services Covered services include the following: • All prescription contraceptive methods that are FDA approved are covered • Over-the-counter drugs, contraceptives and supplies • Maternity-related services	Coverage includes family planning services for members of childbearing age who choose to delay or prevent pregnancy. Members do not need a

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• Sterilization procedures if requested and they are performed in an appropriate setting for the procedure(s) Services for women Covered services include the following: • Comprehensive family planning preventive medicine visits • Routine gynecological exams, including cervical, vaginal and breast cancer screening exams • Screening and treatment for STD-I, including lab tests and procedures for HIV testing • Education and supplies for FDA-approved contraceptives, natural family planning and abstinence • Twelve months of oral contraceptives, patches and rings can be prescribed and dispensed at one time without prior authorization • Mammograms for women ages 40 years of age and older (and women age 39 and younger with prior approval) • Colposcopy and related medically needed follow-up services Services for men Covered services include the following: • Office visits where the primary focus and diagnosis is contraceptive management (including condoms and vasectomy counseling) and/or there is a medical concern • Over-the-counter contraceptives, drugs and supplies • Screening and treatment for STD-I, including lab tests and procedures for HIV testing	referral for family planning services. Members may choose a network or non-network provider.

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• Education and/or supplies for FDA-approved contraceptives, natural family planning and abstinence • Prostate cancer screening • Prior authorization is not required. • Providers should encourage members to obtain family planning services from network providers to ensure continuity of services. • Members may self-refer to any in-network or out-of-network provider. Encourage patients to receive family planning services in-network to ensure continuity of service	
Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs)	Coverage includes access to covered services offered through a FQHC if the member lives in the service area of the clinic and either: • Chooses the FQHC as their PCP. • Needs emergency care.	Yes
Flu Shots	Child and adult members may receive the flu immunization in a provider office. Adults with Wellpoint pharmacy benefits may get a free flu immunization at participating pharmacies.	Yes
Gastroenterology Services	Prior authorization is not required for a network provider for: • Evaluation and management testing • Certain procedures	Yes
Genetic or DNA Testing	Genetic testing services include the following: • Evaluating the possibility of a genetic disorder • Diagnosing such disorders	Yes Prior approval may be required
Gynecology (also see Obstetrical Care)	Prior authorization is not required for a network provider for: • Evaluation and management testing • Certain procedures	Yes
Habilitative Services	Habilitative services are services and devices provided for a person to prevent deterioration or attain or maintain a skill or function never acquired	Yes Hearing aids

Service	Descriptions/Notes	Covered for Wellpoint Members?
	due to a disabling condition. Covered benefits include the following: • Six physical therapy visits • Six occupational visits and • Twelve speech therapy visits per diagnosis	
Hearing Aids	Prior authorization is not required for hearing aids. Children (age 20 and under): Hearing aids: monaural and binaural hearing aids, including fitting, follow-up care, batteries and repair. Replacement: Hearing aid(s), which includes the ear mold, when all warranties are expired and the hearing aid(s) are one of the following: • Lost • Beyond repair • Not sufficient for the client's hearing loss • Ear mold(s) when the client's existing ear mold is damaged or no longer fits the client's ear Batteries with a valid prescription from an audiologist Repair: maximum of two repairs, per hearing aid, per year, when the repair is less than 50% of the cost of a new hearing aid. To receive payment, all the following must be met: • All warranties are expired. The repair is under warranty for a minimum of 90 days. Adults (age 21 and older): • One new non-refurbished monoaural hearing aid which includes the ear mold, every 5 years • Binaural hearing aids	

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• Hearing aids: non-refurbished, monaural hearing aids and binaural hearing aids, including replacement and repair. • Repairs: Two repairs per hearing aid per year when the cost of the repair is less than 50% of the cost of a new hearing aid • Cochlear and Bone-anchored hearing aids. Prior authorization is required. Children (age 20 and under: • Cochlear implants: bilateral cochlear implants, including implants, parts, accessories, batteries, chargers and repairs. • Bone-anchored hearing aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts and batteries. • There is no limit on the number of batteries or repairs. Adults (age 21 and older): • Repair or replacement of external parts of cochlear devices and bone-anchored hearing aids (BAHA). • Repair or replacement of external parts of bone conduction hearing aids, whether implanted or worn with a headband. If the client has bilateral bone conduction hearing aids, both devices are eligible for repair and replacement of external parts Prior authorization may be required for digital hearing aids. For code-specific requirements, visit our provider website. Noncovered adult services include batteries, tinnitus	

Service	Descriptions/Notes	Covered for Wellpoint Members?
	maskers, Frequency Modulation systems, and nonprescription hearing aids or similar devices. For code-specific requirements, visit our provider website	
Home Health Care/Home Health Aide, Home Health Services/Home infusion (Enteral)	Covered services include the following: • DME, home health, home infusion and medical supply services provided in the home • Home health skilled services provided for acute, intermittent, short-term and intensive courses of treatment, including: • Full skilled nursing services • Brief skilled nursing visit if one of the following is performed: • An injection • Blood draw • Placement of medicine in containers • Home infusion therapy • Infant phototherapy for an infant diagnosed with hyperbilirubinemia • Limited high-risk obstetrical services for a medical diagnosis that complicates pregnancy and may result in poor outcomes for the mother, unborn child or newborn • Physical, occupational or speech/audiology services given in the home for members age 20 and younger when the member is not able to get these services in the local community Coverage includes skilled nursing, therapeutic care, supplies and health aide services provided in a member's residence. Covered services include the following: • Medically needed tube-fed products and supplies for eligible adults	Yes

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• Medically needed oral and tube-fed enteral nutrition for eligible children age 20 and younger • Repairs and replacement parts for tube-delivered enteral nutrition equipment when: • Owned by the patient. • The equipment is less than five years old and no longer under warranty Prior authorization is required for: • Skilled nursing • Physical, occupational and speech therapy services. (yearly coverage limitation apply regardless of setting). • Private duty nursing (for members ages 17 and under). Prior authorization is not required: • Home Health Aide • Drugs, physician ordered supplies and medical equipment and supplies may require separate prior authorization. • Medical Social Workers are not a covered service	
Hospice Care	Prior approval may be required for certain home health hospice services. End of life service intensity add-on payment, for SIA payments there is a maximum limit of 112 units per a client's lifetime Covered services include the following: • A brief period of inpatient care, general or respite care provided in a Medicare-certified hospice care center, hospital or nursing home. Limited to 6 days or less in a 30-day consecutive period.	Yes Prior approval is required.

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• Adult day care • Coordination of care, including medically needed care not related to the member's terminal illness • Communication with non-hospice providers concerning care not related to the member's terminal illness so the member's plan of care (POC) needs are met and not compromised • Drugs, vaccines and over-the-counter medicines for pain control and symptom management • Home health aide and homemaker services ordered by a member's physician and recorded in the POC • Interpreter services as needed for the POC • Medically needed medical equipment and supplies related to the member's illness and conditions • Medical transportation services required by the POC related to the member's illness and conditions • Physical, occupational and speech language therapy to manage symptoms or allow the member to safely perform activities of daily living and basic functional skills • Skilled nursing care • Other services or supplies needed for pain control and symptom management • Pediatric Palliative Care • Concurrent care-Medically necessary services delivered at the same time as hospice services, providing a blend of curative and palliative services to clients age 20 and younger who are enrolled in hospice. • HCA's PPC case management/coordination services cover up to six PPC contacts per client per calendar month	

Service	Descriptions/Notes	Covered for Wellpoint Members?
Hospital Admission (Medical and Behavioral Health)	Prior authorization is required for elective admissions and some same-day/ambulatory surgeries. We must be notified within 24 hours or the next business day if a member is admitted into the hospital through the emergency room. Administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late or lack of notification of admissions or failure to obtain precertification, if required. Appeals for administrative denials must address the reason for the denial. Preadmission testing must be performed by a Wellpoint-preferred lab vendor or network facility outpatient department. Please see our provider directory for a complete listing. wellpoint.com/wa > Member support > Search providers Clinical information to substantiate the admission must be submitted within the next business day to determine medical necessity of the admission. We do not cover: • Personal comfort and convenience items/services. • Services and supplies not directly related to patient care (telephone charges, take-home supplies, etc.).	
Imaging	Carelon Medical Benefits Management manages prior authorization of diagnostic imaging services. Requests for prior authorization for radiology should be submitted on the Carelon Medical Benefits Management Provider Portal (for example, CT scan, MRA, MRI, pet scan).	Yes

Service	Descriptions/Notes	Covered for Wellpoint Members?
	providerportal.com/Default.aspx	
Immunizations	Providers must use vaccines available without charge under the VFC program for Apple Health enrollees age 18 years and younger. Immunizations will be given in conjunction with EPSDT/ well-child visits. • Ages 19 and younger: Vaccines and immunizations covered in accordance with the Advisory Committee on Immunization Practices guidelines are covered through the Vaccines for Children Program (VFC). • Ages 19-20: As part of the EPSDT benefit, CDC/ACIP recommended immunizations are a covered service and are not available from the VFC program. • Ages 21 and older: Immunizations are covered for hepatitis A, influenza, pneumococcal, shingles, and human papillomavirus diseases (vaccine and administration).	Yes, please reference the apple health billing guide
Inpatient Hospital Services (Stays Expected to Last More Than 24 Hours)	Hospital care needed for the treatment of an illness or injury that can only be provided safely and adequately in a hospital setting. Covered services include the following: • Nursing services • Dietary services • Ancillary services such as: • Lab • Radiology • Pharmacy • Medical supplies • Blood and blood by-products • A semi-private room for: • Routine care	Yes

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• Surgical care • Obstetrics and newborn nurseries Note: A private inpatient room is covered if a member's medical condition requires isolation.	
Laboratory Services (Outpatient)	Prior authorization is required for certain laboratory services except hospital laboratory services in the event of an emergency medical condition. All laboratory tests must be submitted to LabCorp, PACLAB, PAML, or TriCities Laboratory, the preferred lab vendors for our members. Contact one of these laboratories at the numbers below for more information, testing solutions and services or to set up an account: • PACLAB/PAML/TriCities Lab: **800-541-7891** • LabCorp: **800-345-4363**	
Medical Equipment and Supplies	Prior authorization is required for certain supplies. Updated physician prescriptions for ongoing orders for supplies and services are required annually. All prescriptions for medical equipment and supplies provided in the home is required	
Medical Injectables	Below are examples of the most commonly prescribed injectables that require prior authorization: • Botox • Erythropoiesis stimulating agents (ESAs), such as Epogen, Procrit and Aranesp • Makena • Zolendronic acid • Colony stimulating factors (CSFs), such as Neupogen and Neulasta • IVIG • Biologic response modifiers, such as Remicade	

Service	Descriptions/Notes	Covered for Wellpoint Members?
	For a complete list, visit our provider website. You may also call Wellpoint Provider Services for assistance.	
Neonatal Intensive Care Unit (NICU)	We must be notified within 24 hours (or next business day) of when the admission occurred. All NICU admissions are reviewed against medical necessity.	Yes
Neurology	Prior authorization is not required for a network provider for: • Evaluation and management testing. • Certain other procedures. Prior authorization is required for: • Neurosurgery. • Spinal fusion. • Artificial intervertebral disc surgery. For code-specific ID requirements, visit our provider website.	
Nutritional counseling	Services covered for 20 and younger Covered by certified registered dieticians.	Yes
Observation Services	Must be furnished by and at a hospital. Covered services include: • Use of a bed and periodic monitoring by a hospital's nursing or other staff needed to assess a member's condition or decide the need for possible inpatient hospital admission; observation is an outpatient service. • Prior authorization is not required for in-network observation. • If your observation results in an admission, you must notify us within 24 hours or on the next business day.	Yes
Obstetric Care (also see the Prenatal Ultrasound section)	Prior authorization is not required for: • Obstetric visits	

Service	Descriptions/Notes	Covered for Wellpoint Members?
	Obstetrical practitioners must notify Wellpoint at the first prenatal visit. Hospitals and midwives must notify Wellpoint within 24 hours of delivery with newborn information (include baby's weight, gestational age, APGARS, and disposition at birth). • We also request notification of obstetric care (at first visit) and Certain diagnostic tests and lab services by a participating provider. • Prenatal ultrasounds • Labor and delivery for newborns up to 12 weeks in age. obstetric admissions exceeding 48 hours after vaginal delivery and 96 hours after Cesarean section, as these require medical necessity review. However, we will not deny claims payment based solely on lack of notification. Obstetric case management programs are available.	
Ophthalmology	All vision services, including routine and medical vision services, are provided by EyeQuest. Phone: - **885-225-2640** Website: **eye-quest.com** Wellpoint does not cover services that are considered to be cosmetic. For code-specific requirements, visit our provider website.	See eye care and vision services.
Oral Maxillofacial	See Plastic/Cosmetic/Reconstructive Surgery.	
Organ Transplant and Related Services	For members diagnosed with certain medical conditions needing heart, kidney, liver, bone marrow, small bowel or pancreas transplants. Services may include: • Reviewing pre-transplant inpatient or outpatient needs.	Yes. Some limits apply. See description.

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• Searching for donors. • Choosing and getting organs/tissues. • Preparing for and performing transplants, convalescent care. If the member receives a transplant covered by a provider who is not in the Wellpoint network, medically needed, nonexperimental services will be given within certain limits after discharge from the acute care hospital that performed the transplant. Experimental transplant procedures are not covered, including but not limited to: • Transplants of three or more different organs during the same hospital stay. • Solid organ and bone marrow transplants from animals to humans. • Transplant procedures used in treating certain medical conditions that use procedures not generally accepted by the medical community, or that efficacy has not been documented in peer-reviewed medical publications.	
Osteopathic Manipulation Treatment	Up to 10 treatments per member per calendar year when given by a licensed osteopathic or naturopathic physician are covered.	Yes Certain limits apply.
Outpatient/ Ambulatory Surgery	• Prior authorization requirements are based on the procedure performed. • For code-specific requirements, visit our provider website.	
Outpatient Nonpsychiatric Hospital Services	For stays not expected to last more than 24 hours and services that can be properly given on an outpatient or ambulatory basis such as lab, radiology, therapies, ambulatory surgery or observations. Covered services include:	Yes Certain limits apply. Prior approval may be required.

Service	Descriptions/Notes	Covered for Wellpoint Members?
	Those that can be properly given on an outpatient or ambulatory basis such as: • Preventive care. • Lab and radiology services. • Therapies. • Ambulatory surgery. • Palliative care. Observation services, if needed to decide whether a member should be admitted to the hospital.	
Pain Management	When medically needed for cancer pain and spasms related to cancer, covered services include: • Implantable infusion pumps • Implantable drug delivery systems • Prior authorization is required for non-evaluation and management level testing and procedures. • For code-specific requirements, visit our provider website	Yes
Physician Services	Services performed in a physician's office such as medical assessments, treatments and surgical services. Services must be given by licensed allopathic or osteopathic physicians.	Yes
Plastic/Cosmetic/Reconstructive Surgery (including Oral Maxillofacial Services)	Prior authorization is not required for evaluation and management services. Prior authorization is required for all other services, such as: • Trauma to the teeth. • Oral maxillofacial medical and surgical conditions. • TMJ. • Reduction mammoplasty. We do not cover: • Services considered cosmetic in nature • Services related to previous cosmetic procedures.	

Service	Descriptions/Notes	Covered for Wellpoint Members?
Podiatry Services	Covered only when there is an acute condition; an exacerbation of a chronic condition or presence of a systemic condition such as metabolic, neurologic or peripheral vascular disease; and evidence that the treatment will prevent, cure or alleviate a condition in the client that causes pain, resulting in inability to perform activities of daily living, acute disability, or threatens to cause the loss of life or limb, unless otherwise specified. For 21 and older What foot care services are not covered? HCA does not cover: • Treatment of or follow-up office visits for chronic acquired conditions of the lower extremities. • HCA pays for prescriptions using the criteria found in the Prescription Drug Program Billing Guide. The following foot care services, unless the client meets criteria and conditions outlined in WAC 182-531-1300: Routine foot care, such as but not limited to: • Cutting or removing warts, corns and calluses • Treatment of tinea pedis • Trimming, cutting, clipping, or debriding of nails Nonroutine foot care, such as, but not limited to treatment of: • Adult acquired flatfoot (metatarsus adductus or pes planus) • Bunions and tailor's bunion (hallux valgus) • Cavovarus deformity, acquired • Equinus deformity of foot, acquired • Flat feet	Yes Certain limits apply.

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• High arches (cavus foot) • Hallux malleus • Hallux limitus • Onychomycosis • Any other service performed in the absence of localized illness, injury, or symptoms involving the foot. Refer to hca.wa.gov Physician Related Service Billing Guide for benefit and coverage limitations.	
Post-Stabilization Care Services	Covered if: • Care is received within or outside the Wellpoint network of • providers and preapproved by Wellpoint. • Care is received within or outside the Wellpoint network of providers, but is not preapproved by Wellpoint because: • Services are given to keep a member's condition stable within one hour of asking Wellpoint for preapproval of more services. • Services are given to maintain, improve or resolve a member's stabilized condition, and: • We do not respond to a request for prior approval within one hour. • The treating physician cannot get in touch with Wellpoint. • Wellpoint and the treating physician cannot agree on the member's care and a network physician is not on hand for consult; if this happens, we will: Give the treating physician the chance to consult with a network physician. Let the treating physician still give care until a network physician is reached or one of the following occurs:	Yes

Service	Descriptions/Notes	Covered for Wellpoint Members?
	▪ A network physician with privileges at the treating hospital becomes responsible for the members' care. ▪ A network physician becomes responsible for the member's care through transfer. ▪ Wellpoint and the treating physician reach an agreement on the member's care. ▪ The member is discharged.	
Preventive Health Services — Adults and Children	Covered services include the following: • Routine physicals • Physical exams when the exam is one or more of the following: A screening exam covered by the EPSDT program An annual exam for members with disabilities A screening Pap smear, mammogram or prostate exam	Yes
Private Duty Nursing	Services must be performed through a home health agency by a registered nurse or licensed practical nurse, under the direction of a physician. Covered services include: • Continuous skilled nursing care that can be provided safely outside an institution (for members age 17 and younger)	Yes Prior approval is required
Prosthetics and Orthotics	Covered services include: • Replacement, corrective or supportive devices prescribed by a physician or other licensed practitioner to: – Artificially replace a missing portion of the body. – Prevent or correct physical deformity or malfunction. – Support a weak or deformed portion of the body. • Repair or change to a current prosthesis; a replacement prosthesis is only covered when the purchase of a replacement is less costly than repairing or modifying the current prosthesis. • Custom-fitted and/or custom-molded orthotic devices to treat certain conditions.	Yes Certain limits apply. Prior approval is required for certain services.

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• Ocular prosthetics for eligible members when provided by an ophthalmologist, an ocularist or an optometrist who specializes in prosthetics.	
Psychiatric Hospital Admission	Prior authorization is required for elective/voluntary psychiatric admissions. Emergency admissions require notification initially, followed by clinical information within 24 business hours. Refer to the Hospital Admission (Medical and Behavioral Health) section for more information.	Yes Prior approval may be required.
Radiology	See Diagnostic Testing.	
Rehabilitation Therapy Services	Services must be prescribed by the PCP or attending physician for an acute condition. Covered services include the following: • Physical therapy • Occupational therapy • Speech therapy All services provided in the home by a home health agency are covered. All services provided for 20 and younger are covered regardless of setting	Yes Prior approval may be required and certain limits may apply
Respite Services	Respite care does not replace care provided by a registered nurse, licensed practical nurse or therapist. Covered services include: • Help with routine activities of daily living • Improving self-help skills	Yes Prior approval may be required.
Revenue (RV) Codes	Prior authorization is required for services billed by facilities with RV codes for the following: • Inpatient • OB • Home Health Care • Hospice • CT, PET and nuclear cardiology • Chemotherapeutic agents	Yes

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• Pain management • Rehabilitation (physical/occupational/respiratory therapy) • Short-term rehabilitation (speech therapy) • Specialty pharmacy agents For a complete list of specific RV codes, visit provider.wellpoint.com/wa.	
Sexual Reassignment Services	Sexual reassignment surgery is covered by the Apple Health state plan. Wellpoint coverage includes: • Case management • Medication	Yes
Skilled Nursing Facility Services	Covered services include: • Skilled services given at licensed nursing facilities when: • These services are not covered by the Washington Department of Social and Health Services' Aging and Disability Services Administration. • Wellpoint decides that nursing facility care is more suited than acute hospital care. • Inpatient physical rehabilitation services. • Prior authorization is required.	Yes Prior approval may be required
Sleep Studies	Prior authorization is required for certain sleep study tests. Studies are allowed at Washington State Health Care Authority Centers of Excellence and member homes. For code-specific requirements, visit our provider website	Yes
Smoking Cessation	The EX Program is a personalized and convenient digital quit-tobacco program built in collaboration with the Mayo Clinic that helps members beat their addiction and live tobacco-free whether they smoke, vape, dip or chew. Wellpoint's adult members can use the link: Go.TheEXProgram.com	Yes

Service	Descriptions/Notes	Covered for Wellpoint Members?
	Members have access to: • Online videos, exercises, and self-guided tools on any device; • Live-chat coaching from experts and personalized texts and emails; • Active online community to lean on for advice, tips, and motivation; • Nicotine patches, gum, or lozenges delivered to the member's home.	
Sterilization and Reversal/ Hysterectomy	Patients must give informed consent on the approved Consent for *Sterilization or Hysterectomy* form located on our provider website for the date span: provider.wellpoint.com/wa. Hysteroscopic sterilizations must be performed by a Health Resources and Services Administration-approved Center of Excellence provider. Sterilization is covered only if: • A person is at least 21 years old at the time consent is given. • A person is not mentally incompetent. • A person has voluntarily given written informed consent. • At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. • An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since he or she gave informed consent for the sterilization. • In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.	Yes

Service	Descriptions/Notes	Covered for Wellpoint Members?
	Sterilization by hysterectomy is covered only if: • A person was already sterile before the hysterectomy. • A person requires a hysterectomy because of a life-threatening emergency situation in which the physician decides that prior acknowledgment is not possible. Documentation of informed consent is required and may not be obtained when the person to be sterilized is: • In labor or childbirth. • Seeking to obtain or obtaining an abortion. • Under the influence of alcohol or other substances that affect the person's state of awareness. Sterilization of a mentally incompetent or institutionalized person is covered if the following are attached to the claim: • A court order stating the person is to be sterilized and indicating the name of the person's legal guardian who will be giving consent for the sterilization. • The sterilization consent form is signed by the person's legal guardian. Hysterectomies are covered when the following requirements are met: • The person or her representative must be told orally and in writing that this procedure will leave the person unable to reproduce again. • Are paid only for medical reasons unrelated to sterilization and require a consent form, regardless of the person's age or diagnosis. • The person/her representative must sign and date an *Acknowledgement of Receipt of*	

Service	Descriptions/Notes	Covered for Wellpoint Members?
	Hysterectomy Information form prior to the procedure; this must be obtained despite diagnosis or age. • This form can be submitted after surgery only if it clearly states the patient was told before surgery that she would be left unable to reproduce. • This form is not required if the person was sterile prior to the hysterectomy or required a hysterectomy due to a life-threatening emergency and the physician decided prior acceptance was not possible. • Prior authorization is not required for men and women ages 21 and • older: • Sterilization • Tubal ligation • Vasectomy • We do not cover reversal of sterilization.	
Surgical Procedures for Weight Loss	Consistent with the strict guidelines of *WAC 182-531-1600*, surgical procedures are covered for weight loss as determined medically necessary and following an approved six-month presurgical program.	Yes Prior authorization is required.
Therapy: OT, PT and ST	Rehabilitative: Prior authorization is not required for participating providers for: • An initial evaluation • Initial six visits (24 units) of care for OT, PT and • Six visits for ST. Subsequent treatments require prior authorization. Therapies for rehabilitative care are covered as medically necessary. Visits are limited per a calendar year. Refer to hca.wa.gov Outpatient Rehabilitation Program for more information about benefit limits. Children:	

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• Unlimited benefit Habilitative: • Prior authorization is required. Covered services include: • Children: unlimited benefit • Adults: Certain benefit limits apply	
Urgent Care Services	Covered services include those given both: • Within 12 hours to avoid the onset of an emergency medical • condition. • At a location designated as an urgent care facility. • Prior authorization is not required for a participating facility.	Yes
Women's Health Services — Abortions	The Office of Public Health *Certification of Informed Consent – Abortion* form must be witnessed by the treating physician; the provider must attach this form to his or her claim form. Services are restricted to these reasons: • A physician has found, and confirms in writing, that on the basis of his or her judgment, the life of the pregnant woman would be in danger if the fetus were carried to term. • In the case of ending a pregnancy due to rape or incest, certain requirements must be met: • The member must report the act to a law enforcement • official unless the treating physician confirms in writing that in his or her expert opinion, the victim was not physically or psychologically able to report the rape or incest. • The report of the act to the law enforcement official or the treating physician's statement that the victim was not able to report the rape or incest must be submitted to Wellpoint.	Yes Voluntary termination of pregnancy is covered through HCA's fee-for-service program, including surgical and medically induced abortions.

Service	Descriptions/Notes	Covered for Wellpoint Members?
	• The member must confirm that the pregnancy is the result of rape or incest; this certification must be witnessed by the treating physician.	
Women's Health Services — Early, elective inductions (before 39 weeks)	For pregnancies that do not meet medically necessary indicators set by The Joint Commission (TJC), early inductions are not covered. Because TJC criteria do not capture all situations in which an early delivery is medically indicated, Wellpoint will review cases that do not meet TJC criteria but which the hospital and delivering provider believe were medically necessary. Delivering physicians will be required to complete Field 19 when completing claims submitted for all deliveries. Existing field information required when completing claims will remain the same. Claims submitted by the delivering physician will be subject to claims editing to determine if the service was an EED. Field 19 on the *CMS-1500* claim form or its electronic equivalents must contain a new *gestational age/delivery* indicator and one of four-digit alphanumeric values. If the value entered in Field 19 contains a character that is not indicated below or is not in the format indicated, the value will be considered invalid, and the claim will be rejected with status code 626 — *Pregnancy Indicator* and reject rule ID 2 – *Delivery claim incomplete without report of valid gestational indicator*: • The 1st and 2nd digits represent the gestational age, based on the best obstetrical estimate. They must be numeric characters and values from 20 through 42. • The 3rd and 4th digits represent the method of delivery. They must be one of the following alpha characters:	No

Service	Descriptions/Notes	Covered for Wellpoint Members?
	– LV – labor non-induced followed by vaginal delivery – LC – labor non-induced followed by caesarean delivery – IV – induced labor followed by vaginal delivery – IC – induced labor followed by caesarean delivery – CN – caesarean delivery without labor, nonscheduled (for example, add-ons) – CS – caesarean delivery, scheduled	
Women's Health Services — Maternal Support Services	Members who are pregnant or have delivered within 60 days are also eligible for maternal support services through the Washington State Health Care Authority. It includes nutritional counseling, targeted case management, family training and counseling, and other services. The goals of the program are to: • Increase early access and ongoing use of prenatal and newborn care. • Increase the initiation and duration of breastfeeding. • Decrease maternal morbidity and mortality rates. • Decrease low birth weights and premature births. • Reduce the number of unintended pregnancies and the number of repeat pregnancies within two years of delivery. • Reduce tobacco use during pregnancy and pediatric exposure to second-hand smoke. • This program is part of DSHS First Steps program. For information, contact **800-322-2588**. For a direct referral to request OB Case Management Services please send a direct referral to: cmrefwash@Wellpoint.com	Yes

Service	Descriptions/Notes	Covered for Wellpoint Members?
Women's Health Services — OB/GYN Services	Covered services for female members include the following: • One routine annual visit. • A second visit based on medical need. • Follow-up treatment given within 60 days after either routine visit if the care relates to: – A condition diagnosed or treated during the visits. – A pregnancy. • Regular gynecologic examinations and screening tests: – Pap test or other similar tests to detect cancer of the cervix and mammography to detect breast cancer – Mammography For patients ages 40 and older, one annual screening mammogram is allowed per calendar year. Screening mammograms for patients 39 years of age and younger are covered only with prior authorization.	Yes
Women's Health Services — Prenatal Services	Covered services include: • Offering direct access to routine OB/GYN services within the Wellpoint network; the OB/GYN will contact the member's PCP to advise that: – These services are being delivered. – The OB-GYN will manage this care with the PCP. • Arranging a risk assessment for all pregnant members. • Ensuring high-risk pregnant members in need of further assessment or care have access to maternal fetal medicine specialists. • Counseling a pregnant member about plans for her child, such as: – Choosing the family practitioner or pediatrician who will perform the newborn exam.	Yes

Service	Descriptions/Notes	Covered for Wellpoint Members?
	– Choosing a PCP to give follow-up pediatric care to the child once the child is enrolled in the Washington State Health Care Authority. Access the state's Women, Infants and Children (WIC) program at doh.wa.gov/YouandYourFamily/WIC.	
Women's Health Services — Postpartum Care	Covered services include the following: • Postoperative care visit following C-section delivery • Postpartum care visit between the 7th and 84th day • post delivery An Electric breast pump is a covered benefit for all post-partum mothers who intend to breast feed. Pump may be ordered at 36 weeks of completed gestation. If necessary, long-term electric breast pump needs are covered by a hospital-grade electric breast pump rental. See also the Family Planning Services section of this grid.	Yes

11.4 Wellpoint Special Services & Free Member Services

Some of our special services include:

Covered Special Services	Description and Coverage Limits
24-hour Nurse HelpLine	The 24-hour Nurse HelpLine is a telephonic, 24-hour triage service Wellpoint members can call to speak with a registered nurse who can help them: • Find doctors when your office is closed, whether after-hours or weekends. • Schedule appointments with you or other network doctors.

Covered Special Services	Description and Coverage Limits
	• Get to urgent care centers or walk-in clinics. • Speak directly with a doctor or a member of the doctor's staff to talk about their healthcare needs. We encourage you to tell your Wellpoint patients about this service and about the advantages of avoiding the emergency room when a trip there isn't necessary or the best alternative. Members can reach the 24-hour Nurse HelpLine at **866-864-2544 (TTY 711**; Spanish **866-864-2545**). Language translation services are also available.
Condition Care Programs	Condition care programs and care managers to help members manage conditions like: • Asthma • Bipolar disorder • Chronic obstructive pulmonary disease • Congestive heart failure • Coronary artery disease • Diabetes • HIV/AIDS • Hypertension • Major depressive disorder • Obesity • Schizophrenia • Transplants
Justice Support Program	Care Coordination and support assisting Wellpoint members entering or leaving any type of incarceration. The Justice Support works with adult and youth members while they are incarcerated and as they transition out from incarceration. The Justice Support Team assist members in accessing physical and behavioral healthcare as well as other transition supports like housing, food, education, and employment. The program will also ensure carceral facilities and Wellpoint providers receive critical information to coordinate members care. Justice Support coordinates with city, county and tribal jails, juvenile detention facilities, Department of Corrections and DCYF Juvenile Rehabilitation.
Women's Health Services — Prenatal Services/ Postnatal Services	Prenatal and Postpartum care services: No-cost My Advocate® program to promote health education through automated telephone outreach, website, or smartphone

	app. On site CM management answers any urgent replies to this line and monitors on a daily basis. • Taking Care of Baby and Me® program, which offers an array of services to pregnant women and newborns to provide the best opportunity to have a healthy baby and be a successful mom. Members have access to the *Pregnancy and Beyond Resource Guide* (PBRG) via the member website. The PBRG contains information about prenatal, postpartum, and well-baby care, pregnancy benefits, and prenatal and postpartum incentive programs. Member may request more information or a printed copy of the PBRG by calling Member Services at **833-731-2167 (TTY 711) Monday through Friday, 8 a.m. to 5 p.m. PT.** Maternal Meal Program| Customized meals to take stress off mom. *Low-sodium, low-fat, diabetic-friendly, gluten-free, vegetarian, renal-friendly, and pureed meal options available.* Members who qualify can receive up to 2 meals per day for 14 days (28 meals per member total). Gestational Diabetes Meal Program Members with gestational diabetes can receive up to two customized meals per day for ten (10) weeks to help improve maternal health and perinatal outcomes. *Low-sodium, low-fat, diabetic-friendly, gluten-free, vegetarian, renal-friendly, and pureed meal options available.* Electric Breast Pump (7 style options) Choice of: • Medela • Spectra • Ameda • Ardo • Freemie • Motif • Lansinoh brand Maternal health support:

Covered Special Services	Description and Coverage Limits
	Pregnant members and moms can choose two of the following items to support with maternal health: • Diapers • Breastfeeding support kit • Breastfeeding pillow • Microwave sterilizer • Microwave steam bags • Baby car seat • Preemie car seat • Portable crib • Highchair • Safe sleep kit • Baby monitor-video • Baby proof items (in other words, plug protectors, doorknob covers, cabinet and drawer latches). For new mothers within the first four days of birth: One in-home visit to include a safety inspection Ongoing access to the 24-hour Nurse HelpLine for help with breastfeeding questions.
Educational, Employment, and advocacy support	No-cost GED testing • For members 17 years of age and older, Wellpoint pays the four required modules of GED testing once per member lifetime. This benefit is accessed through coordination with local community colleges. Wellpoint will work with the school to verify eligibility and arrange payment. To help members learn more, advise them to contact Member Services at **833-731-2167 (TTY 711) Monday through Friday, 8 a.m. to 5 p.m. PT.** **TutorMe – Online Tutorial** • Get help with language arts, math, science, social studies, and foreign language. TutorMe is an online platform used to improve student engagement and success by providing easy access to detailed information on student's progress, hours spent, tutoring and subject analytics

Covered Special Services	Description and Coverage Limits
	Max allowance of 24 hrs. per member per year. Member must be age 8-17 and at risk of failing a grade or individual subject or in the juvenile justice system Internet Essentials Package* * Up to a $300 allowance to help cover the cost of internet services. Funds can be used for installation and set-up fees, to purchase modems, routers and any additional equipment that is essential to obtain (or strengthen) an internet connection, as well as to help cover monthly service charges Employment Industry Certification*: We will cover the cost of employment certifications in fields such as early childhood education, foundations of reading, business education, computer science, technology education, English language arts, health and marketing Free Laptop Program**: Members transitioning from incarceration will be able to receive a free laptop to help with employment and educational pursuits Members must have been previously incarcerated within the last 12 months *Eligible for members seeking employment or furthering education, once per lifetime National disability advocacy organizations: Members with disabilities may enroll in an annual membership to one of four national disability advocacy organizations: • Autistic Self Advocacy Network • American Association of People with Disabilities • National Council on Independent Living • TASH

Covered Special Services	Description and Coverage Limits
Just for Kids	Newborn circumcisions: We pay for newborn circumcisions up to $150 for members. Use CPT codes 54150, 54160 or 54161. Sports physicals: These are paid once a year for members ages 7-18. We pay in-network primary care providers for performing sports physicals for our members ages 7-18. Use current CPT code 99212 with DX Z02.5 when you bill. You can bill for both a wellness visit and a sports physical on the same day by including modifier 25. Same day well-child and sick visits: We pay for sick visits and complete preventive well-child assessment visits on the same day. Use evaluation and management (E&M) CPT codes for the level of complexity combined with the age. Bill with the age-appropriate early and periodic screening, diagnostic and treatment (EPSDT) service codes (99381-99385 and 99392-99395) using one of the appropriate sick visit E&M codes with modifier 25. Allowable sick visits are limited to the following: • A minor (for example, 10 minutes) new patient E&M visit • A minor established patient E&M visit • A minimal (for example, five minutes) established patient E&M visit When modifier 25 is not billed appropriately, the sick visit is denied. Appropriate diagnosis codes must also be billed for every visit. Same day wellness visits are not applicable to the After-Hours Care program; after-hours care is for sick visits only. Boys & Girls Club membership: Where available for members ages 6-18 Healthy Families program: We give families with children ages 7-13 coaching and support on nutrition and physical activity. Memberships for WA State 4-H:

Covered Special Services	Description and Coverage Limits
	This benefit is available for members ages 5-18 to support with youth development statewide. YMCA membership: Members who qualify for the Y scholarship at Wenatchee and Cowlitz County up to 19 years old are eligible for this benefit. Calm app: This is an annual membership for members up to 18 years old. The Calm App provides age appropriate meditations and sleep aids to help calm the mind and body. TutorMe-online tutorial: TutorMe is an online platform used to improve student engagement and success by providing easy access to detailed information on student's progress, hours spent, tutoring and subject analytics. The maximum allowance is 24 hours per member, per year. This benefit is available for members between 8-17 years of age and at risk of failing a grade or individual subject, or in the juvenile justice system.
Adults — filling the gaps	Eyeglasses: Members ages 21-64 are covered for one pair, once a year, up to $100. This service is available through EyeQuest, our eye care vendor. You must be contracted with EyeQuest directly to have services reimbursed at the in-network level. Acupuncture: Wellpoint pays for seven acupuncture visits per calendar year, with contracted providers. Providers must use the following codes: 97810: Acupuncture, one or more needles, without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient; Wellpoint fixed price of $30

Covered Special Services	Description and Coverage Limits
	97811: Each additional 15 minutes of personal one-on-one contact with the patient, with reinsertion of needles; Wellpoint fixed price of $30 97813: Acupuncture, one or more needles, with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient; Wellpoint fixed price of $50 97814: Each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needles; Wellpoint fixed price of $50 Costco membership: Members can receive a one-year Costco Gold Star membership. This membership is a household card and valid at all Costco locations. Only one membership per family is available. Members should call the National Call Center at **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT** to request, verify their address and report the benefit they are trying to access. The Costco Gold Star membership card will then be mailed to the member. Flu Pandemic kit: Flu Pandemic kit benefit helps members to remain prepared for the next flu season or pandemic. The kit may include essential and preventive safety items such as face masks, hand sanitizer and wipes. DISCLAIMER: Limit one per member per year. Transportation services: Non-Medical Transportation| One card per year. Choice of: • $50 Gas Card or • $50 Uber/Lyft Card or • $50 Orca Card (King County only) Tobacco cessation: All members ages 18 years and older may enroll in Quit for Life, the state's tobacco cessation program. Members enroll by phone at **866-**

Covered Special Services	Description and Coverage Limits
	QUIT-4-LIFE (**866-784-8454**) or online at quitnow.net. Wellpoint provides additional resource information and local tobacco cessation program promotion via collaborative partnerships. Wellpoint also pays PCPs for smoking cessation referral evaluations, smoking cessation prescription evaluation and face-to-face counseling for all members ages 18 years and older. Intensive smoking cessation counseling (procedure 99407 for greater than 10 minutes) is limited to one per day. Two cessation counseling attempts (or up to eight sessions) are allowed every 12 months. An attempt is defined as up to four cessation counseling sessions. EX By Truth Initiative Program: The EX Program is a personalized and convenient digital quit-tobacco program built in collaboration with the Mayo Clinic that helps members beat their addiction and live tobacco-free whether they smoke, vape, dip or chew. Wellpoint's adult members can use the link: Go.TheEXProgram.com Members have access to: • Online videos, exercises, and self-guided tools on any device; • Live-chat coaching from experts and personalized texts and emails; • Active online community to lean on for advice, tips, and motivation; • Nicotine patches, gum, or lozenges delivered to the member's home.
Staying fit	WW® (formerly Weight Watchers): Members can receive one WW voucher good for sign-up fee and 13 weeks of classes and 14 weeks of digital tools. They must be over age 17 and get permission from their doctor. This is a one-time benefit. FitnessCoach Program:

Covered Special Services	Description and Coverage Limits
	Services include online exercise classes and online information on fitness and exercise topics, including information available to special needs populations. Gym Membership: $100 allowance for a gym membership for members ages 18 and older who have been diagnosed with obesity, diabetes, prediabetes, and/or hypertension. Light box for seasonal affective disorder (SAD): Members must be diagnosed with SAD or depression to be eligible. No preauthorization is required; however, members with past or current eye problems, such as glaucoma, cataracts or eye damage from diabetes, must get advice from their eye doctor before starting light therapy. Life Transition Kit: A Life Transition Kit includes: first-aid supplies such as bandages and ointment, toothpaste, travel toothbrush, mouthwash, dental floss, and a $15 Subway gift card. This benefit is intended to help members get back on their feet more quickly when transitioning out of an institutional setting or for anyone enrolled in supportive employment. Emotional Well-being Resources: Online program and coaching support to learn ways to manage stress, anxiety, depression, substance use, and sleep issues that affect your emotional well-being. Ages 13+ Peer-to-peer counselor benefit: Certified peer counselors work with their peers (adults and youth) and the parents of children receiving mental health services. They draw upon their experiences to help peers find hope and make progress toward recovery. Because of their own life experience, they

Covered Special Services	Description and Coverage Limits
	are uniquely equipped to provide support, encouragement and resources to those with mental health challenges. Washington state's Peer Support Program has trained and qualified mental health consumers as certified peer counselors since 2005. A *consumer* is someone who has applied for, is eligible for or who has received mental health services. This also includes parents and legal guardians when they have a child under the age of 13, or a child 13 or older when they are involved in their treatment plan (WAC 388-865-0150). Members contact Member Services to request payment for the program. Member Services will contact David Escame at the health plan, david.escame@Wellpoint.com: • $90 initial registration fee • $75 annual renewal fee • $165 total unit cost
Online and mobile resources	**Wellpoint On Call:** Members may speak to a nurse about medical questions or concerns, day or night, even on holidays. Translation services are available for more than 150 languages. Wellpoint On Call/24-hour Nurse HelpLine: **866-864-2544** **SafeLink®:** Qualified members may secure a cellphone with up to 350 free minutes of service each month, plus the member may be eligible for the following: • 200 extra one-time bonus minutes when the member chooses to • receive free health text messages • Unlimited wellness text messages from Wellpoint, plus reminders • to renew benefits on time • Unlimited minutes when calling our Member Services department and Wellpoint On Call Members who are enrolled in Case Management receive an 8.5 GB Plan with unlimited talk and text. Note: SafeLink Wireless® is a Lifeline-supported service. Lifeline is a government benefit program. Only those who qualify may enroll in

Covered Special Services	Description and Coverage Limits
	Lifeline. It can't be transferred. It is limited to one per household. Members may need to show proof of income or that they take part in the program to enroll. **Lifeline Program:** Qualified members may receive a smart phone with 4.5 GB of data, up to 300 minutes, and unlimited text messaging. **Affordable Connectivity Program:** Qualifying case management members can secure a free smart phone and receive: • Unlimited talk and text • 25 GB of data • 5 GB of hotspot • Free international calling to Canada and Mexico. **Wellpoint mobile ID card and app:** Members may use this feature to safely access ID cards, find a doctor and increase access to health resources.
Additional resources	**First-aid kit and dental hygiene kit:** These kits are available at no cost when a personal disaster plan is completed online. **Wound care kit:** Wound kits are available for members experiencing homelessness. Kits include instructions and supplies to properly care for minor wounds.

11.5 Blood Lead Screenings

You are not required to use the *Lead Toxicity Screening Risk Factor Questionnaire* and should use clinical judgment when screening for lead toxicity. However, to comply with federal government requirements, you must perform a blood lead test at 12 months and 24

months of age to determine lead exposure and toxicity. You should also give blood screening lead tests to children older than 24 months up to 72 months if you have no past record of a test. You can find blood lead risk forms at provider.wellpoint.com/wa.

11.6 Immunizations

Providers must enroll in the Vaccines for Children (VFC) program administered by the Washington State Department of Health. Call **866-397-0337** to find out how to enroll.

Once enrolled, you may request state-supplied vaccines for members through the age of 18 in accordance with the current American Committee on Immunization Practices schedule. You must report all immunizations of children up to age 2 to the State Health Division's Immunization Registry. If you do not have the capability to meet these requirements, we can help you.

We do not cover any immunizations, biological products or other products that are available at no charge from the State Health Division.

Our members can self-refer to any qualified provider in- or out-of-network.

We reimburse local health departments for the administration of vaccines regardless of whether or not they are under contract with us.

We only cover the administration fee for members ages 20 and younger. All adult vaccines that are recommended by the Centers for Disease Control and Prevention (CDC) are covered. Adult members can receive vaccines at the pharmacy or Provider office.

11.7 Medically Necessary Services

Wellpoint is responsible for covering medically necessary services related to:

- Prevention, diagnosis, and treatment of physical and behavioral health impairments.
- Achievement of age-appropriate growth and development.
- The attainment, maintenance or regaining of functional capacity.

Medically necessary services are reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions that:

- Endanger life.
- Cause suffering or pain.
- Result in an illness or infirmity.
- Threaten to cause or aggravate a handicap.
- Cause physical deformity or malfunction.

- There is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the Enrollee requesting the service.

There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purposes of this section, course of treatment may include more observation or, where appropriate, no medical treatment at all. The amount and duration of services that are medically necessary depend on each member's medical condition.

A covered service is considered to be medically necessary if it is recommended by the member's treating provider and the Wellpoint medical director or provider designee, and if all of the following conditions are met:

- The purpose of the service, supply or intervention is to treat a medical condition.
- It is the most appropriate level of service, supply or intervention considering the potential benefits and harm to the patient.
- The level of service, supply or intervention is known to be effective in improving health outcomes.
- The level of service, supply or intervention recommended for the condition is cost-effective compared to alternative interventions, including no intervention.
- For new interventions, effectiveness is determined by scientific evidence; for existing interventions, effectiveness is determined, first, by scientific evidence, then by professional standards, then by expert opinion.

Additional information on medical necessity, including established guidelines and review processes, is available in the Medical Necessity and Clinical Review Criteria section of this manual.

11.8 Taking Care of Baby & Me Pregnancy Support Program

Taking Care of Baby and Me® is a proactive, case management program for mothers and their newborns that uses extensive methods to identify pregnant women as early in their pregnancy as possible through review of state enrollment files, claims data, hospital census reports, Availity Essentials 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 mothers have access to necessary services.

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy.

That's why we encourage all of our moms-to-be to take part in our Taking Care of Baby and Me program — a comprehensive case management and care coordination program offering:

- Individualized, one-on-one case management support for women at the highest risk.
- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.
- Incentives to keep up with prenatal and postpartum checkups.

As part of the Taking Care of Baby and Me program, members are also offered the My Advocate® program. This program provides pregnant women proactive, culturally appropriate outreach and education through interactive voice response (IVR). Eligible members receive regular phone calls with tailored content from a voice personality (Mary Beth), or they may choose to access the program via a smartphone application or website. This program does not replace the high- touch case management approach for high-risk pregnant women. However, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our case managers, and improve member and baby outcomes. For more information on My Advocate, visit myadvocatehelps.com.

Wellpoint encourages notification of pregnancy after the first prenatal visit and notification of delivery following birth. You may choose to complete the notification of pregnancy and delivery in the online Interactive Care Reviewer or fax the forms to **800-964-3627**.

In addition, for infants who are admitted to Neonatal Intensive Care Unit (NICU) a notification of such admission is required to ensure timely and appropriate coverage and coordination of services.

You should also complete the Availity Essentials platform's Maternity Module.

- 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" you may provide the estimated due date, if it is known, or leave it blank if the due date is unknown.
- After submitting your answer, the E&B will display. If the member was identified as pregnant, a Maternity form will be generated. You may access the form by navigating to the "Applications" tab and selecting the "Maternity" link.

NICU Case Management

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

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

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

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

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

Our case managers are here to help you. If you have a patient in your care that would benefit from NICU Case Management program, please call Provider Services at **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT** or email cmrefwash@Wellpoint.com with any referrals or for more information.

Partnership Access Line (PAL) for Moms

Partnership Access Line (PAL) for Moms is a free state-funded program providing perinatal mental health consultation, recommendations and referrals for providers caring for pregnant or postpartum patients.

How does it work?

- Call **877-725-4666** (PAL4MOM), **available weekdays 9 a.m. - 5 p.m**.
- Complete a brief intake
- Consult with a UW perinatal psychiatrist (usually immediately, or within 1 business day)
- Receive written documentation of recommendations and resources

The Perinatal Support Washington Parent Warm Line is answered by trained parents who have experienced and recovered from a perinatal mental health issue. Contact the PS-WA Warm Line at **888.404.7763**.

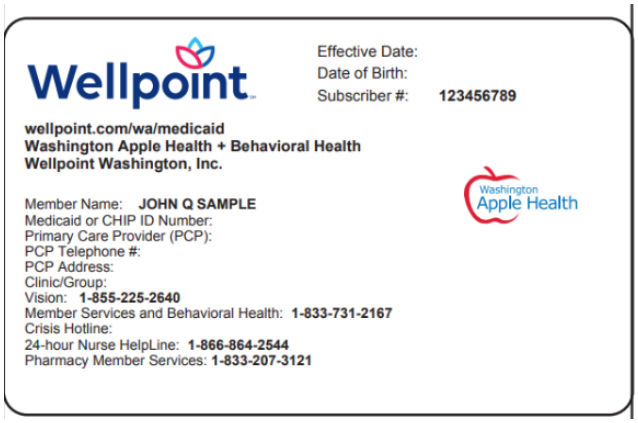
11.9 Identification Cards

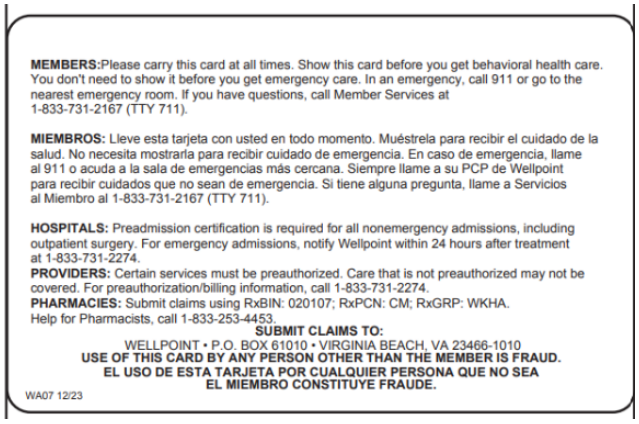
Every member identification card lists the following:

- Effective date of membership
- Member date of birth
- Subscriber number (identification number)
- PCP name
- Copayments for office visits, emergency room visits and pharmacy services (if applicable)
- Vision service plan phone number
- Member Services and Nurse HelpLine phone numbers
- Crisis Hotline

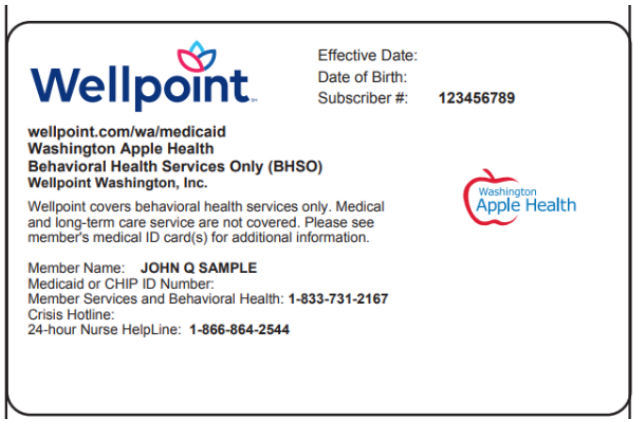
Member identification card samples:

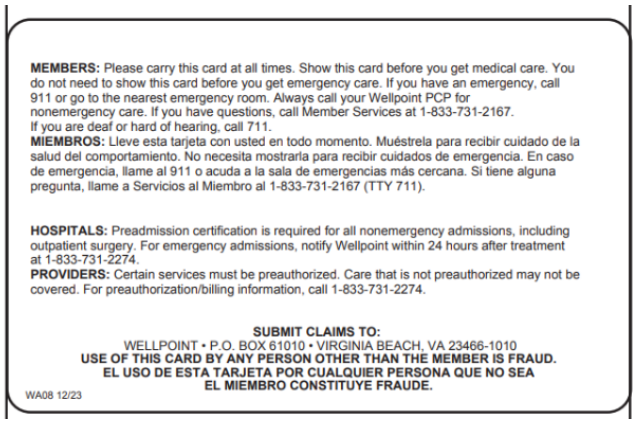
Apple Health + Behavioral Health



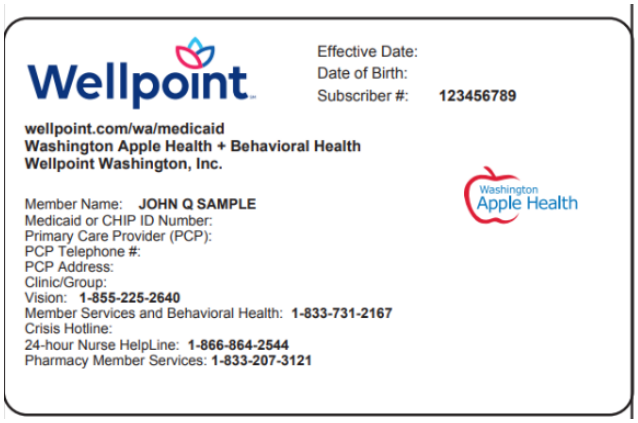


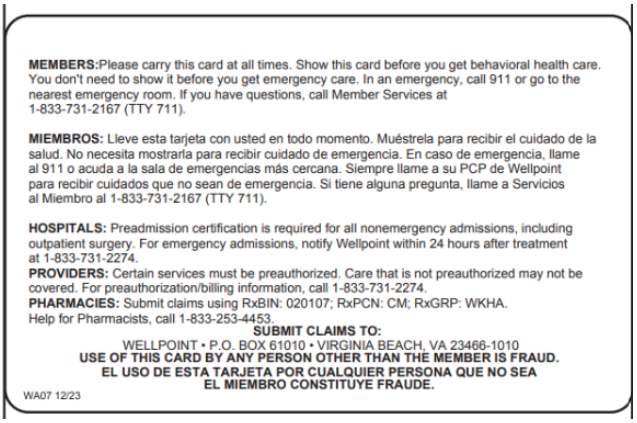
BHSO Only





Integrated Managed Care:





Presentation of a member identification card does not guarantee eligibility; providers should verify a member's status by inquiring online or via phone prior to the provision of services. Online support is available for provider inquiries on the website, and phone verification may be obtained through the automated Provider Inquiry Line at **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT.**

Providers should encourage members to protect their identification cards as they would a credit card, to carry their health benefits card at all times, and report any lost or stolen cards to our company as soon as possible. Understanding the various opportunities for fraud and working with members to protect their health benefit identification card can help prevent fraudulent activities. If you or a patient suspect identification theft, call our compliance and Ethics Helpline at **877-725-2702**, send an email to ethicsandcompliance@wellpoint.com or mail the Ethics Office, c/o Chief Compliance Officer, P.O. Box 791, Indianapolis, IN 46206. Providers should instruct their patients who suspect identification theft to watch the *Explanation of Benefits* for any errors and then contact member services if something is incorrect.

COMPLIANCE

12.1 Fraud, Waste & Abuse

First Line of Defense Against Fraud

We are committed to protecting the integrity of our healthcare program and the effectiveness of our operations by preventing, detecting and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

- **Fraud**: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it -- or any other person. This includes any act that constitutes fraud under applicable Federal or State law.

- **Waste**: Includes overusing services, or other practices that, directly or indirectly, result in excessive costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse**: behaviors that are inconsistent with sound financial, business and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet professionally recognized standards for healthcare. This includes any member actions that result in unnecessary costs.

To help prevent fraud, waste and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Our company may not accept responsibility for the costs incurred by providers supplying services to a person who is not a member, even if that person presents a member identification card. Providers should take measures to ensure the cardholder is the person named on the card.

12.2 Reporting Fraud, Waste and Abuse

If you suspect a provider (**for example**, provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visiting our website and completing the ***Report Waste, Fraud and Abuse Form*** at fighthealthcarefraud.com > select "Report It" at the top of the page, or call the Medicaid hotline listed on this site.
- Calling Provider Services at **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT** if you are a network provider.
- You may also report Medicaid fraud directly to the Health Care Authority using the contact information at **hca.wa.gov/about-hca/medicaid-fraud-prevention**
- The Office of Inspector General (OIG) through **oig.hhs.gov/fraud/report-fraud/**

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of provider fraud, waste and abuse:

- 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

When reporting concerns involving a **provider** (a doctor, dentist, counselor, medical supply company, etc.) include:

- Name, address and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Apple Health 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

Examples of member fraud, waste and abuse:

- Forging, altering or selling prescriptions
- Letting someone else use the member's identification card
- Relocating to out-of-service plan area and not notifying us
- Using another individual's identification card

When reporting concerns involving a **member** include:

- The member's name
- The member's date of birth, member ID or case number if you have it
- The city where the member resides
- Specific details describing the fraud, waste or abuse

Investigation Process

We investigate all reports of fraud, abuse and waste for all services provided under the contract, including those that subcontracted to outside entities. 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 communication (checks, correspondence) should be sent to:

Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Paper medical records and claims are a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator. An opportunity to submit claims and medical records electronically is an option if you register for an Availity Essentials account. Contact Availity Essentials Client Services at **800-282-4548** for more information.

About Prepayment Review

One method we use to detect FWA is through prepayment Claim review. Through a variety of means, certain Providers (Facilities or Professionals), or certain Claims submitted by Providers, may come to our attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider is an outlier compared to his/her/its peers.

Once a Claim, or a Provider, is identified as an outlier or has otherwise come to our attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination the Provider's action(s) may involve FWA, unless exigent circumstances exist, the Provider is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider is on prepayment review, the Provider will be required to submit medical records and any other supporting documentation with each Claim so the SIU can review the

appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation in accordance with this requirement will result in a denial of the Claim under review. The Provider will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, we may review coding, documentation, and other billing issues. In addition, one or more clinical utilization management guidelines may be used in the review of Claims submitted by the Provider, even if those guidelines are not used for all Providers delivering services to Plan Members.

The Provider will remain subject to the prepayment review process until the health plan is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider could face corrective measures, up to and including termination from the network at the direction of the State.

Providers are prohibited from billing a Member for services the health plan has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their Provider Agreement, proper billing procedures and state law. Providers also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Acting on Investigative Findings

If, after investigation, the SIU determines a provider appears to have committed fraud, waste, or abuse the provider:

- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination
- Will be referred to other authorities as applicable and/or designated by the State
- The SIU will refer all suspected criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

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 state approval.

12.3 Privacy, Confidentiality and Compliance

We're committed to safeguarding patient/member information. As a contracted provider, you must have procedures in place to demonstrate compliance with *Health Insurance Portability and Accountability Act (HIPAA)* privacy regulations. You must also have

safeguards in place to protect patient/member information, such as locked cabinets clearly marked and containing only protected health information (PHI), unique employee passwords for accessing computers, and active screen savers.

42 CFR Part 2 Compliance

- When providers use, disclose, maintain or transmit PHI protected by *42 CFR Part 2*, they acknowledge and agree that in receiving, storing, processing or otherwise dealing with any such records for patients, they are fully bound by *42 CFR Part 2*. If necessary, they will resist any efforts to obtain access to such records except as permitted under *42 CFR Part 2*. Providers also acknowledge and agree that any patient information they receive that is protected by *42 CFR Part 2* is subject to protections that prohibit providers from disclosing such information to agents or subcontractors without the specific written consent of the patient.

Compliance with State Standards

In addition to federal standards, Wellpoint observes and complies with Washington state regulations regarding confidentiality, privacy and compliance programs.

HIPAA:

- Improves the portability and continuity of health benefits.
- Provides greater patient rights to access and privacy.
- Ensures greater accountability in healthcare fraud.
- Simplifies the administration of health insurance.

Member individual privacy rights include the right to:

- Receive a copy of our provider notice of privacy practices.
- Request and receive a copy of his or her medical records and request those records be amended or corrected.
- Get an accounting of certain disclosures of his or her PHI.
- Ask that his or her PHI not be used or shared.
- Ask each provider to communicate with him or her about PHI in a certain way or location.
- File a complaint with his or her provider or the Secretary of Health and Human Services if privacy rights are suspected to be violated.
- Designate a personal representative to act on his or her behalf.
- Authorization disclosure of PHI outside of treatment, payment or healthcare operations and may cancel such authorizations.

We only request the minimum member information necessary to accomplish our purpose. Likewise, you should only request the minimum member information necessary for your purpose. However, regulations do allow the transfer or sharing of member information to:

- Conduct business and make decisions about care.

- Make an authorization determination.
- Resolve a payment appeal.

Requests for such information fit the *HIPAA* definition of treatment, payment or healthcare operations.

You should maintain fax machines used for transmitting and receiving medically sensitive information in a restricted area. When faxing information to us:
- Verify the receiving fax number.
- Notify us you are faxing information.
- Verify we received your fax.

Do not use email (unless encrypted) to transfer files containing member information to us. You should mail or fax this information. Mail medical records in a sealed envelope marked confidential and addressed to a specific individual or department in our company.

Our voice mail system is secure and password protected. You should only leave messages with the minimum amount of member information necessary. When contacting us, please be prepared to verify the following:
- Name
- Address
- NPI number
- TIN
- Wellpoint provider number

Utilization Management

13.1 Prior Authorization

Referrals to in-network specialists are not required. However, some specialty services require prior authorization or prior notification as specified below. Wellpoint encourages members to consult with their primary care providers (PCPs) prior to accessing nonemergency specialty services. The two processes are defined below.

Prior authorization means obtaining Wellpoint approval for a healthcare service before the service is provided. The approval is required for us to pay the provider for the service. Approval is based on medical necessity criteria. Receipt of prior authorization does not guarantee payment. Expedited prior authorization and limitation extension are types of prior authorization.

Prior notification means notifying Wellpoint of services to be given to the member before the member receives treatment or services. This must be done via, fax or phone. There is no

review against medical necessity criteria. However, member eligibility and provider status (network and non-network) are verified. In some instances (**for example**, emergency visits) providers should notify Wellpoint within 24 hours of the visit. Prior notifications are not available in the provider portal.

Additional information on these processes specific to your services may be included in your contract.

13.2 Confidentiality of Information During the Process

We maintain procedures to help ensure patients' protected health information (PHI) is kept confidential. PHI is shared only with those individuals who need access to it to conduct the following functions:

- Utilization management (UM)
- Case management
- Condition Care
- Discharge planning
- Quality management
- Claims payment
- Pharmacy

UM staff are available **Monday-Friday from 8 a.m.-5 p.m**. for inbound collect or toll-free calls regarding UM issues. Staff can receive inbound communication regarding UM issues after normal business hours. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.

13.3 Interactive Care Reviewer

Our Interactive Care Reviewer (ICR) is the preferred method for submitting prior authorization requests, offering 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, ICR or other online tool). Capabilities and benefits of the ICR include:

- Initiating preauthorization requests online — eliminating the need to fax. The ICR allows detailed text, photo images and attachments to be submitted along with your request.
- Making inquiries on previously submitted requests via phone, fax, ICR 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, including email notifications if requested using a valid email address.

- Viewing real-time results for common procedures with immediate decisions.

You can access the ICR under Authorizations and Referrals on the Availity Essentials Portal (Availity.com). For an optimal experience with the ICR, use a browser that supports 128-bit encryption. This includes Internet Explorer, Chrome, Firefox and Safari. The ICR is not currently available for:

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

We will update our website as additional functionality and lines of business are added throughout the year.

13.4 Coverage Guidelines

Prior authorization is required for all visits and procedures performed by nonparticipating providers.

We have clinical staff available 24 hours a day, 7 days a week to accept prior authorization for emergency inpatient requests. When a medical request is faxed, we:

- Verify our member's eligibility and benefits.
- Determine the appropriateness of the request.
- Issue you a reference number.

For urgent requests, we give you a decision within one business day. If documentation is not complete, we will ask for additional necessary documentation.

If your request is denied by our medical director, you can discuss your case with him or her through Peer-to-Peer within the time limits listed below before the final determination is made. We will mail a denial letter to the hospital, the member's PCP and the member, which includes the member's appeal and fair hearing rights and process.

- Inpatient/outpatient preauthorization: Two business days (one Business Day for BH)
- Inpatient concurrent stay: Two business days (one Business Day for BH)

Call the Washington Medical Director peer to peer line at **206-695-7081**, ext. **106-124-5230**.

13.5 Nonemergent Outpatient and Ancillary Services

We require prior authorization for coverage of certain non-emergent outpatient and ancillary services. Prior authorization is also required for services provided by nonparticipating providers. To ensure timeliness, you must include the following:

- Member name and ID

- Name, phone and fax number of the physician providing the service
- Name of the facility and telephone number where the service will be performed
- Name of servicing provider and telephone number
- Date of service
- Diagnosis with ICD-10 code
- Name of elective procedure/DME/etc. with CPT or HCPCS codes
- Medical information to support the request
- History and physical
- Past and current treatment plans
- Response to treatment plans
- Medications, including frequency and dosage

For the most up-to-date prior authorization/notification requirements, visit provider.wellpoint.com/wa > Resources > Prior Authorization Lookup Tool.

13.6 Prenatal Ultrasounds

The following are frequently asked questions and answers about our prenatal ultrasound policies.

What are the prior authorization requirements for total obstetric care?	For obstetric care, we do not require prior authorization. We only require notification by phone (**833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT**) or fax (**800-964-3627**).
In which trimester of a woman's pregnancy is she determined to be an obstetric patient?	A member is considered to be an obstetric patient once pregnancy is verified.
Are there prior authorization requirements for prenatal ultrasound?	There are no prior authorization requirements for prenatal ultrasound studies. Payment is administered by matching the procedure with the appropriate diagnosis code submitted on the claim.
Is there a medical policy covering prenatal ultrasound procedures?	Yes, there is a detailed policy covering certain prenatal ultrasound procedures. To review the complete policy: • Go to provider.wellpoint.com/wa Choose Resources > *Medical Policies and Clinical UM Guidelines* > Search by CG-MED-42Select Prenatal Ultrasound from the policy list.

	The policy describes coverage of ultrasound studies for maternal and fetal evaluation as well as for evaluation and follow-up of actual or suspected maternal or fetal complications of pregnancy.
Does the policy describe limits on the number of prenatal ultrasound procedures a woman may have during her pregnancy?	Two ultrasounds for an average risk singleton pregnancy is considered medically necessary. Prenatal ultrasounds for fetal and maternal evaluations or for follow-up of suspected abnormalities are covered when medically necessary and supported by the appropriate diagnosis code for the ultrasound study performed. Not all diagnosis codes are acceptable and appropriate for all ultrasounds. When submitted incorrectly, a claim will be denied.
Which ultrasound procedures are covered under this policy?	The policy does not apply to ultrasound studies with CPT codes not specifically listed in the policy, such as nuchal translucency screening, biophysical profile and fetal echocardiography. • For CPT codes 76801 (+76802) and 76805 (+76810), 2 routine PNU studies • are covered per pregnancy. • For CPT codes 76811 (+76812), 76815, 76816 and 76817, additional • ultrasound studies are covered when medically necessary and supported by • the appropriate diagnosis code for the ultrasound study being requested.
Are there exceptions to this policy?	The policy does not apply to maternal fetal medicine specialists (S142, S083, S055 and S088) or radiology specialists (S164 and S232). The policy also does not apply to ultrasounds performed in place of service code 23 — emergency department.

13.7 Emergency Services

Emergency services do not require prior authorization. We do not deny access to or discourage our members from using 911 or accessing emergency services when warranted.

When a member seeks emergency services at a hospital, he or she is examined by a licensed physician to determine if a need exists for such services. The physician will note the results of the emergency medical screening examination on the member's chart.

If there is a concern about transferring the member, we defer to the judgment of the attending physician. If the emergency department cannot stabilize and release our member, we will help facilitate the inpatient admission.

Any transfer from a non-network hospital to a network hospital can only take place after the member is medically stable.

Behavioral Health Crisis Services

Crisis services are available 24 hours a day, 7 days a week, and 365 days a year. Wellpoint coordinates with crisis service providers, including crisis hotlines, to ensure members have access to these services when necessary. Prior authorization or intake assessments are not required for crisis interventions. Members, providers or other concerned persons may contact crisis services at any time. Contacting the regional crisis line also connects individuals with local crisis providers, who may have additional walk-in crisis service options.

Regional behavioral health crisis line numbers are available at hca.wa.gov/assets/program/county-crisis-line-phone-numbers.pdf.

Prior authorization may be required if, during the provision of crisis services, it is suspected or determined that a member meets criteria for inpatient services or other less restrictive alternatives.

13.8 Medical and Behavioral Health Inpatient Admissions

Notification is required within 24 hours or by the next business day for any inpatient admission, whether emergent or previously authorized. Network hospitals can call Provider Services 24 hours a day, 7 days a week to notify us of any admission.

- For medical hospital admissions, call **833-731-2274** Monday through Friday, 8 a.m. to 5 p.m. PT or send a fax to **800-964-3627.**
- For psychiatric hospital admissions, call **833-731-2274** Monday through Friday, 8 a.m. to 5 p.m. PT.

Emergent Admissions

Notification of the admission must be received within one business day. Failure to notify Wellpoint of an emergent admission within the time frame will result in an administrative denial of the inpatient stay. Administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late or lack of notification of admissions or failure to obtain precertification, if required. Appeals for administrative denials must address the reason for the denial.

Our medical management staff will verify eligibility and determine coverage. A licensed clinician will review and authorize the coverage of emergent admissions.

Clinical information to substantiate the admission must be submitted within the next business day to determine medical necessity of the admission.

Documentation must be complete. We will notify the hospital if additional documentation is necessary.

If our medical director denies coverage, the attending provider will have an opportunity to discuss the case with him or her. We will mail a denial letter to the hospital, the member's PCP and the member that includes the member's appeal and fair hearing rights and process.

Elective Admissions

We require prior authorization of all elective inpatient admissions. The referring PCP, clinician or specialist is responsible for prior authorization. Requests for prior authorization with all supporting documentation immediately upon identifying the inpatient admission must be submitted at least 72 hours prior to the scheduled or rescheduled admission date. This will allow us to verify benefits and process the prior authorization request. For services that require prior authorization, we make case-by-case determinations that consider the individual's healthcare needs and medical history in conjunction with nationally recognized standards of care. The hospital can confirm that a prior authorization is on file by visiting our provider website or calling Provider Services at **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT**.

If the request does not meet criteria for approval, the requesting provider will be afforded the opportunity to discuss the case with the medical director. Call the Washington Medical Director Peer to Peer line at **206-695-7081** ext**. 1061245230** within the following time limits:

- Inpatient/outpatient preauthorization: Two business days
- Inpatient concurrent stay: Two business days

Our utilization management clinician will review the coverage request and the supporting medical documentation to determine the medical appropriateness of all procedures. When appropriate, our utilization management clinician 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, we will issue a Wellpoint reference number 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 medical necessity criteria for the admission are not met on the initial review, the requesting provider will be able to discuss the case with the Wellpoint medical director prior to the determination.

If the prior authorization documentation is incomplete or inadequate, the prior authorization nurse will not approve coverage of the request but 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 member's fair hearing appeal rights) will be mailed to the requesting provider, member's PCP and the member.

13.9 Inpatient Reviews

Admission Review

We review all inpatient hospital admissions and urgent and emergent admissions within one business day of notification. We determine the member's clinical status through communication with the hospital's Utilization Review department.

We then document appropriateness of stay and help facilitate care coordination and discharge planning in collaboration with the facility.

Concurrent Review

To determine the authorization of coverage, we conduct a concurrent review of the hospital medical record by Electronic Medical Record or fax.

We authorize the covered length of stay based on medical necessity utilizing MCG, InterQual and/or American Society of Addiction Medicine criteria. A medical director review is conducted when medical necessity criteria/level of care are not met. We will communicate approved days and bed level coverage to the hospital for any continued stay.

We will communicate approved days and bed level coverage to the hospital for any continued stay.

Physical Health No Placement Administrative Days

Wellpoint Inc. reviews each case for appropriateness for administrative days when a member no longer meets criteria for an inpatient stay but is not able to be discharged due to the unavailability of an appropriate step down level of care or placement. Cases that meet criteria for administrative days will be reviewed every 7-14 days, or more frequently as needed. Facilities will be expected to provide documentation of a comprehensive discharge

plan and on-going efforts to secure appropriate placement and aftercare. Facilities may coordinate with their Wellpoint Utilization Care Manager for additional assistance with discharge coordination.

Newborn Administrative Days

In accordance with *WAC 182-550-4550*, 5 days of inpatient hospital stay may be granted for a post-partum parent when the post-partum parent no longer meets medical necessity, but the newborn remains inpatient on a hospital claim for monitoring post-in utero exposure to substances that may lead to physiological dependence and where continuous care by the post-partum parent is the appropriate first line treatment. In order to qualify for Newborn Administrative Days, the following criteria must be met:

- Newborn- The newborn was exposed in utero to a substance or substances that may lead to physiologic dependence and continuous care by the postpartum parent is the appropriate first-line treatment (i.e., "Eat, Sleep, Console" or other similar, non-pharmacologic model defined by continuous care by the birth parent).
- Postpartum parent- The postpartum parent rooms in with the newborn and provides continuous support and care. The newborn administrative days are for the postpartum parent.
- Medication- The billing hospital provides all prescribed medications to the postpartum parent for the duration of the stay, including medications prescribed to treat substance use disorder. The hospital bills these medications as a line item separate from inpatient pharmacy.
- Additional services- The billing hospital provides at least the following services to the postpartum parent while an inpatient during the newborn administrative day: o A hospital bed/rooming in with the newborn
  - Nutritional support for the parent
  - Other support services depending on the newborn's needs (for example, lactation support, nursing assessment and intervention, rounding, discharge planning)

Physical Health Newborn Additional Administrative Days

Wellpoint Washington Inc. allows for additional administrative days for the post-partum parent beyond the initial five days when the stay meets the criteria outlined in *WAC 182-550-4550* for both the first five initial newborn administrative days and the criteria below:

1. The newborn requires ongoing monitoring and does not meet criteria for discharge because the newborn is having difficulty with one or more of the following:
   a. Feeding or sucking, or poor weight gain
   b. Gastrointestinal disturbance (for example, vomiting, diarrhea, cramping)
   c. Sleep (i.e., falling asleep or maintaining sleep)
   d. Being consoled (for example, excessive crying or irritability, tremors, hypertonia)
2. The newborn can receive continuous care from the postpartum parent:

e. The newborn has not transferred into the neonatal intensive care unit (NICU) or the pediatric specialty unit for closer monitoring o The postpartum parent is staying at the hospital to provide continuous care

13.10 Extenuating Circumstances

Per *WAC 284-43-2060, 2000*, extenuating circumstances may be identified when providers are unable to:

- Obtain prior authorization before treating the member.
- Notify the health plan within a contracted, predefined time period of the patient's admission.

In these situations, claims will not be automatically denied for lack of timely admission notification (for example, 24 hours) or for lack of prior authorization as long as the services are covered benefits for the patient and meet the health plan's criteria for medical necessity. The following are circumstances outlining extenuating situations:

- Unable to know coverage: The provider organization does not have current insurance information on file for the patient and is unable to get correct insurance information from the patient.
- Unable to anticipate service: The provider organization, prior to seeing the patient, could not anticipate the need for a procedure requiring prior authorization, and any delay in delivering the procedure to obtain an authorization would adversely impact the health of the patient.
- Inherent components: The provider organizations obtained a prior authorization for at least one service in an inherently related set of services but not for other inherently related services in the set.
- Misinformation: The provider organization can demonstrate that a health plan representative and/or the health plan's website gave inaccurate information about the need for a prior authorization or admission notification.
- Delayed notification: The health plan's decision/notification took longer than the time frames outlined in *WAC 284-43-2000*, and the provider can demonstrate they met all of their supporting documentation and time frame requirements in submitting requested information (in other words, the service was provided after the prior authorization was requested and submission and notification time frames had passed, but it was provided before a prior authorization notification decision was given to the provider).

A request for extenuating circumstance must be completed before a claim is submitted. Once a claim has been submitted and denied the case no longer meets the criteria for extenuating circumstance and must be submitted to the claims appeal process.

13.11 Discharge Planning

Our Utilization Management clinicians and case managers coordinate our members' discharge planning needs with:

- The hospital's utilization review/case management staff.
- The attending physician.
- Follow-up providers.
- Community partners
- Members

The attending physician and/or facility coordinates follow-up care with the member's PCP or follow-up provider. This includes the development of a discharge summary comprised of a summary of diagnoses, care provided, medication lists, and follow-up plans that is provided to the PCP or other follow-up provider. Written discharge instructions are given to the member and family/guardian clearly explaining: 1) the discharge plan, 2) any medication instructions or education on appropriate use of medications, and 3) contact numbers for the member or family/guardian for questions regarding discharge.

We may refer cases to our Case Management staff for care coordination or case management services during or post hospitalization.

For ongoing care, we work with the provider to plan discharge to an appropriate setting, and may require prior authorization for the following services such as:

- Hospice facility
- Convalescent facility
- Home Health Care program (for example, home infusion, skilled nursing and/or therapies in the home)
- Skilled nursing facility
- Inpatient rehabilitation
- Long-term acute care (LTAC).
- Medical equipment
- Outpatient medical injectables
- Follow-up visits to certain practitioners
- Outpatient procedures
- Behavioral health residential treatment and stabilization

Non-Covered Benefits:

Exception to Rule: The provider or member may ask Wellpoint to approve a service that is not a covered benefit or has been denied as not covered. For adults (21 and older), this is called an Exception to Rule (ETR):

- It must be requested and approved prior to services being provided.
- To be approved, the provider must provide documentation that the member's condition is so different from most people.
- No other covered, less costly service will meet the member's needs
- The request must meet the rules in Washington Administrative Code (WAC) 182-5010160 for approval. ETR decisions are final and cannot be appealed.

Exception to Rule/Limitation form can be found at:
provider.wellpoint.com/docs/gpp/WAWA_Exception_Rule_Request_Form.pdf

Limitation Extension: Providers may ask Wellpoint to approve more services than the member's benefit package allows. It may be more in scope, number, length of time, or how often a service is provided.

- This is called a Limitation Extension (LE). To be approved, it must meet the rules in Washington Administrative Code (WAC) 182-501-0169:
- It must be requested and approved before services are provided
- Member's condition must show it is improving due to the services you have already received.
- Member's condition must show it will likely continue to improve with more services, and that it will likely worsen without continued services.
- Members can ask for an appeal at the same time as providers ask for a Limitation Extension.

EPSDT Early and Periodic Screening, Diagnostic and Treatment

Wellpoint shall review requests for any non-covered service to determine medical necessity, including evaluation of safety and effectiveness of the requested service and to establish it as not experimental. If determined to be medically necessary, Wellpoint shall cover the service as long as it does not violate HCA contract or federal rules.

Services, treatment or other measures must be: Medically Necessary, safe and effective, not experimental.

If EPSDT services exceed "soft limits" place on the scope, we will use Limited Exception procedures to determine medical necessity and authorize additional services as indicated. Standard Precertification rules apply.

Other Health Insurance: All requests despite primary or secondary coverage will be reviewed for medical necessity.

CLAIMS

14.1 Claim Submissions

You have the option of submitting claims electronically or by mail.

We encourage you to submit claims electronically as you will be able to:

- Submit claims either through a clearinghouse or through the Availity Essentials Portal
- Receive payments quickly
- Eliminate paper
- Save money
- All NPIs submitted on a claim form must be on the HCA *Active-Open* list to receive claim reimbursement. NPIs that are in *Pending* status with the HCA are not considered active. Claims will reject if any NPI billed is not on the HCA *Active-Open* list. If you are not in active status, contact the HCA at providerenrollment@hca.wa.gov or **800-562-3022**, extension **1613**.
- Any claim submitted to Wellpoint without a taxonomy code for the billing and servicing (if applicable) provider will be rejected. Providers should select the taxonomy that best describes the service rendered and also be within the scope of licensure for the provider performing the service.
- For Certified Public Expenditure (CPE) Hospitals Only:
- All inpatient service claims for Supplemental Security Income (SSI) enrollees of the Apple Health program must be submitted directly to the Washington State Health Care Authority and contain prior authorization information from Wellpoint.
- This requirement applies to all managed care companies who serve Apple Health SSI enrollees and the following CPE hospitals:
  - Cascade Valley Medical Center
  - Evergreen Hospital and Medical Center
  - Harborview Medical Center
  - Olympic Medical Center
  - Samaritan Hospital — Moses Lake
  - Skagit County Hospital District #2 — Island
  - Skagit Valley Hospital
  - University of Washington Medical Center
  - Valley General Hospital — Monroe
  - Valley Medical Center — Renton

To request prior authorization from Wellpoint for Supplemental Security Income members, do one of the following:

- Log on to provider.wellpoint.com/wa.
- Fax **800-964-3627**
- Call **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT**
- For Licensed Behavioral Health Agencies
- Wellpoint has adopted the Service Encounter Reporting Instructions (SERI) for behavioral health services for Integrated Managed Care (IMC). These instructions describe the requirements and timelines for reporting service encounters, program information and assignment of standardized nomenclature, which accurately describes data routinely used in the management of the behavioral health system. Information regarding the Service Encounter Reporting Instructions (SERI) can be found on the Wellpoint provider website provider.wellpoint.com/wa > Resources > Provider Manuals and Guides.
- The SERI guide can be found on the State's website at the following link: hca.wa.gov/billers-providers-partners/behavioral-health-recovery/service-encounter-reporting-instructions-seri

Wellpoint processes all claims under the member's Wellpoint ID. Ensure all claims, including Newborn claims are billed with Wellpoint member ID. Failure to use the correct ID will result in claim denials.

Wellpoint Newborn Claim Processing Guidelines:
Washington State law RCW 48.43. 115(3)(f), known as the *Erin Act*, requires that health plan's that provide maternity benefits must provide comparable coverage, at no additional charge, for an insured mother's newborn for up to [three] weeks ([21] days) even if there are separate hospital admissions.

The Wellpoint process to comply with this Revised Code of Washington (RCW) is as follows:
Upon receipt of the first newborn claim, Wellpoint will determine if the Health Care Authority (HCA) has issued the newborn a member ID:

- If the HCA has issued the newborn a member ID, Wellpoint will require the newborn's ID on claims and will process the claims under that ID. Wellpoint does not process newborn claims under the mother's ID.
- If the HCA has not yet issued an ID to the newborn, Wellpoint will create a temporary ID to facilitate the processing of the newborn's claims. To have a temporary ID created, submit the claim with the Mother's Wellpoint ID, the baby's first name and last name, date of birth and the baby's gender in the subscriber/client information fields instead of the mother's information. In addition, you must use "SCI=B" in the Billing Note section of the claim.
- When billing for multiple births, enter the infant's identifying information in the comment or remarks area. For example, the first infant would be "SCI=BA," the second infant would

be “SCI=BB,” and the third infant would be “SCI=BC.” Each newborn must have services provided to that newborn billed on a separate claim.
- This temporary ID will remain in place until we receive updated eligibility from the HCA.

14.2 Electronic Claim Submissions

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

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

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

EDI Response Reports

Claims submitted electronically will return reports that may contain rejections. If using a Clearinghouse or Billing Vendor, please ensure you are receiving all reports. It’s important to review rejections on the EDI reports as they will not continue for claims processing. For questions on electronic rejections contact your Clearinghouse or Billing Vendor or Availity Essentials if you submit directly at **800- 282-4548**.

EDI Payer ID:
WLPNT

Electronic Remittance Advice (835):

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

- Log in to Availity **Essentials**
- Select **My Providers**
- Select **Enrollment Center** and select **Transaction Enrollment**

Note: If you use a clearinghouse or vendor, please work with them on 835 registrations, updates and/or changes.

Availity Support:

Contact Availity Essentials Client Services with any questions at **800-282-4548 8 a.m. - 8 p.m. EST**.

Electronic Funds Transfer (EFT):

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

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

EDI Submission for Corrected Claims

For corrected professional (*837P*) claims submitted via EDI claim professional, providers should use one the following frequency codes to indicate a correction was made to a previously submitted and adjudicated claim:

- 7 – Replacement of Prior Claim
- 8 – Void/Cancel Prior Claim

Note: A full definition of each code and confirmation of the use of these codes on a professional claim can be found on the NUCC website NUCC.org

- Indicator Placement
- Loop: 2300 (Claim Information)
- Segment: CLM 05-03 (Claim Frequency Type Code)
- Value: 7, 8

For corrected institutional (837I) claims submitted via EDI, providers should use one the following Bill Type Frequency Codes to indicate a correction was made to a previously submitted and adjudicated claim:

- 0XX5 — Late Charges Only Claim
- 0XX7 — Replacement of Prior Claim
- 0XX8 — Void/Cancel Prior Claim

14.3 Paper Claims Submission

You must submit a properly completed *CMS-1450* or *CMS-1500* claim form:

- Within the timely filing guidelines in your provider contract for inpatient services (from the date of discharge) or outpatient services (from the date of service) as applicable.
- On the original red claim forms (not black and white or photocopied forms).Laser-printed or typed (not handwritten).
- In a large, dark font.
- Submit paper claims to:
  Washington Claims
  Wellpoint
  P.O. Box 61010
  Virginia Beach, VA 23466-1010

There are exceptions to the timely filing requirements. They include:

- Cases of coordination of benefits/subrogation: The time frames for filing a claim will begin on the date of the third party's resolution of the claim.
- Cases where a member has retroactive eligibility: The time frames for filing a claim will begin on the date Wellpoint receives notification from the enrollment broker of the member's eligibility/enrollment.

Claim forms must include the following information (*HIPAA*-compliant where applicable):

- Patient's ID number
- Patient's name
- Patient's date of birth
- ICD-10 diagnosis code/revenue codes
- Date of service
- Place of service
- Procedures, services or supplies rendered CPT codes/HCPCS codes/DRGs
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract

- Billing provider information
- Taxonomy code
- NPI of billing and rendering provider when applicable
- Coordination of benefits/other insurance information
- Prior authorization number or copy of prior authorization
- Name of referring physician
- NPI/API
- NDC, unit of measure and quantity for medical injectables
- Any other state-required data
- For medication codes billed under the medical benefit, inclusion of a national drug code on your medical claim is necessary for claim processing of drugs billed with a not otherwise classified (NOC) code:
- Both the Healthcare Common Procedure Coding System (HCPCS) and National Drug Code (NDC) must be accurate and applicable to the medication requested.
- The manufacturer of the submitted NDC must participate in the Medicaid Drug Rebate Program.
- The submitted NDC must not be for a DESI 5 or 6 drug. (DESI 5 or 6 drugs are drugs that have been defined by the FDA as less than effective.)
- Participating manufacturers and DESI designations are updated quarterly and can be found at data.medicaid.gov/dataset/0ad65fe5-3ad3-5d79-a3f9-7893ded7963a/data.

We cannot accept claims with alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return.*CMS-1500* and *CMS-1450* forms are available from the CMS website at cms.gov.

14.4 Encounter Data

If you are reimbursed by capitation, you must send encounter data to Wellpoint for each member encounter.

Please refer to your contract for timely filing standards related to encounter submissions.
- EDI submission methods.
- *CMS-1500* claim form.
- Other arrangements approved by Wellpoint.

Include the following information with your encounter submission:
- Member name (first and last name)
- Member date of birth
- Provider name according to contract
- Coordination of benefit information

- At least $.01 in billed charges for each service rendered
- Date of encounter
- Diagnosis code
- Types of services provided (using current procedure codes and modifiers if applicable)
- Provider tax ID number
- Taxonomy code
- NPI/API number

Our Utilization and Quality Improvement staff monitors compliance, coordinates with the medical director and then reports to the quality management committee on a quarterly basis. Lack of compliance may result in the following:

- Training
- Follow-up audits
- Termination

14.5 Claims Adjudication

We are dedicated to providing timely adjudication of claims. We process all claims according to generally accepted claims coding and payment guidelines defined by the CPT and ICD-10 manuals.

You must use *HIPAA*-compliant billing codes when billing Wellpoint. When billing codes are updated, you are required to use appropriate replacement codes for submitted claims. We will reject claims submitted with noncompliant billing codes.

We reserve the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure.

Whether you submit claims through EDI or on paper, ensure you submit clean and complete claims.

For your claims payment to be considered, you must adhere to the following time limits:

- From the date of service.
- From the date of discharge for inpatient claims filed by a hospital.
- In the case of other insurance, submit the claim within the timely filing guidelines in your provider contract for 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 the timely filing guidelines in your provider contract. It will be from the date the eligibility is added and we are notified of the eligibility/enrollment.

We will deny claims submitted after the filing deadline.

14.6 International Classification of Diseases, 10th Revision (ICD-10)

ICD-10 is 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.

What is ICD-10?

ICD-10 is a diagnostic and procedure coding system endorsed by the World Health Organization. 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:

- ICD-10-CM (clinical modification) is used for diagnosis coding.
- ICD-10-PCS (procedure coding system) 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 1 and 2 for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, Volume 3 for inpatient hospital procedure coding.

14.7 Clean Claim Payments

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted on time.
- Is accurate.
- Is submitted on a *HIPAA*-compliant standard claim form (*CMS-1500*, *CMS-1450* or successor forms).
- Requires no further information, adjustment or alteration to be processed and paid.
- Is not from a provider who is under investigation for fraud or abuse.
- Is not a claim under review for medical necessity.
- Appropriate taxonomy code is present.

We will adjudicate clean claims to a paid or denied status within 30 calendar days of receipt. If we do not pay the claim within 61 calendar days, we will pay all applicable interest as required by law.

We produce and mail an *EOP* twice weekly. It shows the status of each claim that has been adjudicated during the previous claim cycle.

If we do not receive all of the required information, we will deny the claim either in part or in whole within 30 calendar days of receipt of the claim. A request for the missing information will appear on your *EOP*.

Once we have received the requested information, we will process the claim within 30 calendar days.

We will return paper claims that are determined to be unclean along with a letter stating the reason for the rejection. We will return electronic claims that are determined to be unclean to the clearinghouse that submitted the claim.

You can check the status of claims at Availity.com, through your registered provider profile, or by calling Provider Services at **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT**.

14.8 Claims 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.

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

14.9 Coordination of Benefits and Third-party Liability

We follow Washington state-specific guidelines when coordination of benefits is necessary. We use covered medical and hospital services whenever available, or other public or private sources of payment for services rendered to our members.

- When Wellpoint learns that more than one plan covers a claimant, we will resolve with the other plan, in no more than 30 days, which plan is primary. If an agreement cannot be reached, both plans must pay.
- If Wellpoint is the secondary plan and we receive a claim without payment details needed to process the claim, Wellpoint will notify the provider or member within 30 days and promptly process the claim once it is resubmitted with the necessary information from the primary payer.
- If the primary plan has not adjudicated the claim within 60 days, the provider or member may submit the claim to Wellpoint, who must pay as the primary within 30 days. When Medicare is the primary payer, federal Medicare law will govern.

When third-party resources and third-party liability resources are available to cover the costs of trauma-related claims and medical services provided to Apple Health members, we

will reject the claim and redirect you to bill the appropriate insurance carrier unless certain pay-and-chase (Wellpoint pays the claim and pursues the third party for reimbursement) circumstances apply — see below. Or if we do not become aware of the resource until after payment for the service was rendered, we will pursue post-payment recovery of the expenditure. You must not seek recovery in excess of the Apple Health payable amount.

The pay and chase circumstances are:

- When the services are for preventive pediatric care, including EPSDT.
- If the claim is for prenatal or postpartum care or if the service is related to OB care.

Any service rendered to a child of an absent parent (in other words, primary coverage is through a noncustodial parent after a divorce.
Our subrogation vendor handles the filing of liens and settlement negotiations both internally and externally.

If you have any questions regarding paid, denied or pended claims, call Provider Services at **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT**.

14.10 Reimbursement Policies

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Wellpoint covered the service for a 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 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 procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

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

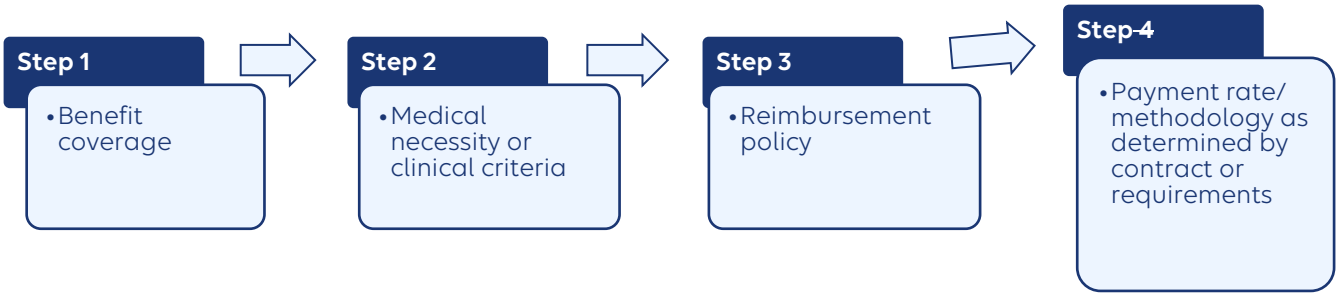
- Reject or deny the claim.
- Recover and/or recoup claim payment.

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



Review Schedule and Updates

Reimbursement policies undergo reviews 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 a Wellpoint business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policies to our provider website.

Medical Coding

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

- Correct modifier use.
- Effective date of transaction code sets (CPT, HCPCS, Service Encounter Reporting Instructions (SERI), ICD-10 diagnosis/procedures, revenue codes, etc.).
- Code editing rules appropriately applied and within regulatory requirements.
- Analysis of codes, code definition and appropriate use.

Reimbursement by Code Definition

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

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

You must follow proper billing and submission guidelines. You are required to use industry-standard, compliant codes on all claims submissions.

- Wellpoint will update the AP-DRG no more than 60 days from the date of receipt of notice of final changes or on the effective date of such changes, whichever is later. APDRG changes will be applied on a prospective basis.
- Reimbursement for readmissions, transfers and outliers will be treated in accordance with the state Apple Health AP-DRG standards.
- Wellpoint will calculate the AP-DRG from the claim submitted by the provider using APDRG software. Payment is based on the calculated AP-DRG.

Outlier Reimbursement - Audit And Review Process

Requirements and Policies

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

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

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

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 or procedure charge. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions including IV or PICC line insertion at bedside, call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Outpatient Services for Facility personnel are also not separately reimbursable. Reimbursement is included in the reimbursement for the procedure or observation charge.

Implants

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

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

IV sedation and local anesthesia

Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, 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 is defined as surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac cath labs, Hybrid Rooms, X-ray, pulmonary and cardiology procedural rooms. The operating room charge will reflect the cost of:

1. The use of the operating room
2. The services of qualified professional and technical personnel

Any supplies, items, equipment, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services. Refer to Routine Supplies section of the manual.

Personal Care Items and Services

Personal care items used for patient convenience are not separately reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, 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.

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 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)

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
	• Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	Supplies and Equipment • Blood Pressure cuffs/Stethoscopes • Thermometers, Temperature Probes, etc. • Pacing Cables/Wires/Probes • Pressure/Pump Transducers • Transducer Kits/Packs • SCD Sleeves/Compression Sleeves/Ted Hose • Oximeter Sensors/Probes/Covers • Electrodes, Electrode Cables/Wires • Oral swabs/toothettes • Wipes (baby, cleansing, etc.) • Bedpans/Urinals • Bed Scales/Alarms • Specialty Beds • Foley/Straight Catheters, Urometers/Leg Bags/Tubing • Specimen traps/containers/kits • Tourniquets • Syringes/Needles/Lancets/Butterflies • Isolation carts/supplies • Dressing Change Trays/Packs/Kits • Dressings/Gauze/Sponges • Kerlix/Tegaderm/OpSite/Telfa

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
	• Skin cleansers/preps • Cotton Balls; Band-Aids, Tape, Q-Tips • Diapers/Chucks/Pads/Briefs • Irrigation Solutions • ID/Allergy bracelets • Foley stat lock • Gloves/Gowns/Drapes/Covers/Blankets • Ice Packs/Heating Pads/Water Bottles • Kits/Packs (Gowns, Towels and Drapes) • Basins/basin sets • Positioning Aides/Wedges/Pillows • Suction Canisters/Tubing/Tips/Catheters/Liners • Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) • Preps/prep trays • Masks (including CPAP and Nasal Cannulas/Prongs) • Bonnets/Hats/Hoods • Smoke Evacuator Tubing • Restraints/Posey Belts • OR Equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) • 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)

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
	• Patient transport fees
0223	Utilization Review Service Charges
0263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) • Medication prep • Nonspecific descriptions • Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges • IV Solutions 250 cc or less, except for pediatric claims • Miscellaneous Descriptions • Non-FDA Approved Medications
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	• Specimen collection • Draw fees • Venipuncture • Phlebotomy • Heel stick

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
	• 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 • 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

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
	• Suction Supplies for Vent Patient • Electrocautery Grounding Pad • Bovie Tips/Electrodes • Anesthesia Supplies • Case Carts • C-Arm/Fluoroscopic Charge • Wound Vacuum Pump • Bovie/Electro Cautery Unit • Wall Suction • Retractors • Single Instruments • Oximeter Monitor • CPM Machines • Lasers • Da Vinci Machine/Robot
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

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
0940 – 0945	Education/Training

14.11 Overpayment Process

Overpayments may be identified by two entities - Wellpoint and its contracted vendors, such as Cotiviti, Optum and Ceris or the providers.

Cost Containment Unit Data Mining and Overpayments (DMO also referred to as Forager) - Wellpoint conducts periodic reviews of previously processed claims to identify overpayments for the following reasons:

- Claim paid as primary insurer (OHI)
- COB Manual Processing Errors
- Duplicate Payment
- Global Configuration
- Hospice COB
- Incorrect Provider Selection
- Manual Processing Error
- Modifier Projects
- Non-Covered Service
- Paid Without Authorization
- Provider Configuration
- Retro Member Disenrollment

All overpayments identified by Wellpoint will be issued a First Notice requesting a refund be submitted within 60 days, a final notice will follow 45 days later if a refund is not received. If a provider believes their overpayment has been identified in error, the provider will be required to submit their dispute in writing and send by one of the following methods:

Fax: **866-920-1874**
Online: Availity Essentials
Mail:

Wellpoint, Cost Containment – Disputes,
P.O. Box 62427,
Virginia Beach, VA 23466-2437.

Overpayments identified by contracted vendors will also be sent two notices with refund and dispute information. Providers may also self-identify overpayments by submitting a Recoupment Request or a Refund Form.

This can be located on the Provider website at **provider.wellpoint.com/wa** > Resources > Forms > Claims &Billing. All self-identified overpayments should include the following:

- Claim number
- Member name
- Member ID number WP ID is preferred
- DOS
- Billed Charges
- Amount of overpayment
- Reason for overpayment
- Fax: **866-920-1874**
- Online: Availity Essentials
- Mail: Wellpoint, Cost Containment – Correspondence
  P.O. Box 62427
  Virginia Beach, VA 23466-2437

Refunds Address:
Wellpoint
P.O. Box 933657
Atlanta, GA 31193-3657

14.12 Documentation of Claim Receipt

The following information will be considered proof that a claim was received timely. If the claim is submitted:

- By **U.S. mail (first-class, return-receipt requested or by overnight delivery service)**: The provider must provide a copy of the claim log that identifies each claim included in the submission.
- **Electronically**: The provider must provide the clearinghouse assigned receipt date from the reconciliation reports.
- **By fax:** The provider must provide proof of transmission.
- **By hand delivery:** The provider must provide a claim log that identifies each claim included in the delivery and a copy of the signed receipt acknowledging the hand delivery.

The claims log maintained by providers must include the following information:

- Name of claimant
- Address of claimant

- Phone number of claimant
- Claimant's federal tax identification number
- Name of addressee
- Name of carrier
- Designated address
- Date of mailing or hand delivery
- Subscriber name
- Subscriber ID number
- Patient name
- Date(s) of service/occurrence
- Total charge
- Delivery method

Good Cause:

If the claim or claim dispute includes a written explanation clearly identifying the delay or other evidence that establishes the reason, Wellpoint will determine good cause based primarily on that statement or evidence and/or if the evidence leads to doubt about the validity of the statement. Wellpoint will contact the provider for clarification or additional information necessary to make a good cause determination.

Good cause may be found when a physician or supplier claim filing delay was due to:

- Administrative error (incorrect or incomplete information furnished by official sources [for example, carrier, intermediary, CMS] to the physician or supplier).
- Incorrect information furnished by the member to the physician or supplier, resulting in erroneous filing with another care management organization plan or with the state.
- Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties, despite reasonable efforts by the physician/supplier to secure such documentation or evidence.
- Unusual, unavoidable or other circumstances beyond the service provider's control, which demonstrate the physician or supplier could not reasonably be expected to have been aware of the need to file timely.
- Destruction or other damage of the physician's or supplier's records, unless such destruction or other damage was caused by the physician's or supplier's willful act of negligence.

Corrected Claims:

When submitting a correction for a previously billed claim on a *CMS 1500* form or CMS 1450/UB04, include all services on the new submission. If any previously submitted changes

or services are not billed on the corrected claim form, they will be removed in the adjustment. Any reduction in payment amount would result in a negative account balance and/or a refund request. Wellpoint does not accept individual lines for correction on a *CMS 1500* form; this mirrors the process for institutional replacement claims submitted on *CMS 1450* claim forms. Standard timely filing guidelines apply to all corrected and replacement claims. Clearly identify the corrected claim as such by referencing the original claim number and including "corrected claim" on the claim form.

14.13 Billing Members

Before rendering a service not covered by Wellpoint, inform our member we do not cover the cost of the service, so he or she will have to pay for the service.

Refer to Washington state legislature item *WAC 182-502-0160* for the limited circumstances where fee-for-service or managed care patients are permitted to choose to self-pay for medical assistance services, and providers have authority to bill fee-for-service or managed care patients for medical assistance services.

If you choose to provide services that we do not cover:

- Understand we only reimburse for services that are medically necessary, including hospital admissions and other services.
- Understand you may not bill or take recourse against a member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Apple Health program.

You cannot balance bill for the amount above that which we pay for covered services.

In addition, you may **not** bill a member if any of the following occurs:

- Failure to submit a claim on time, including claims not received by Wellpoint
- Failure to submit a claim to Wellpoint for initial processing within the timely filing deadline for providers
- Failure to dispute a corrected claim within the clean-claim submission period
- Failure to appeal a claim within the 90-day payment dispute period
- Failure to appeal a utilization review determination within 30 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Provider error(s) in claims preparation, claims submission or the appeal/dispute process

14.14 Client Acknowledgment Statement

You may bill a member for a service that has been denied as not medically necessary or not a covered benefit (only if the following conditions are true):

- The member requests the specific service or item.
- The provider obtains the Washington State Health Care Authority form *Agreement to Pay for Healthcare Services* as referenced in *WAC 182 502 0160* (hca.wa.gov/assets/billers-and-providers/13_879.pdf).
- 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>, the services or items I have requested to be provided to me on <date(s) of service(s)> may not be covered under Wellpoint as being reasonable and medically necessary for my care or are not a covered benefit. I understand that Wellpoint has established the medical necessity standards for the services or items that I request and receive. I also understand that 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 the Wellpoint medically necessary standards for my care or are not a covered benefit.

Signature: _____

Date: _____

PROVIDER DISPUTES & APPEALS

15.1 Medical Necessity Appeals

A member, a member's authorized representative or a provider acting on behalf of a member with the member's written consent may file an appeal as follows:

- For an appeal of standard service authorization decisions, a member must file an appeal, either orally or in writing, within 60 calendar days of the date on the Wellpoint *Notice of Adverse Benefit Determination.* This also applies to a member's request for an expedited appeal.
- For an appeal for termination, suspension or reduction of previously authorized services when the member requests continuation of such services, the member must file an appeal within 10 calendar days of the date of the Wellpoint mailing of the *Notice of Adverse Benefit Determination*. If the member is notified in a timely manner and the member's request for continuation of services is not timely, Wellpoint is not obligated to continue services and
- the time frame for appeals of standard resolution apply.
- Oral inquiries seeking to appeal actions will be treated as appeals. All appeals are acknowledged in writing to both the member and requesting provider within 5 calendar days of receipt of the appeal.

We will make a decision and notify the member on standard resolution of appeals and appeals for termination, suspension or reduction of previously authorized services within 14 calendar days from the date of receipt of the appeal. The member or Wellpoint can extend the appeal for up to 14 calendar days but cannot delay the decision beyond twenty-eight (28) calendar days of the request for appeal.

For any extension not requested by the enrollee, Wellpoint shall resolve the appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

If an extension is requested by Wellpoint to complete the appeal, Wellpoint will document that there is need for additional information and how the delay is in the enrollee's best interest and make reasonable efforts to provide oral notice of the delay. We will notify the member orally within 2 calendar days and follow up with a written notice and to inform member of the right to file a grievance if they do not agree with our decision.. In all circumstances, the appeal determination must be resolved as expeditiously as the member's health condition requires and no later than the date the extension expires.

We will make a decision and notify the member on the expedited appeals within 72 hours after we receive the appeal. A written notice is sent to the member and we will also make

reasonable effort to provide member oral notice of the decision. We will also make reasonable efforts to provide oral notice of the decision to the member.
Our goal is to handle and resolve every appeal as quickly as the member's health condition requires. We ensure decision-makers regarding appeals:

- Have not been involved in previous levels of review or decision-making.
- Are not subordinates or direct reports of staff involved in previous levels of review or decision-making.
- Have clinical expertise in treating the member's condition or disease.

We will inform the member of the limited time they have to present evidence and allegations of fact or law with expedited resolution. And we also ensure that no punitive action will be taken against a provider who supports an expedited appeal.

A written-notice is sent to the member on all standard and expedited appeals within 14 calendar days of receipt of the appeal. The notice will include:

- The date completed.
- Reasons for the determination in easily understood language.
- A written statement of the clinical rationale for the decision, including how the requesting provider or member may obtain the utilization management clinical review or decision-making criteria.
- Next level of appeal rights if dissatisfied with the appeal decision if available.

If an appeal is not wholly resolved in favor of the member, the notice will include:

- The right for our member to request a state fair hearing and how to do so.
- The right to receive benefits while this hearing is pending and how to request them.
- Notice that the member may have to pay the cost of these benefits if the state fair hearing officer upholds the Wellpoint action.

Medical necessity denials may be appealed one time. Appeals for medical necessity denials cannot be processed as a Claims Payment Dispute.

15.2 Expedited Appeals

Our expedited appeal process is available upon the member's request or when a provider indicates a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum function. The member or provider may file an expedited appeal either orally or in writing. No additional written follow-up on the part of the member is required for an oral request for an expedited appeal.

All expedited appeal requests are immediately reviewed to determine if the request for medical care or treatment meets the definition and or criteria for an expedited appeal. This

determination is made within 24 hours of the request for an expedited appeal. Providers need to fax clinical documentation to support their oral request for an appeal.

If you have an expedited appeal, send by mail or fax to:

Mail: Attn: Appeals Department
Wellpoint
705 Fifth Ave. S., Suite 300
Seattle, WA 98104
Fax: **844-759-5953**

No punitive actions are taken against providers who request expedited resolutions or support members' appeals.

Wellpoint will resolve each expedited appeal and provide notice to the member as quickly as the member's health condition requires and within 72 hours of receipt of the expedited appeal request. We will provide written notice of the resolution of the appeal and also make reasonable efforts to provide oral notice. We will include the date completed and reasons for the determination in easily understood language. A written statement of the clinical rationale for the decision, including how the requesting provider or enrollee may obtain the utilization management clinical review or decision-making criteria, will also be issued.

If we deny a request for expedited resolution of an appeal, the appeal will follow the timeframe for standard resolution. We will make reasonable efforts to notify the member of the denial by phone and follow up with a written denial notice within two calendar days. The member has a right to file a grievance regarding the denial of a request for expedited resolution in the notices of denial.

Medical necessity denials may be appealed one time. Appeals for medical necessity denials cannot be processed as a Claims Payment Dispute.

15.3 Administrative Hearing Process

Only the member or the member's authorized representative may request a hearing. A provider may not request a hearing on behalf of a member unless the member deems, in writing, the provider to be his or her authorized representative.

The member must exhaust all levels of resolution and appeal within the Wellpoint appeal system prior to filing a request for a hearing with the HCA.

If Wellpoint fails to adhere to the notice and timing requirements, the member is deemed to have exhausted the Wellpoint appeal process and may initiate a State Fair Hearing.

The member or his or her representative will submit a request for an administrative hearing to the HCA. For hearings regarding a standard service, the request must be submitted within 120 calendar days of the date of the notice of resolution of the appeal. For hearings regarding termination, suspension or reduction of a previous authorized service, if the member requests continuation of services, the request must be submitted within 10 calendar days of the date on the Wellpoint mailing of the notice of resolution of the appeal.

When a hearing is requested, Wellpoint will provide the HCA and the member, upon request and within three business days, and for expedited appeals, within one business day, all Wellpoint-held documentation related to the Wellpoint appeal, including but not limited to any transcript(s), records or written decision(s) from participating providers or delegated entities.

The HCA will notify Wellpoint of hearing determinations. Wellpoint will be bound by the hearing determination, whether or not the hearing determination upholds the Wellpoint decision.

Implementation of such a hearing decision will not be the basis for termination of enrollment by Wellpoint.

After exhausting both the Wellpoint appeal process and the hearing process, an enrollee has a right to independent review in accordance with Washington legislation *RCW 48.43.535* and *WAC 284-43-630*. If a member, Wellpoint or the HCA is aggrieved by the final decision of an independent review or administrative hearing, an appeal of the decision may be made to the HCA Board of Appeals in accordance with *Chapter 388-526 WAC*. Notice of this right will be included in the written determination from Wellpoint or the independent review organization.

When GFS funding for a requested contracted service is exhausted, any appeals process, independent review, or agency administrative hearing process will be terminated, since contracted services cannot be authorized without funding regardless of medical necessity.

15.4 Continuation of Benefits During Appeals or Administrative Hearings

We are required to continue a member's benefits while the appeals process or the state fair hearing is pending if all of the following are true:

- The appeal, hearing, or independent review is submitted to us on or before the latter of the two:
- Within 10 calendar days of our mailing the *Notice of A*dverse Benefit Determination, which of actions involving services previously authorized, shall be delivered by a method that certifies receipt and assures delivery within 3 calendar days.
- Or the intended effective date of our proposed adverse determination.

- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment.
- An authorized provider ordered the services.
- The original period covered by the original authorization has not expired.
- The member requests an extension of benefits.
- The services were ordered by an authorized provider.

If the decision is against the member, we may recover the cost of the services the member received while the appeal was pending.

If, at the member's request, Wellpoint continues or reinstates the member's services while the appeal, hearing, or independent review is pending, the services shall be continued until one of the following occurs in accordance with 42 C.F.R. § 438.420 and WAC 182-526-0200 and WAC 182-538-110.

- The member withdraws the appeal, hearing, or independent review request.
- The member has not requested a hearing (with continuation of services until the hearing decision is reached) within 10 calendar days after Wellpoint mailed the notice of resolution of the appeal
- When the Office of Administrative Hearings issues a decision adverse to the member.

If the final resolution of the appeals upholds the Wellpoint Adverse Benefit Determination, Wellpoint may recover from the member the amount paid for services provided to the member for the first 60 calendar days during which the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

15.5 Claim Inquires

Inquiries do not result in changes to claim payments but may result in the initiation of a claim payment dispute. For additional questions, our Provider Services team supports the Availity Essentials Chat feature and can be accessed through **Availity Essentials Monday-Friday 8am-5pm PST**.

15.6 Claim Correspondence

A Claim Correspondence is when a claim or part of claim may be denied, due to more information being required to process the claim. This information is requested through the Explanation of Payment (*EOP)* or via a mailed letter. Once the information is received, Wellpoint will finalize the claim.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of Issue	What Do I Need to Do?
EOP Requests for Supporting Documentation (Sterilization/ Hysterectomy/Abortion Consent Forms, Itemized Bills and Invoices)	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the supporting documentation to: Claims Correspondence Wellpoint P.O. Box 61599 Virginia Beach, VA 23466-1599
EOP Requests for Medical Records	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the medical records to: Claims Correspondence Wellpoint P.O. Box 61599 Virginia Beach, VA 23466-1599
Need to Submit a Paper Corrected Claim due to Errors or Changes on Original Submission	Submit a *Claim Correspondence Form* and your corrected claim to: Claims Correspondence Wellpoint P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Standard timely filing guidelines apply to all corrected and replacement claims. Please reference your contract for timely filing standards. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI *EOB*.
Submission of Coordination of Benefits (COB)/Third-Party Liability (TPL) Information	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the COB/TPL information to: Claims Correspondence Wellpoint P.O. Box 61599 Virginia Beach, VA 23466-1599
Emergency Room Payment Review	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the medical records to: Claims Correspondence Wellpoint P.O. Box 61599 Virginia Beach, VA 23466-1599

15.7 Provider Claim Payment Dispute Process

If you disagree with the outcome of a claim, you may begin the provider payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized, but you disagree with the outcome.

Please be aware there are three common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, we've defined them briefly here:

- **Claim inquiry**: a question about a claim but not a request to change a claim payment
- **Claims correspondence**: when Wellpoint requests further information to finalize a claim; typically includes medical records, itemized bills or information about other insurance a member may have
- **Medical necessity appeals**: a pre-service appeal for a denied service; for these, a claim has not yet been submitted

For more information on each of these, please refer to the appropriate section in this provider manual.

The provider payment dispute process consists of two steps. You will **not** be penalized for filing a claim payment dispute, and no action is required by the member.

- **Claim payment reconsideration**: This is the first step in the 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.
- **Claim payment appeal**: This is the second step in the provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.

A claim payment dispute may be submitted for multiple reason(s), including:

- Contractual payment issues.
- Disagreements over reduced or zero-paid claims.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.

- Timely filing issues.*

* We will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can:
1. provide documentation the claim was submitted within the timely filing requirements or
2. demonstrate **good cause** exists.

15.8 Claims Payment Reconsideration

The first step in the claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally and through our secure provider website within 24 months from the date on the EOP. Reconsiderations filed more than 24 months from the *date on the EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect. If a reconsideration requires clinical expertise, the appropriate clinical Wellpoint professionals will review it.

Wellpoint 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 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar day.

We will send you our decision in a determination letter, which will include:
- A statement of the provider's reconsideration request.
- A statement of what action Wellpoint intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes or provider manual references.
- An explanation of the provider’s right to request a claim payment appeal within 60 calendar days of the date of the reconsideration determination letter.
- An address to submit the claim payment appeal.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

15.9 Claim Payment Appeal

If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal. We accept claim payment appeals through our provider website or in writing within 60 calendar days of the date on the reconsideration determination letter.

Claim payment appeals received more than 60 calendar days after the claims reconsideration determination letter will be considered untimely and upheld unless good cause can be established. When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical Wellpoint professionals.

Wellpoint will make every effort to resolve the claim payment appeal within 30 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.

We will send you our decision in a determination letter, which will include:

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

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

15.10 How to Submit a Claim Payment Dispute

We have several options to file a claim payment dispute:

- Verbally (for reconsiderations only): Call Provider Services at **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT.**
- Online (for reconsiderations and claim payment appeals): 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.

* For appeals, your Availity Essentials user account will need the Claim Status role. To send attachments from Claim Status, you'll need the Medical Attachments role.

- Written (for reconsiderations and claim payment appeals): Mail all required documentation (see below for more details), including the *Claim Payment Appeal Form* or the *Reconsideration Form*, to:

  Payment Dispute Unit
  Wellpoint
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

Submit reconsiderations on the *Claim Payment Reconsideration Submission Form*, located at provider.wellpoint.com/wa > Resources > Forms
Submit written claim payment appeals on the form *Claim Payment Appeal Submission Form*, located at provider.wellpoint.com/wa > Resources > Forms.

15.11 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 his or her Wellpoint or Apple Health ID number
- A listing of disputed claims in an excel spreadsheet which should include the
- Wellpoint claim number and the date(s) of service(s)
- All supporting statements and documentation

PHARMACY

16.1 Pharmacy Services

The Wellpoint pharmacy benefit provides coverage for medically necessary medications from licensed prescribers for the purpose of saving lives in emergency situations or during short-term illnesses, sustaining life in chronic or long-term illnesses, or limiting the need for hospitalizations. 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.
- Coordinating with licensed prescribers.
- Ensuring members receive all medications for which they are eligible.
- Coordinating benefits when members also receive or have other insurance benefits.

- Providing emergency supplies of prescribed medications any time prior authorizations are not available, if the prescribing providers cannot be reached or are unable to request prior authorizations, and when prescriptions must be filled without delay for medical conditions; these supplies will be provided for as long as is sufficient to bridge the time until an authorization determination is made.

Wellpoint contracts with a pharmacy benefit manager to process pharmacy claims using a computerized point-of-sale system. This system gives participating pharmacies online, real-time access to beneficiary eligibility, drug coverage (including prior authorization requirements), prescription limitations, pricing and payment information, and prospective drug utilization review.

16.2 Covered Drugs

Wellpoint Washington drug formulary is comprised of drug products reviewed and approved by the Wellpoint National Pharmacy and Therapeutics Committee and drug products that are part of the Apple Health Single Preferred Drug List (PDL). The Apple Health PDL is a list of all brand-name and generic drugs available on the plan. The Health Care Authority (HCA) implemented the Apple Health PDL. For medications listed in the Apple Health PDL, please visit **hca.wa.gov/billers-providers-partners/programs-and-services/apple-health-preferred-drug-list-pdl**. For medications that are not included in the Apple Health Single PDL, such as diabetic supplies, spacers and vaccines, please visit **client.formularynavigator.com/Search.aspx?siteCode=1735434011**.

The formulary includes all therapeutic classes in the Washington State Health Care Authority Single Preferred Drug List (PDL) which contains a variety of drugs in each therapeutic class to meet members' medically necessary healthcare needs. Formulary over-the-counter products are covered when they are prescribed by a licensed prescriber and filled at a network pharmacy.

See the **Obtaining Prior Authorizations** section below for more information on prescribing non-preferred drugs or preferred medications that require prior authorization.

Wellpoint may limit coverage of certain drugs. Procedures used to limit utilization may include prior approval, cost-containment caps or adherence to specific dosage limitations according to Federal Drug Administration-approved product labeling.

The following are examples of covered items:

- Legend drugs
- All FDA approved contraception products
- Insulin
- Diabetic supplies including Omnipod

- Disposable insulin needles/syringes
- Smoking cessation therapies
- Compounded medication of which at least one ingredient is a legend drug and listed on the Wellpoint *PDL*
- Over-the-counter medications such as aspirin, OTC emergency contraception, acetaminophen, ibuprofen and nicotine patches
- Any other non-excluded drug, which under the applicable state law, may only be dispensed upon the written prescription of a physician or other lawful prescriber and is listed on the Wellpoint *PDL*

16.3 Obtaining Prior Authorizations

Providers are strongly encouraged to write prescriptions for preferred products as listed on the formulary or *PDL*. If for medical reasons members cannot use preferred products, providers are required to use one of the following methods for obtaining approval:

- Submit your prior authorization request online at covermymeds.com.
- Call Wellpoint Provider Services at **833-731-2274 Monday through Friday, 8 a.m. to 5 p.m. PT**.
- Fax a Pharmacy Prior Authorization Form to **844-493-9207**.

Be prepared to provide relevant clinical information regarding the member's need for a nonpreferred product or a medication requiring prior authorization.

Decisions are based on medical necessity and are determined according to established medical criteria.

Examples of medications that require prior authorizations are listed below. This list is not all-inclusive and is subject to change:

- Drugs listed on the formulary or *PDL* or drugs that require clinical prior authorization
- Drugs not listed on the formulary or PDL
- Certain self-administered injectable products
- Drugs that exceed certain cost and/or dosing limits (for information on these limits, please see our website or contact the Wellpoint Pharmacy department by calling Provider Services)

An emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization is not available. This applies to all drugs requiring prior authorization, either because they are nonpreferred drugs on the *PDL* or because they are subject to clinical edits.

The emergency supply should be dispensed anytime a prior authorization cannot be resolved within 24 hours for a medication that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a prior authorization, the pharmacy should provide an emergency supply.

A pharmacy can dispense a product packaged in dosage form that is fixed and unbreakable (for example, an albuterol inhaler) as an emergency supply.

16.4 Dispensing Limitations

Several drugs have dispensing limitations to ensure patient safety and appropriate use. Refer to the formulary and/or *PDL* to identify drugs subject to these restrictions.

16.5 Excluded Drugs

The following drugs are excluded from the pharmacy benefit:

- Drug products that are classified as less-than-effective by the FDA Drug Efficacy Study Implementation
- Drugs excluded from coverage following Section 1927 of the Social Security Act, 42 U.S.C.A. §1396r-8:
  - Weight control products, excluding Alli, which requires prior authorization
  - Drugs used for cosmetic reasons or hair growth
  - Drugs used for experimental or investigational indication
  - Infertility medications
  - Erectile dysfunction drugs to treat impotence
- Non-legend drugs other than those listed above or specifically listed under covered non-legend drugs
- Pharmaceutical products prescribed by any providers related to services provided under separate contracts with the HCA

16.6 Specialty Drug Program

Wellpoint covers many specialty drugs under the pharmacy benefit through CarelonRx. To obtain one of the listed specialty drugs, follow the prior authorization procedures described above. Most specialty drugs require prior authorization. Refer to the *PDL* to identify drugs subject to these restrictions.

The following is a list of conditions typically treated with specialty injectable drugs:

- Growth hormone deficiency
- Chronic inflammatory conditions
- Multiple sclerosis

- Rheumatoid arthritis
- Respiratory Syncytial Virus
- Cystic fibrosis

Drug Waste:

Per the Washington State Health Care Authority, drug waste is only covered for Medicare crossover bills. Drug waste is reported by modifier JW.

CarelonRx is an independent company providing utilization management services on behalf of the health plan.
CarelonRx is an independent company providing pharmacy benefit management services on behalf of the health plan.

provider.wellpoint.com/wa

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