WellCare of Kentucky

Provider Orientation

WellCare®
Beyond Healthcare. A Better You.[1]

Welcome to WellCare

Thank you for being a star member of our provider team!

When partnering with WellCare, you get:

- Local market focus – We have dedicated staff to assist you in the communities you serve.
- Prompt payments – Submit claims electronically for quicker payment.
- Quality improvement programs – We emphasize patient care and closure of care gaps.

If you haven't already, you will soon receive a welcome letter with your Provider ID. The welcome letter also includes the line(s) of business with which you are contracted and effective date(s).

Keep your Provider ID handy. You will need it when registering for our secure Provider Portal and for managing your business with WellCare Health Plans, Inc.

WellCare understands that having access to the right tools and resources are important to help you and your staff streamline day-to-day administrative tasks.

This Provider Orientation presentation will help you in getting to know us better and provide information on the resources available to you and your staff.

Again, welcome!

About WellCare of Kentucky

WellCare Health Plans, Inc. is an American health insurance company that provides managed care services primarily through Medicaid, Medicare Advantage and Medicare Prescription Drug plans for members across the United States.

WellCare began operations in 1985 and became a subsidiary of Centene Corporation in January 2020.

Centene is committed to helping people live healthier lives. We provide access to high-quality healthcare, innovative programs and a wide range of health solutions that help families and individuals get well, stay well and be well.

Centene serves over 28 million managed care members across all 50 states. 1 in 15 individuals in the United States are covered by a Centene health plan.

Dental and Vision Contracted Partner

Avesis is a contracted partner with WellCare that administers our vision and dental benefits for our Medicaid and Medicare Advantage providers and members.

All dental and vision claims, as well as prior authorizations are managed directly by Avesis. Avesis has a provider portal that can be accessed at: https://www.avesis.com

For more information, you may outreach Avesis at the following telephone numbers:

Dental: Avesis: **1-855-704-0432**

Vision: Avesis: **1-855-469-3368**

Medicare Advantage Hearing Contracted Partner

Hearing Care Solutions (HCS) is a contracted partner with WellCare that administers our hearing benefits for our Medicare Advantage providers and members.

All hearing claims, as well as prior authorizations are managed directly by HCS. HCS has a provider portal that can be accessed at:

https://www.hearingcaresolutions.com

For more information, you may outreach to HCS at: **1-866-344-7756**

Medicare Advantage Transportation Contracted Partner

Access2Care is one of the nation's largest managers of Non-Emergency Medical Transportation (NEMT) services, and WellCare's partner in providing members who have the transportation benefit as part of their Medicare Advantage plan.

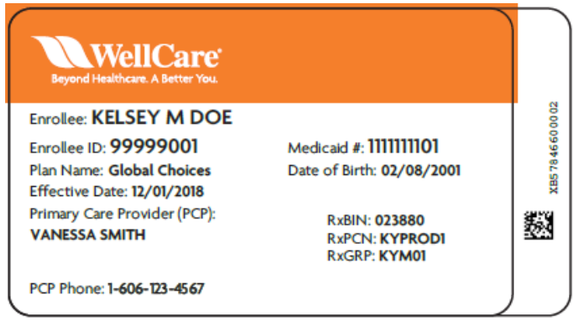
Their program capabilities include:

- Eligibility and benefit verification
- Level-of-service determinations
- Call center management delivered from accredited facilities
- Web-based electronic claims payment
- Fraud, waste, and abuse prevention
- Electronic data exchanges
- Complaint and grievance monitoring and resolution
- Reporting, including online data access
- Long distance travel arrangements including lodgings and meal stipends

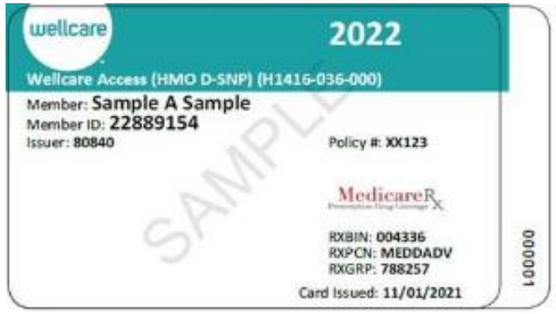
For more information, you may call **1-888-975-4833**, or go to: https://www.access2care.net/

Sample Member ID Cards

Medicaid



Medicare



Medicaid Member Benefit Overview

Medicaid member benefits include, but are not limited to:

Vision
My Health Pays Rewards
Health and Wellness Items
WW (formerly Weight Watchers)
Good Measures
Tutoring
Internet Hot Spot
GED® Program
Scholarships
Reading Scholarship Application

Free Cell Phone
Extras for Moms and Moms-To-Be
Free Text4Baby®
Girl Scouts® and Boy Scouts of America®
Free Sports Physical
Steps2Success Training
WellCare Works
Criminal Record Expungement
Meals Program
XtraSavings

For more information, please go to this link:

https://www.wellcareky.com/members/medicaid/benefits/Additional-benefits.html

Medicare Member Benefit Overview

In Kentucky, WellCare offers a range of Medicare products, including Medicare Advantage Prescription Drug plans (MAPD) and standalone Prescription Drug Plans (PDP). Our MAPD plans offer affordable coverage beyond Original Medicare, including a range of benefits such as dental, hearing and vision services; prescription drug services; Flex Cards; transportation services; telehealth visits; wellness programs; in-home support services; and special supplemental benefits for the chronically ill. WellCare's standalone PDPs help to cover the cost of prescription drugs including low monthly premiums and $0 or low co-pays on medications; access to a broad pharmacy network of 60,000 retail locations; easy and convenient delivery of medications; and additional savings on insulin medications.

For more information, please go to this link:
https://www.wellcare.com/Kentucky/Find-My-Plan

Interpretation/Translation Services

At WellCare Health Plans, Inc., we value everything you do to deliver quality care to our members – your patients – and to ensure they have a positive health care experience. That's why we strive to see that members who need language services have adequate communication support.

We have resources available to provide assistance when you identify members who have potential cultural or language barriers. These include:

- Interpreter services for languages other than English or members who have limited English proficiency
- Sign language interpreter services for the hearing impaired
- Telephone system technology (TTY line) for the hearing impaired

Providers can access communication support for medical encounters as follows:

- ***Non-urgent*** – If a member needs a sign language or foreign language interpreter for a medical appointment, the Customer Service Department arranges for this service through a locally contracted vendor. Live, in-person translation is preferred to telephonic translation in nonurgent cases; the telephonic service will only be used when an interpreter for the required language cannot be found in or near the particular area. Please request interpreter services at least 5 business days in advance by completing the Interpreter Request Form and emailing it to InterpreterRequests@wellcare.com.

- ***Urgent/Emergent*** – If a member needs language translation at the time of an urgent or emergent encounter and the provider does not have bilingual staff, the provider should call Customer Service 1-877-389-9457. The Customer Service agent will work to patch in a translator for telephonic translation.

Scan QR Code for the Requesting Interpreter Services Form

Interpretation/Translation Services: Medicaid

- Providers will identify Enrollees who have potential linguistic barriers for which alternative communication methods are needed and will contact WellCare to arrange appropriate assistance.
- Enrollees may receive interpreter services at no cost when necessary to access Covered Services through a vendor, as arranged by the Customer Service Department.
- Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency and sign language for the hearing-impaired. These services will be provided by vendors with such expertise and are coordinated by WellCare's Customer Service Department.
- Written materials are available for Enrollees in large print format and certain non-English languages prevalent in WellCare's service areas.

Hearing-impaired, interpreter and sign language services are available to WellCare Enrollees through WellCare's Customer Service. PCPs should coordinate these services for WellCare Enrollees and contact Customer Service if assistance is needed. Please refer to the Quick Reference Guide at https://www.wellcareky.com/providers/medicaid.html for the Customer Service telephone numbers. These services are available at no cost to the enrollee per federal law.

Interpretation/Translation Services: Medicare

In accordance with Title VI of the Civil Rights Act, Prohibition Against National Origin Discriminations, the President's Executive Order 131166, Section 1557 of the Patient Protection and Affordable Care Act, the Health Plan and its providers must make language assistance available to persons with Limited English Proficiency (LEP) at all points of contact during all hours of operation. Language services are available at no cost to WellCare members and providers without unreasonable delay at all medical points of contact. The member has the right to file a complaint or grievance if cultural and linguistic needs are not met. Language services include:

- Telephonic interpretation
- Oral translation (reading of English material in a members preferred language)
- Face-to-face non-English interpretation
- American Sign language
- Auxiliary aids, including alternate formats such as large print and Braille
- Written translations for materials that are critical for obtaining health insurance coverage and access to healthcare services in non-English prevalent languages

Information is deemed to be critical for obtaining health insurance coverage or access to health care services if the material is required by law or regulation to provide the document to an individual. To obtain language services for a member, contact WellCare Provider Services. Face-to-face and American Sign Language services should be requested as soon as possible, or at least five business days before the appointment. All Providers (Medical, Behavioral, Pharmacy, etc.) can request language services by calling our Provider Customer Contact Center at: 1-855-538-0454 (TDD/TTY 711).

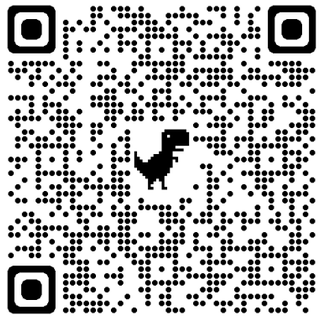
Provider Demographic Update

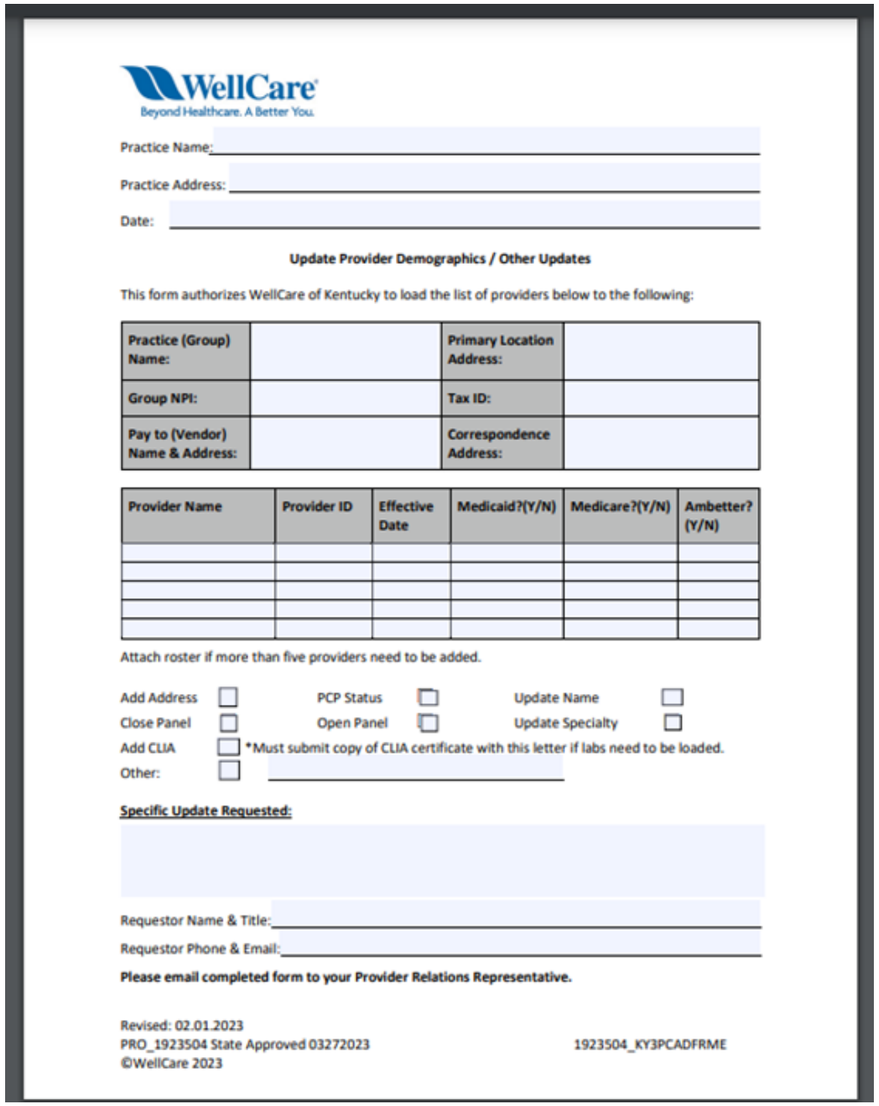
Prior notice to a Provider Relations representative or WellCare's Provider Services team is required for any of the following changes:

- **1099 mailing address;**
- **Tax Identification Number (TIN) or Entity Affiliation (W-9 required);**
- **Group name or affiliation;**
- **Physical or billing address;**
- **Telephone and fax number;**
- **Panel changes; and/or**
- **Directory listing.**

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

For Copy of Form please scan QR Code Below





WellCare
Beyond Healthcare. A Better You.

Practice Name: _____

Practice Address: _____

Date: _____

Update Provider Demographics / Other Updates

This form authorizes WellCare of Kentucky to load the list of providers below to the following:

Practice (Group) Name:		**Primary Location Address:**	
Group NPI:		**Tax ID:**	
Pay to (Vendor) Name & Address:		**Correspondence Address:**	

Provider Name	Provider ID	Effective Date	Medicaid?(Y/N)	Medicare?(Y/N)	Ambetter? (Y/N)

Attach roster if more than five providers need to be added.

Add Address ☐ PCP Status ☐ Update Name ☐
Close Panel ☐ Open Panel ☐ Update Specialty ☐
Add CLIA ☐ *Must submit copy of CLIA certificate with this letter if labs need to be loaded.
Other: ☐ _____

Specific Update Requested:

Requestor Name & Title: _____

Requestor Phone & Email: _____

Please email completed form to your Provider Relations Representative.

Revised: 02.01.2023
PRO_1923504 State Approved 03272023 1923504_KY3PCADFRME
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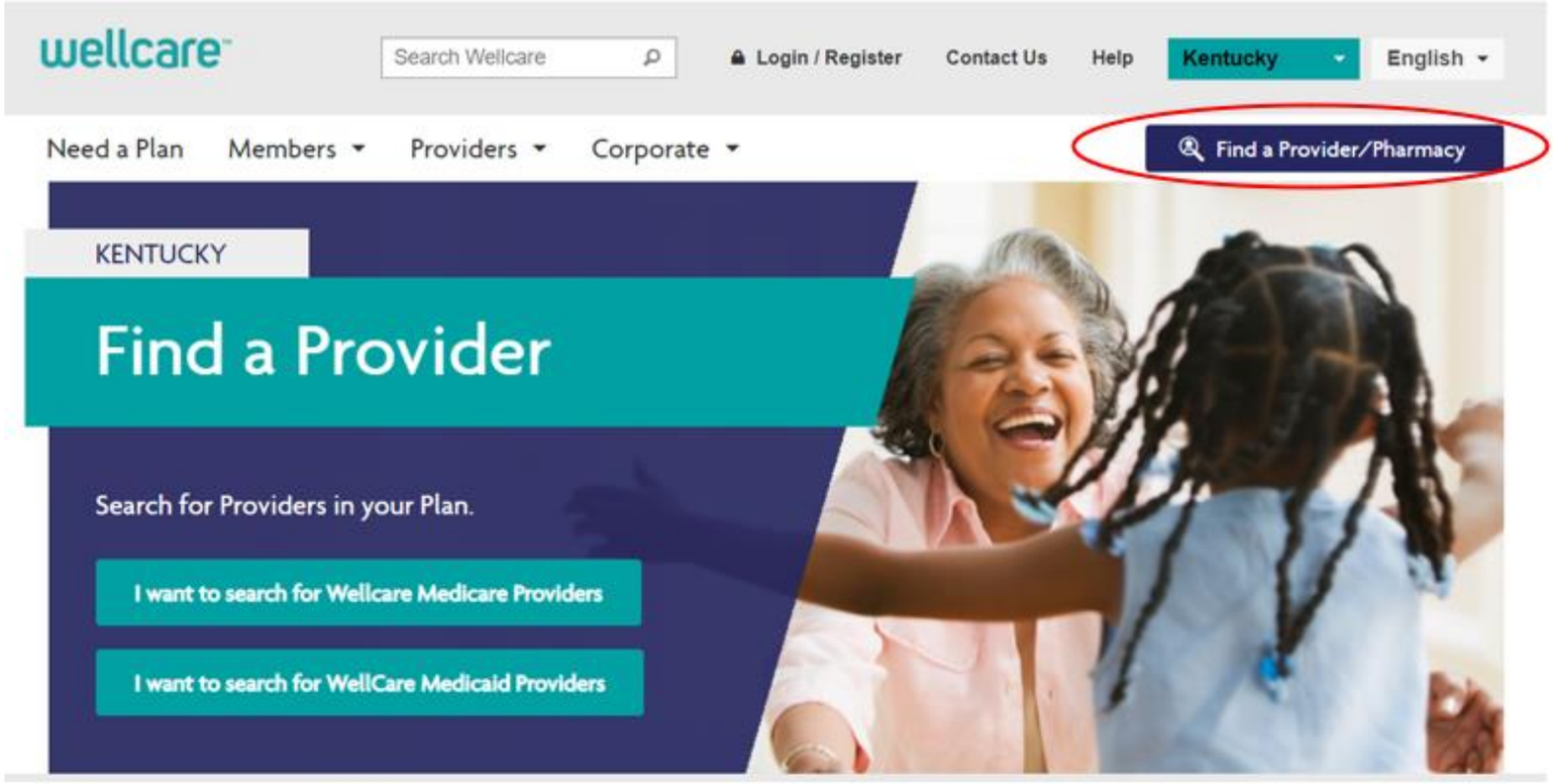
Provider Directory

On our public website, the Find-A-Provider look-up tool permits a search from our Provider Directory by line of business, zip code, county, city, state, radial distance, specialty, and/or provider name.

To access, please go to: https://www.wellcare.com/Kentucky/Kentucky-FAP



Case Management

Information for Health Care Professionals

Case and Disease Management

Providing Your Patients, Our Members, with the Best Possible Care

Brighten Your Patients' Health Outlook

WellCare offers comprehensive Case and Disease Management services to facilitate patient assessment, planning and advocacy to improve health outcomes for patients with select diseases or disorders. WellCare trusts you will help coordinate the placement and cost-effective treatment of patients who are eligible for our Case and Disease Management programs.

In turn, our Case and Disease Managers alleviate your workload by focusing on time-consuming tasks such as:

Evaluation – The Case Manager is a Registered Nurse (RN) or a Licensed Clinical Social Worker (LCSW). The Case Manager will conduct a comprehensive assessment of the member to determine where he/she is in the health continuum. This assessment gauges the members' support systems and resources, and seeks to align them with appropriate clinical needs.

Planning – The Case Manager collaborates with you, the member and/or the caregiver to identify the best way to fill any identified gaps or barriers to improve access and adherence to the provider's plan of care.

Facilitation – The Case Manager works with community resources to facilitate member adherence with the plan of care. Activities may be as simple as reviewing the plan with the member or caregiver, or as complex as arranging services, transportation and follow-up.

Advocacy – The Case Manager is the members' advocate within the complex labyrinth of the health care system. Case managers assist members with seeking services to optimize their health.

When you refer patients to the Case and/or Disease Management programs, you are taking a proactive step to assist patients with serious, complicated diseases and disorders, and helping them get the personalized health care and attention they need.

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How Our Programs Go Above and Beyond to Provide Care for Your Patients

We're here to help you!

WellCare's Case Managers support you and your hectic schedules – freeing you to spend more time with your patients by:

- Collaborating with providers and physicians to create a targeted assessment and care plan for the patient's identified needs
- Maintaining communication between the patients and their families, and the team of physicians
- Identifying opportunities for intervention, such gaps in care or lack of financial resources to meet needs
- Assisting with patient transition when discharged from the program

The types of cases targeted by our Case Management Program include, but are not limited to, the following types of patients:

- Complex care needs requiring coordination of multiple outpatient services
- Transplants
- Frequent inpatient admissions and readmissions
- Prolonged or debilitating illnesses or injuries

Our Case Management Program identifies potential participants through:

- Referrals from physicians
- Self-referrals from patients
- Pharmacy and medical claims data
- Review of services utilized

WellCare's Disease Managers also provide support and free you to spend more time with your patients by:

- Educating patients on how to deal with the challenges of their disease
- Documenting progress in clinical notes

Our Disease Management Program targets the following conditions*:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension

** Programs vary by contractual requirements.*

How to Refer Your WellCare Patients to Our Case or Disease Management Programs

If you would like to refer your WellCare patients to either or both of these programs, please call the Case and Disease Management Referral Line at **1-866-635-7045**, Monday–Friday from 8 a.m. to 5 p.m. Eastern.

Member Rights and Responsibilities

WellCare Enrollees have the right to:

- To get information about WellCare, its services and its doctors and Providers and Enrollee rights and responsibilities;
- To get information about their rights and responsibilities;
- Respect, dignity, privacy, confidentiality, accessibility and nondiscrimination;
- Participate with doctors in making decisions about their care;
- To talk openly about care they need for their health, no matter the cost or benefit coverage, and the choices and risks involved. The information must be given in a way they understand;
- To have a say in WellCare's Enrollee rights and responsibilities policy;
- A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;
- Consent for or refusal of treatment and active participation in decision choices;
- Ask questions and receive complete information relating to the Enrollee's medical condition and treatment options, including Specialty Care;
- Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and request a State Fair Hearing from the Contractor and/or the Department;
- Timely access to care that does not have any communication or physical access barriers;
- Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;
- Assistance with Medical Records in accordance with applicable federal and state laws;
- Timely referral and access to medically indicated Specialty Care;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- Receive information in accordance with 42 C.F.R. 438.10;
- Be furnished healthcare services in accordance with 42 C.F.R. Part 438; and
- Any American Indian enrolled with the Contractor eligible to receive services from a participating I/T/U Provider or an I/T/U PCP shall be allowed to receive services from that Provider if part of Contractor's Network.

Member Rights and Responsibilities

WellCare Enrollees have the responsibility:

- To become informed about Enrollee rights;
- To give information that WellCare, its doctors and its Providers need to deliver care;
- To abide by WellCare's and the Department's Policies and Procedures;
- To become informed about service and treatment options;
- To actively participate in personal healthcare decisions and practice healthy lifestyles;
- To report suspected fraud and abuse;
- To follow plans and instructions for care that they have agreed to with their Provider;
- To understand their health problems;
- To help set treatment goals that they agree to with their Provider;
- To read the Enrollee Handbook to understand how the plan works;
- To carry their Enrollee ID cards at all times;
- To carry their Medicaid cards at all times;
- To show their ID cards to each Provider;
- To schedule appointments for all non-emergency care through their Provider;
- To get a referral from their Provider for specialty care;
- To cooperate with the people who provide their healthcare;
- To be on time for appointments;
- To tell the doctor's office if they need to cancel or change an appointment;
- To respect the rights of all Providers;
- To respect the property of all Providers;
- To respect the rights of other patients;
- To not be disruptive in the doctor's office;
- To know the medicines they take, what they are for and how to take them the right way;
- To make sure their Providers have copies of all previous medical records; and
- To let WellCare know within 48 hours, or as soon as possible, if they are admitted to the hospital or get emergency room care.

Provider Portal – How to Register

WellCare understands that having access to the right tools can help you and your staff streamline day-to-day administrative tasks.

The Provider Portal will help with those routine tasks.

Users can create an account by visiting: https://provider.wellcare.com/Provider/Accounts/Registration.

- You will create a brief profile and select your username and security questions.
- You will need to accept the Terms and Conditions.
- After completing these steps, you will receive an email asking you to confirm your registration.
- After clicking the confirmation link, proceed to the secure password screen, where you will set your password. Please be sure to keep your username and password for future reference.
- You will then need one of the following to request access to tools and information in the portal: – WellCare Contract Name and ZIP Code OR – If a Sub-Group for your medical group or facility exists, your WellCare-issued Provider ID number (located in your welcome packet or on your Explanation of Payment)
- Your access request will be sent to your contract or sub-group administrator, who will review the request and grant or deny access. Once action is taken on your request, you will receive an email and can then login to access tools and information in the portal.

Provider Portal Training

Provider Portal Training – https://www.wellcareky.com/providers/medicaid/training/new-provider-portal-overview-training.html

WellCare offers robust technology options to save you time. On the portal you will be able to view and complete :

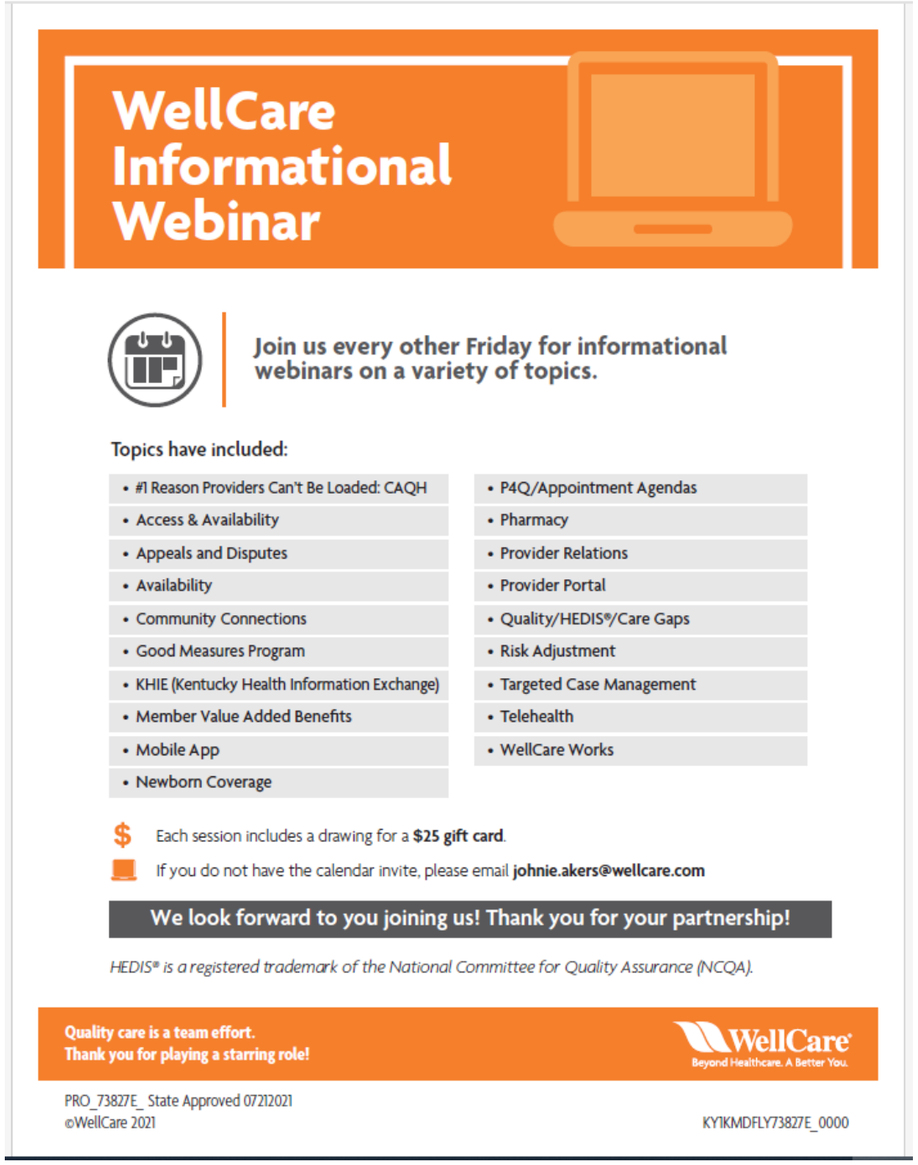
- Authorization Requirements
- Authorization Status
- Authorization Request
- Benefit Information
- Claims Status
- Co-Payment
- Eligibility Verification
- Submit Appeals
- Appeals Status
- Submit Claim Disputes
- Submit Claims
- Submit Corrected Claims

For more information on the WellCare portal please scan QR Code.

WellCare Informational Webinar

Bi-weekly, WellCare hosts an informational webinar that covers a variety of topics of interests to providers. The webinars are free. No registration is needed. For the WellCare Informational Webinar calendar invite, please contact your Provider Relations Representative and they will share the invite as well as an informational flyer.

As a token of our appreciation for attending, each webinar we randomly draw a name from the list of attendees and provide a free $25 gift card to the name drawn.



WellCare Informational Webinar

Join us every other Friday for informational webinars on a variety of topics.

Topics have included:

- #1 Reason Providers Can't Be Loaded: CAQH
- Access & Availability
- Appeals and Disputes
- Availability
- Community Connections
- Good Measures Program
- KHIE (Kentucky Health Information Exchange)
- Member Value Added Benefits
- Mobile App
- Newborn Coverage
- P4Q/Appointment Agendas
- Pharmacy
- Provider Relations
- Provider Portal
- Quality/HEDIS®/Care Gaps
- Risk Adjustment
- Targeted Case Management
- Telehealth
- WellCare Works

$ Each session includes a drawing for a **$25 gift card**.

If you do not have the calendar invite, please email **johnie.akers@wellcare.com**

We look forward to you joining us! Thank you for your partnership!

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

Quality care is a team effort.
Thank you for playing a starring role!

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Provider Manuals

A Provider Manual is intended for Providers that are contracted with WellCare and provide healthcare service(s) to WellCare Enrollees enrolled in a WellCare managed care plan. The Manual serves as a guide to the policies and procedures governing the administration of WellCare's plans and is an extension of and supplements the Provider Contract between WellCare and healthcare Providers.

Provider Manuals are available for Medicaid and Medicare Advantage at the following links:

Medicaid: https://www.wellcareky.com/providers/medicaid.html Then click on the Provider Manual link

Medicare Advantage: https://www.wellcare.com/Kentucky/Providers/Medicare Then click on the Provider Manual link

Quick Reference Guide-Medicaid

Quick Reference Guides (QRG) are available online at the WellCare of Kentucky public website. They provide information on important telephone numbers, addresses, claims submission, appeals, disputes, authorizations, and other pertinent information in summary form.

The Medicaid QRG can be accessed here:

https://www.wellcareky.com/content/dam/centene/wellcare/ky/pdfs/KY_Medicaid_Provider_Quick_Reference_Guide.pdf

Quick Reference Guide-Medicare

Quick Reference Guides (QRG) are available online at the WellCare of Kentucky public website. They provide information on important telephone numbers, addresses, claims submission, appeals, disputes, authorizations, and other pertinent information in summary form.

The Medicare QRG can be accessed here:

https://www.wellcare.com/Kentucky/Providers/Medicare

Claims

WELLCARE OF KENTUCKY PAYER ID - If your clearinghouse or billing system is not connected to Change Healthcare and requires a 5-digit Payer ID, please use the following according to the file type (Fee-for-Service or Encounters):

- **Fee For Service (FFS) is defined in the Transaction Type Code BHT06 as CH, which means Chargeable, expecting adjudication.**
- **Encounters (ENC) is defined in the Transaction Type Code BHT06 as RP, which means Reportable only, NOT expecting adjudication.**

Claim Type	Fee for Service (CH-Chargeable) Submissions	Encounter (RF- Reporting only) Submissions
Professional or Institutional	14163	59354

CHANGE HEALTHCARE CPIDs – If your billing system is connected to Change Healthcare and requires a 4-digit Change Healthcare payer ID, please use the following according to the file type (Fee-For-Service or Encounters):

Claim Type	Fee for Service (CH-Chargeable) Submissions	Encounter (RF- Reporting only) Submissions
Professional	1844	3211
Institutional	8551	4949

PAPER SUBMISSION GUIDELINES: WellCare of Kentucky follows the Centers for Medicare & Medicaid Services (CMS) guidelines for paper claim submissions. Since **Oct. 28, 2010**, WellCare accepts only the original "red claim" form for claim and encounter submissions. **WellCare does not accept handwritten, faxed or replicated claim forms**. **WellCare does not accept media storage devices such as CDs, DVDs, USB storage devices or flash drives.**

Medicaid

Claim forms and guidelines are at
https://www.wellcareky.com/providers/medicaid/claims.html

MAIL PAPER CLAIM SUBMISSIONS TO:
WellCare of Kentucky
Attn: Claims Department
P.O. Box 31224
Tampa, FL 33631-3224

Medicare

Claims forms and guidelines are at
https://www.wellcare.com/Kentucky/Providers/Medicare/Claims

MAIL PAPER CLAIM SUBMISSIONS TO:
WellCare
Attn: Claims Department
P.O. Box 31372
Tampa, FL 33631-3372

Coordination of Benefits Information Medicaid

WellCare shall coordinate payment for Covered Services in accordance with the terms of an Enrollee's benefit plan, applicable state and federal laws and CMS guidance.

WellCare gathers COB information regarding our enrollees from multiple sources. This ensures we pay claims appropriately and that Medicaid is the payor of last resort (42 C.F.R. 433.139). In accordance with our contract with the Department for Medicaid Services (Section 14.2), if WellCare is aware of other Third-Party Resources, WellCare shall avoid payment by "cost avoiding" (denying) the claim and redirecting the provider to bill the other Third-Party Resource as a primary payer. If WellCare does not become aware of another Third-Party Resource until after the payment for service, WellCare will seek recovery from the Third-Party Resource. Please note this does not occur in instances where the member has Medicare as primary.

Providers shall bill primary insurers for items and services they provide to an Enrollee before they submit claims for the same items or services to WellCare. Any balance due after receipt of payment from the primary payer should be submitted to WellCare for consideration and the claim must include information verifying the payment amount received from the primary plan. Coordination of Benefits (COB) information can be submitted to WellCare by an EDI transaction with the COB data completed in the appropriate COB elements. Only paper submitters need to send a copy of the EOB. Providers shall follow WellCare Policies and Procedures regarding subrogation activity.

If Medicaid does not have a price for codes included on a crossover claim because it is covered by Medicare but not Medicaid, the Medicare coinsurance and deductible will be paid.

For more information, please see the provider manual @ https://www.wellcareky.com/providers/medicaid.html

Coordination of Benefits Information Medicare

WellCare shall coordinate payment for Covered Services in accordance with the terms of a Member's Benefit Plan, applicable state and federal laws, and applicable CMS guidance. If WellCare is the secondary insurer, Providers shall bill primary insurers for items and services they provide to a Member before they submit claims for the same items or services to WellCare. Any balance due after receipt of payment from the primary payer should be submitted to WellCare for consideration and the claim must include information verifying the payment amount received from the primary payer. COB information can be submitted to WellCare by an EDI transaction with the COB data completed in the appropriate COB elements. Only paper submitters need to send a copy of the primary insurer's explanation of benefits. WellCare may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services, to the extent permitted by applicable laws.

Members under the Medicare Advantage line of business may be covered under more than one insurance policy at a time. For example:

• If a claim is submitted for payment consideration secondary to primary insurance carrier, other primary insurance information, such as the primary carrier's EOB, must be provided with the claim. WellCare has the capability of receiving EOB information electronically. To submit other insurance information electronically, refer to the WellCare Companion Guides at wellcare.com. Select the appropriate state from the drop-down menu and click on Claims under Medicare in the Providers drop-down menu.

• If WellCare has information on file to suggest the Member has other insurance primary to WellCare's, WellCare may deny the claim.

• If the primary insurance has terminated, the Provider is responsible for submitting the initial claim with proof that coverage was terminated. If primary insurance has retroactively terminated, the Provider is responsible for submitting the initial claim with proof payment has been returned to the primary insurance carrier.

• If benefits are coordinated with another insurance carrier as primary and the payment amount is equal to or exceeds WellCare's liability, no additional payment will be made.

Unless the applicable benefit plans (the Benefit Plan issued by WellCare and the benefit document issued by the other payer) or applicable law provide otherwise, the grid below for MA Members outlines when WellCare would be the primary or secondary payer:

For more information, please see the provider manual @ https://www.wellcare.com/Kentucky/Providers/Medicare

Pharmacy: Medicaid

PHARMACY SERVICES: 1-800-210-7628 (24/7)
Med Impact is the Pharmacy Benefit Manager for all Kentucky Medicaid Managed Care Organizations (including after-hours and weekends)

Rx BIN	Rx PCN	Rx GRP
023880	KYPROD1	KYM01

**Any claims for dates of service prior to July 1, 2021, should be submitted to CVS 1-877-389-9457

FORMULARY:
For a list of preferred drugs, including over-the-counter (OTC) drugs, covered by the Kentucky Medicaid Single Preferred Drug Listing visit
https://kyportal.medimpact.com

MEDICATION APPEALS:
Fax: 1-858-790-6060

MAIL APPEAL WITH SUPPORTING DOCUMENTATION TO:
Appeals and Grievances Department MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Court
San Diego, CA 92131

Note: Medication appeals for dates of service prior to July 1, 2021, should be submitted to WellCare. Please note that all appeals fled verbally also require a signed, written appeal.

PDL INCLUSIONS:
To request consideration for inclusion of a drug to WellCare's formulary, providers may submit a medical justification to WellCare in writing.

PRIOR AUTHORIZATION REQUESTS:
Fax: 1-858-357-2612
Phone: 1-844-336-2676

Submit a Prior Authorization Request Form for:
- Drugs not listed on the Preferred Drug List (PDL)
- Drugs listed on the PDL with a prior authorization (PA)
- Duplication of therapy
- Prescriptions that exceed the FDA daily or monthly quantity limits (QL)
- Most self-injectable and infusion drugs (including chemotherapy) administered in a physician's office
- Drugs that have a step edit (ST) and the first-line therapy is inappropriate
- Drugs that have an age limit (AL)
- Multi-ingredient compounds exceeding $100 cost (PA)

Pharmacy: Medicare

PHARMACY SERVICES:
1-877-389-9457
Including after-hours and weekends – CVS Caremark®

Rx BIN	Rx PCN	Rx GRP
004336	MCAIDADV	RX8893

Click here to locate CVS Caremark®

Mail Order Info:
1-866-808-7471
TTY: 1-866-236-1069
Fax: 1-866-892-8194

MEDICATION APPEALS: Fax: 1-866-388-1766
Click here to locate Medication Appeal Request (form) and mail with supporting documentation to:
Appeals and Grievances Department
MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Court
San Diego, CA 92131

ACARIAHEALTH™
AcariaHealth is a national comprehensive specialty pharmacy focused on improving care and outcomes for patients living with complex and chronic conditions.

Phone: 1-866-458-9246 (TTY 1-855-516-5636)
Website: www.acariahealth.com

COVERAGE DETERMINATION REQUESTS: **Fax: 1-858-357-2612** Click here to locate Coverage Determination Request (form) to be submitted for the exceptions listed below:

- Medications not listed on the formulary
- Drugs listed on the formulary with a prior authorization (PA)
- Duplication of therapy
- Prescriptions that exceed the FDA daily or monthly quantity limit (QL)
- Most self-injectable and infusion medications (including chemotherapy administered in a physician's office)
- Drugs that have a step edit (ST) and the first-line therapy is inappropriate
- Drugs that have an age limit (AL)
- Drugs listed on the formulary with a quantity limit (QL)

For more information on WellCare Medicare Pharmacy please visit the Quick Reference Guide that can be reached on the WellCare website
https://www.wellcare.com/Kentucky/Providers/Medicare

Prior Authorization Process: Medicaid

All services rendered by nonparticipating providers and facilities require prior authorization. Primary care physicians (PCPs) must direct enrollees to participating specialists when available. It is the responsibility of the provider rendering care to verify that the authorization request has been approved before services are rendered. A searchable Authorization Lookup Tool is available at https://provider.wellcare.com/Provider/Login.

URGENT AUTHORIZATION REQUESTS AND ADMISSION NOTIFICATIONS – CALL 1-877-389-9457

- Notify the plan of unplanned inpatient hospital admissions within 1 business day of the admission (except normal maternity delivery admissions). Telephone authorizations must be followed by a fax submission of clinical information – by the next business day.
- Prior Authorization is not required for births or the inception of NICU services and notification is not required as a condition of payment.
- Outpatient authorizations may be requested by phone for urgent and time-sensitive services when warranted by the enrollee's condition. Please include CPT and ICD-10 codes with your authorization request. Standard authorization requests may be submitted online or via fax to the numbers listed on the associated forms located here.
- Web submissions are faster, and if the procedure requested meets clinical criteria, the Web provides an approval that can be printed for easy reference.
- Obtaining authorization does not guarantee payment, but rather only confirms whether a service meets WellCare's determination criteria at the time of the request. WellCare of Kentucky retains the right to review benefits limitations and exclusions, beneficiary eligibility on the date of the service, the medical necessity of services and correct coding and billing practices.
- Please remember to consult the authorization lookup tool on the provider portal and obtain appropriate prior authorization. Failure to obtain prior authorization where required may result in denial of the claim.

Prior Authorization Process: Medicare

For members enrolled in a PPO plan, authorization is not required for non-participating providers and facilities, however, services on the medical necessity/authorization required list below must be covered services within the benefit plan and considered medically necessary for the plan to pay a portion of the out-of-network claim.

For members enrolled in a non-PPO plan, all services rendered by non-participating providers and facilities require authorization, including requests to use the member's Point-of-Service benefits. Specialists must coordinate all services with the member's PCP. It is the responsibility of the provider rendering care to verify that the authorization request has been approved before services are rendered.

Urgent Authorization Requests and Admission Notifications: Call 1-855-538-0454 and follow the prompts.

• Notification is required for Inpatient Hospital admissions by the next business day (except normal maternity delivery admissions). Phone authorizations must be followed by a fax submission of clinical information.
• Outpatient authorizations for urgent and time-sensitive services may be submitted by phone when warranted by the member's condition.
• Please include CPT and ICD-10 codes with your authorization request. Standard authorization requests may be submitted online or via fax to the numbers listed on the associated forms located here.
• WellCare does not accept media storage devices such as CDs, DVDs, USB storage devices or flash drives.
• Web submissions are faster, and if the procedure requested meets clinical criteria, the Web provides an approval that can be printed for easy reference.
• Obtaining prior authorization does not guarantee payment, but rather only confirms whether a service meets the health plan's determination criteria at the time of the request. WellCare retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, the medical necessity of services and correct coding and billing practices.
• WellCare may delegate Prior Authorization to the contracted MSO, IPA or Medical Groups who then determine prior authorization requirements for their assigned members.

– IPAs must make every attempt to authorize services that are the financial responsibility of WellCare to a provider within WellCare's contracted network. If a member requires out-of-network services because WellCare is not contracted with a provider of like specialty, the IPA is required to notify WellCare's Utilization Management Department prior to issuing an authorization. The Utilization Management Department will discuss the case with the WellCare Contracting Department and notify the IPA accordingly such that an authorization may be issued. For services that are the financial responsibility of the IPA, the IPA is required to follow its organization's policy in reference to authorization of out-of-network providers.

– Emergency admissions that are outside the IPA/Group's service area are monitored by the WellCare Utilization Management Department. WellCare's Medical Management Department will be responsible for issuing an authorization, performing concurrent review, and working with the IPA to coordinate transfer of the member to an in-network facility once the member has been stabilized.

– For specific authorization requirements, please follow your group's direction.

Provider Appeals Process: Medicaid

The claim payment appeals process is designed to address claim denials for issues related to untimely filing, incidental procedures, unlisted procedure codes and non-covered codes, etc. Claim payment appeals must be submitted in writing to WellCare within **24 months** of the date on the EOP. All supporting documentation must be submitted along with the claim payment appeal request. Submit all claims payment appeals with supporting documentation at https://provider.wellcare.com/

MAIL ALL CLAIM PAYMENT APPEALS WITH SUPPORTING DOCUMENTATION TO:
WellCare of Kentucky
Attn: Claim Payment Appeals
P.O. Box 31370
Tampa, FL 33631-3370

Note: Any appeals related to a claim denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification must be sent to the Appeals (Medical) address. Providers may seek an appeal through the Appeals Department within **60 calendar days**.

MAIL OR FAX MEDICAL APPEALS WITH SUPPORTING DOCUMENTATION TO: Fax: 1-866-201-0657
WellCare of Kentucky
Attn: Appeals Department
P.O. Box 436000
Louisville, KY 40253

Examples include Explanation of Payment Codes DN001, DN004, DN0038, DN039, VSTEX, DMNNE, HRM16 and KYREC. However, this is not an all-encompassing list of Appeals codes. Anything else related to authorization, or medical necessity that is in question should be sent to the Appeals P.O. Box with all substantiating information like a summary of the appeal, relevant medical records and enrollee-specific information.

For more information on Appeals and Claim Disputes please visit
https://www.wellcareky.com/content/dam/centene/wellcare/ky/pdfs/ProviderQRG/KY_Medicaid_Provider_Quick_Reference_Guide.pdf

Provider Appeals Process: Medicare

All non-participating Medicare provider appeals must be submitted within **60 calendar days,** and they must also submit a signed waiver of liability (WOL) with their request for processing. Participating providers also can seek an appeal through the Appeals Department within **90 calendar days** of a claim denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification. Examples include Explanation of Payment Codes DN001, DN004, DN038, DN039, VSTEX, DMNNE, HRM16 and KYREC. However, this is not an all-encompassing list of Appeals codes. Anything else related to authorization or medical necessity that is in question should be sent to the Appeals P.O. Box. Include all substantiating information (please do not include image of claim) like a summary of the appeal, relevant medical records and member-specific information.

NOTE: WellCare does not accept media storage devices such as CDs, DVDs, USB storage devices or flash drives.

MAIL OR FAX ALL MEDICAL APPEALS WITH SUPPORTING DOCUMENTATION TO:

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

The Claim Payment Dispute Process is designed to address claim denials for issues related to untimely filing, unlisted procedure codes, non-covered codes etc. Claim payment disputes must be submitted in writing to WellCare within **90 calendar days** of the date on the EOP. Submit all claims payment disputes with supporting documentation at https://provider.wellcare.com/.

NOTE: WellCare does not accept media storage devices such as CDs, DVDs, USB storage devices or flash drives.

MAIL ALL CLAIM PAYMENT DISPUTES WITH SUPPORTING DOCUMENTATION TO:

WellCare
Attn: Claim Payment Disputes
P.O. Box 31370
Tampa, FL 33631-3370

For more information regarding Appeals and Claim Disputes see the Quick Reference Guide @ https://www.wellcare.com/Kentucky/Providers/Medicare

Access and Availability Standards: Medicaid

All Providers must adhere to standards of timeliness for appointments and in-office waiting times. These standards take into consideration the immediacy of the Enrollee's needs. WellCare shall monitor Providers against these standards to ensure Enrollees can obtain needed health services within the acceptable appointment time frames, in-office waiting times and after-hours standards. Providers not in compliance with these standards will be required to implement corrective actions set forth by WellCare.

Type of Appointment	Access Standard
PCP – Urgent	< 48 hours
PCP – Routine Care	< 30 days
Specialist – Routine	< 30 days
Specialist – Urgent	< 48 hours
Vision – Regular	< 30 days
Vision – Urgent	< 48 hours
Lab and X-ray – Regular	< 30 days
Lab and X-ray – Urgent	< 48 hours
Dental – Regular	< 30 days
Dental – Urgent	< 48 hours
Voluntary family planning, counseling and medical services	As soon as possible within a maximum of 30 days. If not possible to provide complete medical services to Enrollees younger than 18 years of age on short notice, counseling and a medical appointment as immediately as possible and within 10 days

In-office waiting times for primary care visits, specialty and urgent care, optometry services and lab and X-ray services shall not exceed 30 minutes. PCPs must provide or arrange for coverage of services, consultation or approval for referrals 24 hours a day, seven days a week (both in and out of network, if such services are not available within WellCare's network).

For more information on Access and Availability Standards please visit the WellCare Medicaid of Kentucky Provider Manual at https://www.wellcareky.com/content/dam/centene/wellcare/ky/pdfs/KY_Caid_Pro_2022_Provider_Manual_Eng_2022_R.pdf

Access and Availability Standards: Medicare

All Providers must adhere to standards of timeliness for appointments and in-office waiting times. These standards take into consideration the immediacy of the Member's needs. WellCare will monitor Providers against the standards below to help Members obtain needed health services within acceptable appointment times, in-office waiting times, and after-hours standards. Providers not in compliance with these standards will be required to implement corrective actions.

Members can access care according to the following standards:

- Urgently needed services and emergency care: immediately or less than 24 hours
- Services that are not emergency or urgently needed but do require medical attention: within one week
- Routine and preventive care: within 30 days

Type of Appointment	Access Standard
PCP – Urgent	≤ 24 hours
PCP – Non -urgent	≤ 1 week
PCP – Regular and Routine	≤ 30 calendar days
PCP – After -hours Care	24 hours per day, 7 days per week
All Specialists (including High Volume and High Impact) – Urgent	≤ 24 hours
All Specialists (including High Volume and High Impact) – Regular and Routine	≤ 30 calendar days
Behavioral health Provider – Urgent Care	≤ 48 hours
Behavioral health Provider – Initial Routine Care	≤ 10 business days
Behavioral health Provider – Non -Life Threatening Emergency	≤ 6 hours
Behavioral health Provider – Routine Care follow -up	≤10 business days

In-office wait times for all standards shall not exceed 15 minutes.

For more information on Access and Availability Standards please visit the Medicare Advantage Provider Manual @
https://www.wellcare.com/Kentucky/Providers/Medicare

Quality – HEDIS Measures Overview

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA). CMS utilizes HEDIS rates to evaluate the effectiveness of a managed care plan's ability to demonstrate improvement in preventive health outreach to its members. As Federal and State governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider.

HEDIS rates are calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include Breast Cancer Screening (routine mammography), and use of Disease Modifying Anti-Rheumatic Drugs for Members with Rheumatoid Arthritis, Osteoporosis Management in Women Who Had a Fracture, Access to PCP Services, and Utilization of Acute and Mental Health Services. Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT II, ICD-10 and HCPCS codes can reduce the necessity of medical record reviews. Examples of HEDIS measures typically requiring medical record review include Comprehensive Diabetes Care (screenings and results including HbA1c, nephropathy, dilated retinal eye exams, and blood pressures), Colorectal Cancer Screening (colonoscopy, sigmoidoscopy, FOBT, CT, Colonography, or FIT-DNA test). Medication Review Post Hospitalization and Controlling Blood Pressure (blood pressure results

How can Providers improve their HEDIS scores?

- Understand the specifications established for each HEDIS measure.
- Submit claims and encounter data for every service rendered. All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with WellCare. Claims and encounter data is the most efficient way to report HEDIS.
- Submit claims and encounter data correctly, accurately, and on time. If services rendered are not filed or billed accurately, they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided. Keep accurate chart/medical record documentation of each Member service and document conversation/services.
- Submit claims and encounter data using CPT codes related to HEDIS measures such as diabetes, eye exam, and blood pressure.

For more information on HEDIS please see the Medicare and Medicaid provider manuals @ Wellcare.com

Cultural Competencies

Cultural competence in healthcare describes a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enable effective work in cross-cultural situations. Healthcare services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

Culturally and linguistically appropriate services (CLAS): The collective set of culturally and linguistically appropriate services (CLAS) mandates guidelines and recommendations intended to inform, guide and facilitate required and recommended practices related to culturally and linguistically appropriate health services. The U.S. Department of Health and Human Services, Office of Minority Health, has issued national CLAS standards. WellCare is committed to a continuous effort to perform according to those standards.

The components of WellCare's Cultural Competency Program include:

- WellCare analyzes data on the populations in each region it serves quarterly and as needed to learn their cultural and linguistic needs as well as any health disparities they may suffer. Such analyses are performed at the time WellCare enters a new market and regularly thereafter, depending on the frequency with which new data become available.
- Community-Based Support – WellCare's success requires linking with other groups having the same goals.
- Management Accountability for Cultural Competency – The Quality Improvement Committee maintains ultimate responsibility for the activities carried out by the health plan related to cultural competency. The committee oversees the day-today operations of the quality program in the health plan including the Cultural Competency Program and improvement activities undertaken by the individual WellCare plans.
- Diversity and Language Abilities of WellCare – WellCare recruits diverse, talented staff members to work in all levels of the organization. WellCare does not discriminate regarding race, religion or ethnic background when hiring staff.
- Diversity of Provider Network
- Linguistic Services
- Electronic Media
- Linkage to Community
- Enrollee/Patient Education
- Enrollee Rights
- Provider Education
- Provider Performance Monitoring
- Ongoing Self-Assessment

Providers must adhere to the Cultural Competency Program as described above. For more information on the Cultural Competency Program, registered Provider Portal users may access the Cultural Competency training at https://www.wellcareky.com/providers/medicaid/training.html. A paper copy, at no charge, may be obtained upon request by contacting Provider Services or a Provider Relations representative.

Fraud, Waste and Abuse Program

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

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

Medicaid - Participating Providers must follow all CMS rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicaid managed care organization meet annual compliance and education training requirements with respect to FWA. To meet federal regulation standards specific to Fraud, Waste and Abuse (§ 423.504), Providers and their employees must complete an annual FWA training program. To report suspected fraud and abuse, please refer to the Quick Reference Guide at https://www.wellcareky.com/providers/medicaid.html or call WellCare's confidential and toll-free compliance hotline. Details of the Corporate Ethics and Compliance Program, and how to contact the Fraud, Waste and Abuse Hotline, may be found at www.centene.com/who-we-are/ethics-and-integrity.html.

Medicare- To meet federal regulation standards specific to Fraud, Waste, and Abuse (§ 423.504), Providers and their employees must complete a FWA training program within 90 days of contracting with the WellCare Health Plan and annually thereafter. As a provider in our Medicare network, Providers are required to check the OIG/GSA Exclusion and CMS Preclusion List prior to hiring or contracting and monthly thereafter as outlined below for all staff, volunteers, temporary employees, consultants, Directors, and any contractors that would meet the requirements as outlined in The Act §1862(e)(1)(B), 42 C.F.R. §§ 422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6), 1001.1901. Medicare payment may not be made for items or services furnished or prescribed by a precluded or excluded provider or entity. To report suspicions of fraud, waste and abuse, call the Fraud, Waste and Abuse Hotline at 1- 866-685-8664.

Provider Relations Support

Each provider has a dedicated Provider Relations Representative available to assist them with questions or issues they may have. Our Provider Relations Representatives all live within Kentucky and are located throughout the state to serve each of our providers in all regions.

To confirm who your Provider Relations Representative is, please request that information by emailing:
ky_providerrelations@wellcare.com

Thank You

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