Wellcare With Superior HealthPlan

Provider Manual

2027

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Partners in Quality Care

Dear Provider Partner,

At Wellcare, we deeply value your commitment to delivering compassionate, high-quality care to our members — your patients. Your role is essential in helping us serve individuals who rely on both Medicare and Medicaid, many of whom face complex health and social challenges.

Together, we ensure our members receive the coordinated care they need to live healthier, more fulfilling lives.

We are committed to quality — and that means supporting you with the tools, resources, and programs that help remove barriers to care. Whether it's identifying care gaps, navigating benefits, or addressing social needs, we're here to work alongside you and your team.

As part of our partnership, we also recognize and reward your efforts to close care gaps and improve outcomes. Your dedication makes a meaningful difference.

The enclosed D-SNP Provider Manual is your guide to working with Wellcare. We encourage you to explore the highlighted sections, which reflect our shared goal of delivering integrated, person-centered care.

Thank you for being a trusted Wellcare provider partner.

Sincerely,

Wellcare

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2027 D-SNP(DUALS) PROVIDER MANUAL REVISION TABLE

Date	Section	Sub-Header	Comments
1/1/2027	2: Member Benefit Information	Sample Member ID Card Special Supplemental Benefits for the Chronically Ill (SSBCI) Emergency Services Member Grievance	Updated member ID card sample; Moved and updated section; Clarified language; Updated language
1/1/2027	4: Utilization Management	Cardiology Surgical Procedures CMS Interoperability APIs — Provider Overview	Added new section; Added new section
1/1/2027	5: Billing and Claims Payment	Retroactive Adjustments	Added new section
1/1/2027	7: Compliance and Regulatory Requirements	FRAUD, WASTE & ABUSE (FWA) Program	Updated language

SECTION 1: GENERAL INFORMATION

Welcome to the Wellcare With Superior HealthPlan Provider Manual. This manual is a comprehensive resource for healthcare providers participating in our Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP), administered by Centene Corporation, called *Wellcare With Superior HealthPlan Dual Align (HMO D-SNP)*. This FIDE-SNP product is designed to deliver seamless, coordinated care to individuals eligible for both Medicare and Medicaid, ensuring access to the full spectrum of covered services.

Within this manual, Providers will find essential information on policies, procedures, and best practices that support high-quality, integrated care. Our goal is to equip Providers with resources to improve outcomes and the Members' experience. We value our partnership with you and remain committed to supporting your efforts in delivering exceptional care to our Members.

BACKGROUND

In May 2022, the Centers for Medicare & Medicaid Services (CMS) finalized regulatory requirements directing states participating in the Medicare-Medicaid Financial Alignment Initiative to end their demonstration programs by December 31, 2025, or transition to an integrated Dual Eligible Special Needs Plan (D-SNP) model.

In response to this guidance, Texas Health and Human Services (HHS) has transitioned its existing program in a FIDE-SNP. A FIDE-SNP is a type of Medicare Advantage plan specifically designed to serve individuals who are dually eligible for both Medicare and Medicaid. It offers coordinated delivery of Medicare and Medicaid benefits - including long-term services and supports (LTSS) and behavioral health services – through a single managed care organization.

FIDE-SNP Program Commitment and Transition Pillars

Wellcare With Superior HealthPlan, in partnership with the Texas Health and Human Services Commission, is committed to enhancing care delivery for low-income seniors and individuals with disabilities who are dually eligible for Medicare and Medicaid. This commitment will be upheld through the implementation of a FIDE-SNP, with the primary goal of ensuring continuity of benefits and maintaining high standards of care.

To support a smooth and effective transition, Wellcare With Superior HealthPlan has adopted the Integrated Care Transition Pillars developed under the CMS Medicare-Medicaid Coordination Office (MMCO) framework, supported by the Resources for Integrated Care (RIC) initiative. These pillars serve as guiding principles for delivering high-quality, person-centered, and equitable care under the FIDE-SNP model.

Integrated Care Transition Pillars

- **Foster Integration and Continuity:** Texas FIDE-SNP program is designed to fully integrate Medicare and Medicaid services, improving access and care quality for dually eligible individuals. The model bridges gaps between physical health, behavioral health, and LTSS. Upon enrollment, Members will maintain access to their existing Providers and services – without changes in amount, scope, or duration – until a comprehensive assessment is completed.

- **Reduce Racial and Ethnic Disparities:** HHS uses a data-driven approach to identify and address health disparities. The FIDE-SNP model emphasizes culturally and linguistically appropriate services, ensuring equitable access to care for individuals with limited English proficiency and those from diverse backgrounds. These efforts align with broader state and federal health equity initiatives.
- **Improve Care Delivery:** FIDE-SNPs use a person-centered care model that prioritizes the holistic needs of each Member. Care coordination will be central, ensuring seamless transitions across care settings and Providers. Interdisciplinary care teams support individualized care planning and service delivery.
- **Promote Self-Determination:** Texas' FIDE-SNPs empower Members to take an active role in directing their care, particularly in LTSS. The program supports flexible, enrollee-directed care models that respect individual preferences, values, and goals.
- **Build a Culture of Quality:** Continuous quality improvement is embedded throughout the FIDE-SNP program. Plans use integrated data systems to monitor performance, identify gaps, and improve outcomes. Key focus areas include care coordination, person-centered planning, health equity, and value-based payment reform.

Program Launch and Implementation

The FIDE-SNP program launched on January 1, 2026, with initial implementation in select counties, as confirmed by the HHS. During the early implementation phase, certain behavioral health services remain partially carved out, with coordination maintained between FIDE-SNP plans and state-contracted behavioral health Providers to ensure continuity and alignment of care.

HOW TO USE THIS MANUAL

The Wellcare With Superior HealthPlan Provider Manual is a digital resource designed to provide comprehensive, easy-to-navigate guidance for participating Providers. The manual is organized into clearly defined sections, each supported by a master Table of Contents and section-specific Tables of Contents for more precise navigation.

To efficiently locate information:

- Start with the primary Table of Contents to identify the relevant section or topic.
- Note the corresponding Section Number.
- Navigate to that section and review its section-specific Table of Contents.
- Locate the page number for the topic you are seeking and proceed directly to that page.

This manual is available digitally at wellcare.superiorhealthplan.com. A printed copy may be requested by contacting Provider Services.

Updates and Revisions

The Wellcare With Superior HealthPlan Provider Manual is a living document, updated regularly to reflect changes in policies, procedures, and program requirements. Minor revisions may be communicated to Providers through routine outreach or informational updates.

In the event of significant changes, a revised version of the manual will be issued and will replace any previous editions. Providers are encouraged to reference the most current version, which is always available on the Wellcare With Superior HealthPlan website at wellcare.superiorhealthplan.com.

KEY CONTACT INFORMATION

To support providers in delivering high-quality care, Wellcare With Superior HealthPlan offers dedicated resources for assistance with clinical, administrative, and operational needs. The following contacts are available to help with questions related to claims, authorizations, pharmacy, and more.

Please refer to the table below for the most commonly used contact information:

Wellcare With Superior HealthPlan Hours of Operation: Monday-Friday, 8am-8pm EST wellcare.superiorhealthplan.com		
Department	**Phone Number**	**Website**
Member Services	1-855-445-3556	N/A
24-Hour Nurse Advice Line		
Service Coordinator		
Behavioral Health Services		
Provider Services	1-855-445-3572	
Prior Authorizations		
Evolent®	1-800-424-5388	RadMD.com
TurningPoint®	1-855-336-4391	TurningPoint Login
Pharmacist	1-833-750-4258	N/A
Express Scripts® (mail order)	1-833-750-0201	expressscripts.com/rx

	Wellcare With Superior HealthPlan Hours of Operation: Monday-Friday, 8am-8pm EST wellcare.superiorhealthplan.com	
Department	Phone Number	Website
Dental: DentaQuest®	1-866-623-1565	N/A
Vision: Premier Eye Care®	1-855-879-1456	N/A
Hearing: TruHearing®	1-800-334-1807	N/A
Non-Emergency Medical Transportation	1-866-393-2166	N/A
Interpreter Services	1-800-977-7522	N/A
Fraud, Waste, & Abuse	1-866-685-8664	N/A
Ethics & Compliance	1-800-345-1642	N/A

SELF-SERVICE TOOLS FOR PROVIDERS

For the fastest results and most efficient customer service, Wellcare With Superior HealthPlan offers robust technology options, such as a Secure Provider Portal, Interactive Voice Response System (IVR), self-service tools, and much more. These tools save Provider's time and allow for convenient and efficient interactions with Wellcare With Superior HealthPlan.

Secure Provider Portal

Wellcare With Superior HealthPlan's online Secure Provider Portal offers immediate access to what Providers need most. Participating Providers who create an account and are assigned the appropriate role/permissions can use the following features:

- **Claims -** Submit a claim, check status, appeal or dispute claims, and download reports.
- **Eligibility -** Verify Member eligibility, and view copays, benefit information, demographic information, care gaps, health conditions, visit history and more.
- **Authorizations -** Submit authorization requests, attach clinical documentation, check authorization status and submit appeals. Providers may also print and/or save copies of the authorization.

- **Pharmacy -** View the most recent copy of Wellcare With Superior HealthPlan's Preferred Drug List (PDL), wellcare.superiorhealthplan.com/drug-pharmacy/formulary, and obtain information about Wellcare With Superior HealthPlan's pharmacy services.

- **Appointment Agenda -** Download and print a checklist for Member appointments for the Continuity of Care Plus program, then submit online to get credit for Partnership for Quality (P4Q).
- **Secure inbox -** An inbox to receive general messages from Wellcare With Superior HealthPlan.
- **Training -** View the latest available training for Providers and submit attestations.

Providers can access the Secure Provider Portal at Provider.SuperiorHealthPlan.com.

Provider Registration Advantage

The Secure Provider Portal lets Providers have one username and password for use with multiple practitioners or offices. Administrators can easily manage users and permissions. Once registered for Wellcare With Superior HealthPlan's portal, Providers should retain username and password information for reference.

How to Register

To create an account, please visit Provider.SuperiorHealthPlan.com. For more information about Wellcare With Superior HealthPlan's web capabilities, please call Provider Services at **1-855-445-3572** to schedule a website in-service training.

Website Resources

Wellcare With Superior HealthPlan offers a variety of online tools at SuperiorHealthPlan.com/Wellcare to assist Providers and their staff. Available resources may include, but are not limited to:

- Authorization look-up tool,
- Clinical Policies (Clinical Coverage Guidelines (CCGs)),
- Clinical Practice Guidelines (CPGs),
- Forms and documents,
- Member rights and responsibilities,
- Newsletters and bulletins,
- Pharmacy and Provider lookup (directories),
- Privacy statement and notice of privacy practices,
- Provider Manuals,
- Quick Reference Guide, and
- Training materials and job aids.

Interactive Voice Response (IVR) System

- New technology to expedite Provider verification and authentication within the IVR.
- Provider or Member account information is sent directly to the agent's desktop from the IVR validation process, so Providers do not have to re-enter information.

- Full speech capability lets Providers speak the information or Providers can use the touch-tone keypad.

Self-Service Features

- Ability to receive Member copay benefits.
- Ability to receive Member eligibility information.
- Ability to request authorization and/or status information.
- Unlimited claims information on full or partial payments.
- Receive status for multiple lines of claim denials.
- Automatic routing to the PCS claims adjustment team to dispute a denied claim.
- Rejected claims information.

Tips for using IVR

Providers should have the following information available with each call:

- NPI or Tax ID for validation.
- For claims inquiries: the Member's ID number, date of birth, date of service and dollar amount.
- For authorization and eligibility inquiries: the Member's ID number and date of birth.

Benefits of using Self-Service

- 24/7 data availability.
- No hold time.
- Providers may work at their own pace.
- Access information in real time.
- Unlimited number of Member claim status inquiries.
- Direct access to PCS – no transfers.

Providers may contact the appropriate departments within Wellcare With Superior HealthPlan at wellcare.superiorhealthplan.com or by contacting Provider Services at 1-855-445-3572.

SECTION 2: MEMBER BENEFIT INFORMATION

ENROLLMENT AND TRANSITION GUIDANCE FOR NEW MEMBERS

Providers should be aware that new Members enrolling in Wellcare With Superior HealthPlan Dual Align (HMO D-SNP) will typically begin receiving their Medicare benefits through the plan on the first day of the month following their enrollment request.

During the initial transition period, Members may continue to receive Medicaid benefits from their previous STAR+PLUS health plan for one additional month. After this period, STAR+PLUS services will be fully integrated and administered through Wellcare With Superior HealthPlan Dual Align (HMO D-SNP). This process ensures no gap in STAR+PLUS coverage.

If a Member elects to disenroll from the plan, their Medicare coverage will end on the last day of the month in which the disenrollment request is made. However, their STAR+PLUS benefits may remain with Wellcare With Superior HealthPlan Dual Align (HMO D-SNP) for one additional month, until their new STAR+PLUS health plan becomes active. This continuity ensures uninterrupted access to Medicaid services.

Providers are encouraged to contact Provider Services at **1-855-445-3572** with any questions regarding Member transitions or coverage coordination.

MEMBER ELIGIBILITY AND ENROLLMENT

To enroll in a Wellcare With Superior HealthPlan, individuals **must:**

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Have full Medicaid benefits (not partial duals)
- Be 21 years of age or older
- Permanently reside in the Wellcare With Superior HealthPlan service areas
- Not be enrolled in hospice
- Be a U.S. citizen or lawfully present in the United States

EXCLUSIONS FROM ENROLLMENT

The following populations are excluded from enrollment in the program:

- Individuals under the age of 21
- Individuals with partial Medicaid eligibility (e.g., QMB, SLMB, QI, ALMB, QDWI)
- Individuals without full Medicaid coverage (e.g., spend-down status)
- Individuals residing in state psychiatric hospitals
- Individuals with commercial HMO coverage
- Individuals with elected hospice services

- Individuals who are incarcerated
- Individuals with presumptive Medicaid Eligibility
- Individuals disenrolled from Medicaid managed care due to special circumstances

NON-DISCRIMINATION STATEMENT

Wellcare With Superior HealthPlan will accept all eligible Members regardless of:

- Race, color, national origin, sex, religion, age, disability, political affiliations, sexual orientation, or family status.
- Furthermore, we will not limit, or condition coverage of plan benefits based on any factor that is related to the Member's health status, including but not limited to:
- Medical condition
- Claims history
- Receipt of healthcare
- Medical history
- Genetic information
- Evidence of insurability or disability

MEMBER RIGHTS AND RESPONSIBILITIES

Members of Wellcare With Superior HealthPlan may have the following rights and responsibilities, in accordance with applicable federal and state laws, regulations, and the terms of the health plan contract:

Access to Information

1. Members may request and receive information about the health plan, including:
    a. Member rights and responsibilities
    b. Participating Providers and their qualifications
    c. Grievance and appeal procedures
    d. Covered benefits and services
2. Provider information – such as location, qualifications, and availability – is accessible via the online Provider directory or by contacting the Customer Experience (CE) Department
3. Members may request information about the plan's structure, operations, and benefits, and can expect responses to reasonable inquiries.
4. Plan rules, benefits, and available options may be explained to Members.

Language and Disability Services

5. Members may access, at no cost:
    a. Language assistance services, including qualified interpreters and translated written materials
    b. Auxiliary aids for effective communication, such as large print documents, audio materials, or accessible electronic formats

6. When available and upon request, the plan may assist in identifying Providers who speak the Member's preferred language

Dignity, Privacy, and Nondiscrimination

7. Members are to be treated with respect and dignity, with consideration for their right to privacy.
8. The plan is expected to comply with applicable laws regarding the confidentiality of personal health information. Members have the right to authorize or decline the release of their personal health information, consistent with those laws.
9. Members are protected from discrimination based on race, color, national origin, religion, sex, age, marital status, disability, sexual orientation, genetic information, source of payment, and other classifications protected by law.
10. Members may not be subjected to restraint or seclusion as a form of coercion, discipline, convenience, or retaliation.
11. Members should be able to exercise their rights without fear of negative consequences from the plan, its Providers, or the State.

Participation in Care

12. Members are encouraged to participate in decisions about their healthcare, including the right to:
    a. Accept or refuse recommended treatment
    b. Discuss treatment options with their Providers, including potential risks, benefits, and alternatives
13. Members may receive healthcare services in accordance with applicable laws and Wellcare With Superior HealthPlan's agreement with the State.
14. Members may have access to a network of Providers, including primary care providers, specialists, hospitals, and American Indian/Alaska Native Providers when appropriate.
15. Members may access emergency services when medically necessary, regardless of network status or prior authorization.

Grievances, Appeals, and Involvement

16. Members may voice concerns or submit grievances and appeals regarding their care or plan services.
17. Members may request and review their medical records and request corrections as permitted by law.
18. Members may receive decisions related to service authorization, benefit coverage, and prescription drugs, including notification of appeal rights.
19. Members may recommend improvements to the plan's policies and procedures.
20. Members may participate in plan governance and operations, consistent with applicable rules and program structure.

Final Protections

21. Members are generally not responsible for bills, cost-sharing, or copayments for services covered by the plan, including those provided by American Indian/Alaska Native Providers, when consistent with applicable program guidelines.

Reasonable Accommodations

22. The plan and its contracted Providers are expected to provide reasonable accommodations for Members with disabilities, as required by law.
    a. Members may be informed annually – and as needed- about their rights to accommodations via the Member handbook.
    b. Providers are informed of these requirements through the Provider manual.
    c. Members may request accommodations through their care coordinator, who can help assess needs and provide available options.
    d. The Utilization Management team reviews accommodation requests and determines whether they can be provided.
    e. Members may appeal decisions regarding accommodations through the appeals process outlines in plan policy.
23. Receive basic information about the plan, orally as well as in writing, upon request, about the organization of Wellcare With Superior HealthPlan including but not limited to Member rights and responsibilities, participating practitioners and Providers, grievance and appeal procedures, and covered services. This information is made accessible to all Members including those with limited English proficiency or reading skills, with diverse cultural ethnic background, and with physical and mental disabilities.

MEMBER BENEFITS AND SERVICES

Wellcare With Superior HealthPlan offers a comprehensive benefit package to Members who are eligible for Medicare and full Medicaid benefits. Covered services are based on medical necessity and must meet professionally accepted standards of care. The plan integrates Medicare and Medicaid benefits, including LTSS, behavioral health, and preventive care.

Covered services may include:

- Primary and specialty care Provider visits
- Hospital inpatient and outpatient services
- Emergency and urgent care services
- Ambulance and emergency medical transportation
- Behavioral health services, including outpatient therapy and psychiatric care
- Prescription drugs (Medicare Part D and Medicaid-covered medications)
- Dental services
- Vision services, including eye exams and eyeglasses
- Hearing services, including hearing aids
- Durable Medical Equipment (DME) and medical supplies
- Home health care and personal care services
- Skilled nursing facility care
- Rehabilitative therapies (physical, occupational, and speech therapy)

- Preventive services, including immunizations and screenings
- Family planning and reproductive health services
- Podiatry and chiropractic care
- Transportation to medical appointments (non-emergency medical transportation)
- Care coordination and case management
- Second medical opinions, when requested
- LTSS, including in-home and community-based services

Additional Notes

- Members are not responsible for co-pays on Medicaid-covered services.
- Prior authorization may be required for out-of-network services, except in the case of emergencies.
- Members have the right to receive care from Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).
- Interpreter services and materials in alternative formats (e.g., large print, braille, or audio) are available at no cost to Members.
- Wellcare With Superior HealthPlan will implement any changes to covered services as directed by the HHS, in alignment with updates to the Texas Medicaid program.

Non-Covered Services

While Wellcare With Superior HealthPlan provides a wide range of integrated Medicare and Medicaid benefits, certain services are excluded from coverage under Texas Medicaid and/or Medicare. These services are not reimbursable and will not be covered by the plan unless required by law or authorized under special circumstances.

Services Not Covered by the Plan include:

- Elective abortions, except in case of rape, incest, or when the life of the pregnant person is endangered
- Experimental or investigational treatments, drugs, or equipment not approved by CMS of HHS
- Cosmetic surgery or procedures performed solely for aesthetic purposes
- Infertility treatments and related medications
- Erectile dysfunction medications (unless medically necessary and covered under Medicare Part D)
- Services not deemed medically necessary by the plan or state guidelines

Behavioral Health and Other Services Managed Outside the Plan

Certain services may be administered outside of the FIDE-SNP benefit package by state-contracted Providers or waiver programs. These services may include, but are not limited to:

- Home and Community-Based Services (HCBS) for individuals with developmental disabilities or traumatic brain injuries

- Services provided through the Department of Human Services (DHS) or Department on Aging (DoA)

In these cases, Wellcare With Superior HealthPlan Providers are expected to assist Members in obtaining referrals or coordinating care with the appropriate state agency or Provider network.

Member ID Cards

Each Wellcare With Superior HealthPlan Member receives a personalized Member ID card upon enrollment. This card serves as proof of coverage and contains essential information that providers should verify prior to delivering services.

Key Information on the Member ID Card

- Member name and identification number
- Plan name and coverage type
- Effective date of coverage
- Contact information for Member Services
- Pharmacy, Vision, and Dental benefit details (if applicable)

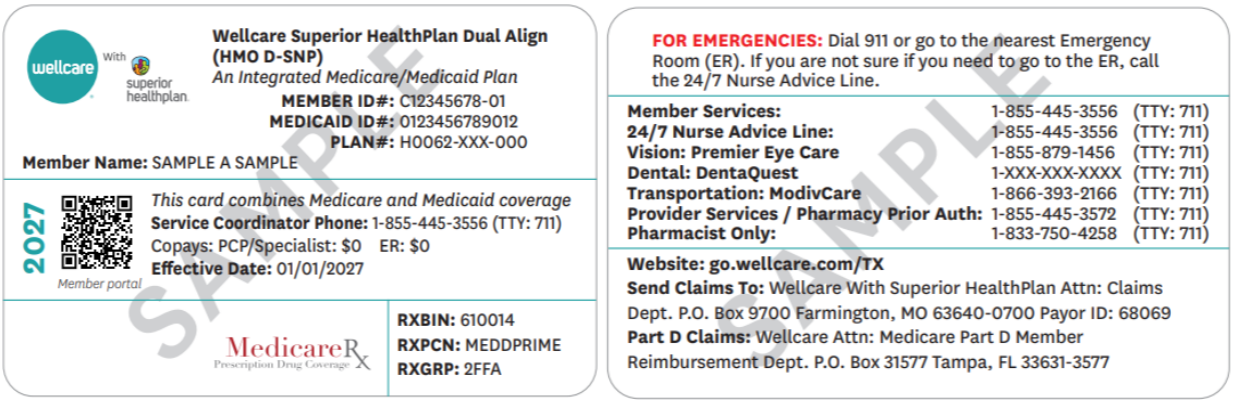
Provider Responsibilities

Providers are expected to:

- Verify Member eligibility and benefits using the information on the ID card and the secure Provider Portal.
- Confirm the Member's identity at the time of service.
- Use the Member ID number for all claims submissions and prior authorization requests.

Note: Possession of a Member ID card does not guarantee eligibility. Always verify current coverage through the Provider Portal or by contacting Provider Services.

Sample Member ID Card



Provider Support

Providers should contact Member Services at **1-855-445-3556** for assistance with:

- Referrals to state-administered services
- Clarification of benefit coverage
- Coordination with behavioral health or waiver program Providers

SPECIAL SUPPLEMENTAL BENEFITS FOR THE CHRONICALLY ILL (SSBCI)

Overview

Special Supplemental Benefits for the Chronically Ill (SSBCI) are supplemental benefits available to eligible members enrolled in a Wellcare With Superior HealthPlan plan that offers SSBCI and who meet CMS-defined eligibility requirements.

Members are continuously reviewed through Wellcare With Superior HealthPlan's automatic eligibility process using available claims, medical records, clinical assessments, and other approved clinical information. This automated process is the primary pathway used to determine SSBCI eligibility.

Provider Attestation Process

Provider attestation is an alternative qualification pathway for SSBCI benefits primarily intended for newly enrolled members when sufficient claims or clinical data may not yet be available to determine eligibility through the automatic eligibility process.

Members should schedule an in-person office visit or contact their healthcare provider to request that an attestation be submitted. A healthcare provider who is familiar with the member's medical history may attest whether the member meets all required SSBCI eligibility criteria.

Providers should visit the Wellcare With Superior HealthPlan SSBCI Provider Attestation Portal to complete the online attestation. Providers with questions regarding the attestation process or who may require additional support with submitting an attestation should contact Provider Services using the phone number listed in the applicable Provider Manual or the phone number listed on the back of the member's ID card.

Please note: Provider attestation is for provider use only. Members cannot self-attest for SSBCI eligibility.

SSBCI Eligibility Requirements

To qualify for SSBCI benefits, members must meet **all** CMS-defined eligibility criteria:

- Enrolled in a plan that offers SSBCI
- Has one or more qualifying chronic conditions that is life threatening or significantly limits overall health or function
- Has a high risk of hospitalization or other adverse health outcomes

- Requires intensive care coordination

A diagnosis of a qualifying chronic condition alone does not qualify a member for SSBCI benefits. In addition to having one or more qualifying chronic conditions, eligibility for SSBCI may be demonstrated through one or more of the following:

- History of hospitalization or emergency department visits, and/or
- Frequent use of outpatient services or specialty care, and/or
- Evidence of poor disease control or medication adherence, and/or
- Non-medical social needs that impact health outcomes

Provider Instructions for Submitting an Attestation

Providers should follow these steps to submit an SSBCI attestation:

1. Access the Wellcare With Superior HealthPlan SSBCI Provider Attestation portal at wellcare.ssbci.rrd.com
2. Review the eligibility criteria and evaluate whether the member meets all required SSBCI eligibility criteria
3. Complete and submit the electronic provider attestation
4. If applicable, submit a claim including the appropriate diagnosis coding consistent with the member's documented chronic condition(s) and services provided

Providers should complete the attestation based on their clinical judgment and evaluation of the member, certifying whether the member meets all required SSBCI eligibility criteria.

Determination Process & Member Notification

Automatic Qualification (Primary Method)

- The clinical algorithm is the fastest and most common way members qualify for SSBCI benefits
- Members are continuously reviewed through the automated eligibility process using available information such as:
  - Claims data
  - Medical records
  - Clinical assessments
  - Other supporting information

Provider Attestation (Intended for New Members)

- For new members who do not yet have sufficient claims history, providers may submit an attestation to support with the eligibility determination in lieu of claims data

- Submission of an attestation does not guarantee approval, as eligibility is based on whether the member meets all required SSBCI criteria

If the member meets the criteria:

- A Detailed Benefit letter is mailed to the member notifying them of their SSBCI eligibility and providing details on the new benefits available to them
- Access to SSBCI benefits is activated within 10 business days of eligibility approval

If the member does not meet the criteria:

- A denial letter with appeal rights is mailed to the member
- The member continues to be reviewed through the automatic process while enrolled in an eligible plan
- If the member later meets all eligibility requirements based on their clinical data, they will qualify for SSBCI benefits

PHARMACY BENEFIT MANAGEMENT

Wellcare With Superior HealthPlan utilizes a Pharmacy Benefit Manager (PBM) to administer Member pharmacy benefits. The PBM provides Wellcare With Superior HealthPlan with a pharmacy network, pharmacy claims management, and adjudication services. Prior to authorizing any drug benefit, each Member's eligibility is determined.

In accordance with the requirements set forth by HHS, Wellcare With Superior HealthPlan adopts the State's Health Plan Common formulary for Medicaid. The formulary is designed to cover the vast majority of therapeutic conditions. However, should a specific medication not listed on the formulary be deemed medically necessary for a Member, a medical necessity exception may be requested through the prior authorization (PA) process. Additionally, certain specialized medications on the drug formulary require a PA before they can be dispensed.

The drug formulary is accessible on the prescriber portal. This formulary should be consulted when prescribing medications for Wellcare With Superior HealthPlan Members. Medicaid Members have coverage for both prescription and specific over-the-counter medication.

While we encourage prescribing within the formulary, we recognize that situations arise where a formulary alternative is not available. Drugs requiring Prior Authorization are identified in the formulary with a PA designation.

Wellcare With Superior HealthPlan requires adherence to the following Prior Authorization procedures for obtaining medically necessary non-formulary/non-covered drug products:

1. To receive a non-formulary/non-preferred medication, the prescriber must submit a prior authorization request. Using the form on our website through covermymeds.com.

2. The Pharmacy Services reviewer may request that the prescriber submit additional clinical information by fax in order to process the request.
3. If the request is approved, pharmacy services will notify the Provider via fax and enter the necessary authorization into the claims processing system for dispensing at a participating pharmacy network Provider.
4. The prescriber may contact Pharmacy Services by telephone at **1-833-750-4258** with any questions or concerns.

MEMBERS WHO LOSE MEDICAID ELIGIBILITY/STATUS

CMS requires FIDE-SNP plans to allow members who lose Medicaid eligibility or experience a status change up to six months to regain eligibility. This timeframe is known as the Deeming Period. Wellcare With Superior HealthPlan applies this six-month period to all FIDE-SNP plans.

During the Deeming Period, members with cost-share protection will have claims processed at 100% of the Medicare allowable rate. Providers must accept this payment as payment in full and may not balance bill the member. The Explanation of Payment (EOP) will indicate cost-share protected status.

Please note: Medicaid services are not covered for members during the Deeming Period.

MEMBER SELF-REFERRALS

Family Planning

Family planning services include any medically approved method – such as diagnostic evaluation, medications, supplies, devices, and related counseling – used to voluntarily prevent or delaying pregnancy, or to detect and treat sexually transmitted diseases (STDs). These services must be provided continuously to individuals of childbearing age, including sexually active minors, who choose to avoid pregnancy, or wish to manage the number and timing of their children.

Infertility treatment is not covered under the family planning benefit.

All Wellcare With Superior HealthPlan Members have the right to choose any qualified family planning Provider, whether in-network or out-of-network. Primary Care Providers (PCPs) should support Members by providing family planning services or assisting them in locating and selecting a family planning Provider, as requested.

Members seeking additional information or assistance with family planning referrals may contact Member Services at **1-855-445-3556**.

Women's Health

Female Members aged 21 and older may self-refer to any in-network OB/GYN for routine annual examinations and preventive screenings, including Pap smears, chlamydia testing, and mammograms. Members may also self-refer to an in-network OB/GYN of their choice for prenatal and perinatal care.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

FQHCs are essential community-based Providers that deliver comprehensive healthcare services. All Wellcare With Superior HealthPlan Members have access to FQHCs when these services are available within their community. The Member Handbook outlines each Member's right to seek care from an FQHC within their service area. For more information or assistance accessing an FQHC, Members may contact Member Services at **1-855-445-3556**.

NON-EMERGENCY TRANSPORTATION

Wellcare With Superior HealthPlan ensures that non-emergency transportation and travel expenses are readily available and accessible for Members requiring medically necessary care. This service supports access to medical appointments, examinations, and treatments as determined necessary by the Member's primary care Provider.

Non-emergency transportation is available to support Members' access to medically necessary care. Covered services include, but not limited to:

- End Stage Renal Disease treatment (hemodialysis)
- Prenatal and preventive care
- Mental health services
- Prescription pickup
- Durable Medical Equipment (DME) supplies

Wellcare With Superior HealthPlan partners with a transportation agency that maintains a Provider network capable of servicing the entire geographic area in which Members reside.

For more information on how to access non-emergent transportation services, Members should consult their Member Handbook or contact Member Services at **1-855-445-3556.**

Accessing Non-Emergent Transportation Services

To schedule non-emergent transportation, the Member, their primary care Provider (PCP), or a Wellcare With Superior HealthPlan representative may call the transportation vendor at **1-866-393-2166** or contact Member Services at **1-855-445-3556** for assistance.

The non-emergent transportation vendor will provide services for the following individuals:

- **Members:** All Wellcare With Superior HealthPlan Members for covered outpatient services.
- **Parents or Legal Guardians:** May accompany legally incapacitated Members to appointments.
- **Other Family Members:** Transportation for additional individuals (e.g., siblings) may be permitted, depending on circumstances and vendor policies.

Transportation is provided to and from participating Providers. In cases where medically necessary services are only available from a non-participating Provider, transportation may be arranged as directed by Wellcare With Superior HealthPlan.

EMERGENCY SERVICES

Wellcare With Superior HealthPlan provides coverage for emergency services in accordance with applicable Medicare and Medicaid requirements. When Texas Medicaid covers emergency services not included under Medicare—or covers them at a greater amount, duration, or scope—Wellcare With Superior HealthPlan will provide those services through Medicaid as outlined in our contract.

- Emergency Care Access: Emergency services are available to Members 24 hours a day, 7 days a week. Members will be screened and stabilized without prior authorization in accordance with the Emergency Medical Treatment and Labor Act (EMTALA), using the prudent layperson standard.
- Medicare-Covered Emergency Services: Wellcare With Superior HealthPlan covers appropriate cost sharing for emergency services and medical screenings provided under Medicare, including:
- Out-of-network or out-of-area emergency services delivered in a hospital emergency department.
- Emergency care received without prior notice to the PCP or plan.
- Emergency transportation and professional services necessary to evaluate or stabilize an emergency medical condition.
- Post-Stabilization Care: Wellcare With Superior HealthPlan ensures coverage for post-stabilization services in alignment with 42 CFR §422.214 and §422.113. Post-stabilization services related to the emergency condition do not require prior authorization. Authorization may be required for non-emergent services following stabilization
- Medical Screening and Stabilization: Hospitals providing emergency services must conduct a medical screening exam to determine if an emergency condition exists. If one is found, the provider must stabilize the Member before discharge or transfer. Emergency services must continue until the Member is clinically stabilized.
- Medicaid Coverage: For services not covered under Medicare but included under Medicaid, Wellcare With Superior HealthPlan will ensure those services are provided as part of the Member's benefits.
- Authorization Requirements After Stabilization: If additional care (e.g., hospitalization or specialty services) is needed following an emergency room visit, prior authorization may be required unless the circumstances meet any of the above exceptions.

Coverage Ends When:

- A Wellcare With Superior HealthPlan Provider assumes responsibility for the Member's care.
- The Member is transferred under the care of a plan-approved Provider.
- An agreement is reached between the treating Provider and the plan.
- The Member is discharged.

Definitions

Emergency Medical Condition

An emergency medical condition is defined as a medical condition manifesting acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, with average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in one or more of the following:

- Placing the health of the individual (or a pregnant woman and her unborn child) in serious jeopardy.
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services

Emergency services are defined as covered inpatient and outpatient services that:

- Are provided by a qualified Provider in accordance with federal requirements under Title 42; and
- Are necessary to evaluate or stabilize an emergency medical condition.

Post-stabilization Care Services

Post-stabilization care services are defined as medically necessary services provided after a Member has been stabilized, and are intended to:

- Maintain the stabilized condition; or
- Improve or resolve the Member's condition, consistent with 42 CFR §438.114(e).

Plan Coverage and Financial Responsibility

The Plan covers and reimburses for emergency services regardless of whether the Provider is contracted with the Plan.

The Plan will not deny coverage for emergency services under the following circumstances:

- The Member experienced an emergency medical condition, even if the absence of immediate medical attention would not have led to the outcomes described above; or
- A Plan representative directed the Member to seek emergency care.

The Plan does not:

- Restrict what qualifies as an emergency condition based solely on diagnosis or symptom lists.
- Deny emergency service claims due to lack of notification to the Member's Primary Care Provider, the Plan, or the HHS within 10 calendar days of treatment.

Members **cannot** be held financially liable for any screening or treatment needed to diagnose or stabilize an emergency medical condition.

The attending emergency provider, or the Provider treating the Member, is solely responsible for determining when the Member is stabilized for discharge or transfer. This determination is binding on the Plan if:

- It adheres to generally accepted medical standards; and
- The services are covered under the Plan's contract.

Post-stabilization Authorization and Coverage

The Plan is financially responsible for post-stabilization services provided by contracted or non-contracted Providers and does not require authorization.

Cost Sharing

Members may not be charged more for post-stabilization services than they would have paid had the services been obtained through a contracted Provider. For the purposes of cost-sharing, post-stabilization services begin upon inpatient admission.

End of Plan Financial Responsibility

Wellcare With Superior HealthPlan's financial responsibility for post-stabilization care services ends when any of the following occurs:

- A Plan-affiliated Provider with hospital privileges assumes responsibility for the Member's care.
- A Plan-affiliated Provider assumes care through transfer.
- The Plan and the treating Provider reach agreement on care; or
- The Member is discharged.

24 HOUR NURSE ADVICE LINE

Wellcare With Superior HealthPlan offers a 24-Hour Nurse Advice Line as a resource to support Members in making informed healthcare decisions. This service is intended to supplement, not replace, the care and guidance of the Members' Primary Care Provider (PCP).

The Nurse Advice Line offers:

- General health information
- Guidance on appropriate levels of care
- Assistance understanding health care benefits
- Information on treatment options and available resources

This service is available at no cost to Members, 24 hours a day, 7 days a week, 365 days a year.

Nurse Advice Line Phone Number: 1-855-445-3556 TTY: 711

Providers should encourage Members to utilize the Nurse Advice Line for non-emergency medical questions or concerns, especially outside of regular office hours.

MEMBER GRIEVANCE

Wellcare With Superior HealthPlan monitors Member grievances and appeals as part of its quality oversight and compliance responsibilities. The grievance and appeal processes outlined below are in accordance with state and federal regulations and apply to all Wellcare With Superior HealthPlan Members.

A grievance is defined as any expression of dissatisfaction about matters other than an "action" (i.e., a denial, reduction, or termination of a service), which would be subject to the appeal process. Examples of grievances may include:

- Delays in obtaining timely appointments or referrals
- Concerns regarding Provider or staff behavior
- Alleged violations of Member rights
- Issues related to the quality of care or services received

Grievances may be submitted by the Member, their authorized representative, or a Provider acting on the Member's behalf. Members may contact Wellcare With Superior HealthPlan Member Services at **1-855-445-3556** to file a grievance.

Wellcare With Superior HealthPlan offers both informal and formal grievance processes. Informal grievances are typically resolved during the initial interaction with Member Services.

Formal grievances should be submitted to:

Wellcare With Superior HealthPlan
Attn: Grievances
P.O. Box 10450
Van Nuys, CA 91410-0450

Upon receipt of a formal grievance, Wellcare With Superior HealthPlan will send written acknowledgment within five (5) business days and issue a resolution within 30 calendar days of receipt. In cases involving clinical urgency, Wellcare With Superior HealthPlan will request a response from the Provider or facility within 24 hours. For standard grievances, Provider responses are expected within seven (7) calendar days to support timely resolution.

Providers are expected to cooperate fully with Wellcare With Superior HealthPlan in the investigation and resolution of Member grievances, including responding to information requests within designated timeframes. Failure to respond may impact the resolution process or be escalated for contractual review.

Members will receive written notification of the grievance outcome, which will include the resolution determination and any next steps, if applicable.

Member Appeals

An appeal is a formal request from the Member, their authorized representative, or Provider to review a decision made by Wellcare With Superior HealthPlan to deny, reduce, delay, or terminate a requested service or payment. Examples include:

- Denial of a service based on medical necessity
- Denial of payment for a service already received
- Termination or reduction of a previously authorized service

Non-Urgent Pre-Service Appeal

Members have 65 calendar days to file an appeal from the date of the denied service. All written or verbal communication by a Member regarding dissatisfaction with a decision to deny, reduce, delay, or terminate a clinical service based on medical necessity or on benefit determination is to be considered an appeal.

A Provider or other authorized representative of the Member such as family member, friend, or attorney may file an appeal on the Member's behalf with the Member's written permission. The Member must submit written permission to Wellcare With Superior HealthPlan for an authorized representative to appeal on their behalf.

Members have the right to appeal an adverse benefit determination. Appeals may be submitted to the Wellcare With Superior HealthPlan Appeals Department or by phone through Member Services at 1-855-445-3556. If submitted in writing, the appeal should include a valid phone number for follow-up and confirmation of receipt.

Appeals should be mailed to:

Wellcare With Superior HealthPlan
Attn: Appeals
P.O. Box 10052
Van Nuys, CA 91410-0052

Within three business days of receiving a Member's appeal, Wellcare With Superior HealthPlan will notify the Member of all the information that is required to process the request. Appeals are reviewed and resolved within 30 calendar days from the date of receipt.

Appeals are reviewed by a qualified clinical peer reviewer holding the same or similar specialty as the treating Provider. The reviewer will not be the same individual who made the initial determination to deny, reduce, or terminate services.

Wellcare With Superior HealthPlan will provide written notification of the appeal decision to the Member, the Provider, and any other Provider directly involved in the appeal.

Expedited Appeals

A Member or their Provider may call Member Services at **1-855-445-3556** to file an expedited appeal if they think that their situation is clinically urgent and reviewing the appeal in the standard timeframe could:

- Seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function based on a prudent layperson's judgment or in the opinion of a practitioner with knowledge of the Member's medical condition
- Subject the Member to severe pain that cannot be adequately managed without the care or treatment

If an appeal is deemed urgent, the Member must obtain written confirmation from their Provider by attesting that the standard appeal timeframe could seriously jeopardize the Member's life, health, or ability to regain maximum function.

Upon receipt of the expedited appeal, Wellcare With Superior HealthPlan will notify the Member within 24 hours if additional information is required. A decision will be rendered within 72 hours of receiving the expedited request.

The outcome will be communicated verbally to the Member, their Primary Care Provider (PCP), and any other Provider involved in the appeal, followed by written notification.

Note: Wellcare With Superior HealthPlan prohibits any punitive action against a Provider who requests an expedited resolution or supports a Member's appeal.

External Review of an Appeal (Expedited)

Members have the right to request a determination by the Insurance Director or his/her designee, or by an independent review organization under the Member's Right to Independent Review Act.

An expedited external appeal may be submitted by the Member and/or the Member's authorized representative within 10 days after the Member receives an adverse determination from the health plan only if the following are met:

- A Provider must substantiate, either orally or in writing, that the standard timeframe for review of the grievance/appeal would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function; and
- The Member has already filed a request for an expedited internal appeal with the health plan.

The request for external review, visit maximusferp.my.site.com/FERP.

External Review of an Appeal (Non-Expedited)

Members have the right to request a determination by the Director or his/her designee, or by an independent review organization under the Member's Right to Independent Review Act. Members must first exhaust the internal appeal process through the health plan before filing a request for an external review with the Department of Insurance and Financial Services (DIFS).

A request for an external review of a grievance/appeal may be submitted by the Member and/or the Member's authorized representative after the Member receives an adverse determination or final adverse determination from the health plan.

To request an external review, visit maximusferp.my.site.com/FERP.

SECTION 3: PROVIDER FUNCTIONS AND RESPONSIBILITIES

PROVIDER CREDENTIALING/RE-CREDENTIALING

Overview

For purposes in this manual, all references to "Providers" shall include all who provide health or health-related services, including the following: providers, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities, and other ancillary facilities/healthcare delivery organizations.

Wellcare With Superior HealthPlan Providers delivering Medicare covered services must be enrolled as a Medicare provider through CMS. All individuals or entities that furnish services to, or order, refer, or certify the need for services provided to individuals eligible under the Texas Medicaid State Plan must be screened and enrolled in the Texas Medicaid program. To receive reimbursement for Medicaid-covered services rendered to eligible Members, Providers must complete the enrollment process and obtain approval through the Provider Enrollment Management System (PEMS). Providers can visit the Texas Medicaid & Health Partnership (TMHP) website for additional information and resources for Texas Medicaid Provider enrollment. State registration does not require Providers to contract with a Medicaid Health Plan.

Please note: Enrollment in PEMS is required for participation in a managed care network but does not obligate Providers to accept Medicaid fee-for-service nor Medicaid managed care Members. For additional information regarding enrollment requirements, Providers are encouraged to consult relevant guidance issued by the HHS and review applicable policy communications.

Providers who contract with Wellcare With Superior HealthPlan (to be part of the Integrated FIDE SNP network) will only display in the Integrated Provider Directory, not other plan directories, unless you are also contracting with our Medicaid, Wellcare, or Ambetter network.

Credentialing is the process by which the appropriate Wellcare With Superior HealthPlan peer review bodies evaluate the credentials and qualifications of Providers. Providers are required to be credentialed prior to being listed as a Wellcare With Superior HealthPlan-participating Provider.

This review includes (as applicable to Provider type):

- Background;
- Education;
- Postgraduate training;
- Certification(s);
- Experience;

- Work history and demonstrated ability;
- Member admitting capabilities;
- Licensure, regulatory compliance, and health status which may affect a practitioner's ability to provide healthcare; and
- Accreditation status, as applicable to non-individuals.

The Credentialing Department, or its designee, is responsible for gathering all relevant information and documentation through a formal application process. The Provider credentialing application must be attested to by the applicant as being correct and complete. The application captures professional credentials and asks for information regarding professional liability claims history and suspension or restriction of hospital privileges, criminal history, licensure, Drug Enforcement Administration (DEA) certification, or Medicare/Medicaid sanctions.

Please take note of the following credentialing process highlights:

- Primary source verifications are obtained in accordance with Federal and State regulatory agencies, accreditation, and Wellcare With Superior HealthPlan policy and procedure requirements, and include a query to the National Practitioner Data Bank.
- Satisfactory site inspection evaluations are required to be performed in accordance with Federal and State accreditation requirements.
- After the credentialing process has been completed and the Credentialing Committee renders a participation decision, a timely notification of the credentialing decision is forwarded to the Provider. If a denial was issued, the Provider is advised of their Appeal Rights in writing.

Credentialing may be done directly by Wellcare With Superior HealthPlan, Centene, or by an entity approved by Wellcare With Superior HealthPlan for delegated credentialing. If credentialing is delegated to an outside agency, the agency shall be required to meet Wellcare With Superior HealthPlan's criteria that the credentialing capabilities of the delegated entity clearly meet Federal and State accreditation (as applicable) and Wellcare With Superior HealthPlan requirements.

Compliance is monitored on a regular basis, and formal audits are conducted annually. Ongoing oversight includes regular exchanges of network information and the annual review of policies and procedures, credentialing forms and files.

Purpose

The Purpose of the Credentialing Program is to set criteria and establish regulatorily compliant policies and procedures to verify the professional qualifications of participating Providers in order to provide an integrated network of qualified Providers and facilities for the provision of safe and effective care and services to enrolled Membership across all of Wellcare With Superior HealthPlan. Credentialing uses primary and secondary source verifications obtained in accordance with regulatory and accreditation requirements, and Wellcare With Superior HealthPlan's policies and procedures. Information and documentation relating to individual Providers or facilities is collected, verified, reviewed, and evaluated in order to approve or deny Provider

network participation. Approved Providers are assigned a specialty and scope of practice that is consistent with their boards of certification, accredited training, or licensure (as applicable). Specialty designations and delineation of scope of services of approved facilities are consistent with recognized industry service standards and/or standards of participation developed by Wellcare With Superior HealthPlan that may include certification, licensure, and/or accreditation, as applicable to Provider type.

Credentialing activities are monitored and reported to Credentialing Committee and the National Medicare Quality Improvement Utilization Management Committee (QIUMC) on a quarterly basis. Work Plan data is reported to the QIUMC.

Baseline Criteria

Baseline criteria for Providers to qualify for Provider network participation:

- License to Practice – Providers must have a current, valid, unrestricted license to practice.
- Drug Enforcement Administration Certificate – Providers must have a current valid DEA certificate (as applicable to Provider specialty), and if applicable to the state where services are performed, hold a current Controlled Dangerous Substance (CDS) or Controlled Substance Registration (CSR) certificate (applicable for M.D., D.O., D.P.M., D.D.S., D.M.D.).
- Work History – Providers must provide a minimum of five years' relevant work history as a health professional.
- Board Certification – Providers must maintain board certification in the specialty being practiced as a Provider for Wellcare With Superior HealthPlan or must have verifiable educational/training from an accredited training program in the specialty requested.
- Hospital Admitting Privileges – Specialist Providers shall have hospital admitting privileges at a Wellcare With Superior HealthPlan-participating hospitals (as applicable to specialty). Primary care Providers may have hospital admitting privileges or may enter into a formal agreement with another Wellcare With Superior HealthPlan-participating Provider who has admitting privileges at a Wellcare With Superior HealthPlan-participating hospital, for the admission of Members.
- Ability to Participate in Medicaid and Medicare – Providers must have the ability to participate in Medicaid and Medicare. Any individual or entity excluded from participation in any government program is not eligible for participation in any Wellcare With Superior HealthPlan plan. Existing Providers who get restricted from participation in any government program are subject to immediate termination in accordance with Wellcare With Superior HealthPlan policy and procedure and the Agreement.
- Providers Who Opt-Out of Medicare – A Provider who opts out of Medicare is not eligible to become a participating Provider. An existing Provider who opts out of Medicare is not eligible to remain as a participating Provider for Wellcare With Superior HealthPlan.
- Liability Insurance – Wellcare With Superior HealthPlan Providers (all disciplines) are required to carry and continue to maintain professional liability insurance, unless otherwise agreed by Wellcare With Superior HealthPlan in writing.

- Providers must furnish copies of current professional liability insurance certificate to Wellcare With Superior HealthPlan, concurrent with expiration.

Eligible Providers

All eligible Providers must complete the credentialing process prior to participating in the Wellcare With Superior HealthPlan network. Recredentialing is required every 36 months to maintain active network status.

Credentialing

The Provider credentialing process requires that all Providers keep the Wellcare With Superior HealthPlan Credentialing Department updated with changes in credentials. In conjunction with this, Providers should respond promptly to any requests to update information so that all credentialing files can be maintained appropriately.

Recredentialing

In accordance with regulatory, accreditation, and Wellcare With Superior HealthPlan policy and procedure, recredentialing is required at least once every three years (36 months). The purpose of this process is to identify any changes in the Provider's licensure, sanctions, certification, competence, or health status which may affect the Provider's ability to perform services under the contract. This process includes all Providers, Facilities, and Ancillary Providers previously credentialed and currently participating in the network. Approximately six months prior to the Provider's three-year anniversary date, the Provider will be notified of the intent to recredential. All necessary forms will be sent for completion. In certain instances, a site visit will also be scheduled.

Monitoring and evaluation of the quality and appropriateness of patient care, review of quality improvement studies, Member surveys, complaints and grievances, clinical performance, utilization data, and Member transfer rates are incorporated in the recredentialing process.

In between credentialing cycles, Wellcare With Superior HealthPlan conducts Provider performance monitoring activities on all participating Providers. Wellcare With Superior HealthPlan reviews monthly reports released by both Federal and State entities to identify any network practitioners/providers who have been newly sanctioned or excluded from Medicare or Medicaid. Wellcare With Superior HealthPlan also reviews member complaints/grievances against providers on an ongoing basis.

A Provider's agreement may be terminated if at any time it is determined by the Wellcare With Superior HealthPlan Credentials Committee that credentialing requirements or standards are no longer being met.

Credentialing Committee

The Wellcare With Superior HealthPlan Credentials Committee, including the Medical Director or their provider designee, has the responsibility to establish and adopt necessary criteria for participation, termination, and direction of the credentialing procedures. Committee meetings are typically held at least monthly and more often as deemed necessary. Failure of an applicant to adequately respond to a request for missing or expired information may result in termination or the application process prior to committee decision.

Expedited Credentialing

A Provider who joins an established medical group that has a current contract with Wellcare With Superior HealthPlan may be eligible for expedited credentialing. The qualifying Provider must request credentialing to be expedited when the required credentialing documentation is submitted to Wellcare With Superior HealthPlan.

To qualify for expedited credentialing, the eligible applicant provider must:

- Be licensed in Texas and in good standing with, the Texas Medical Board;
- Submit all documentation and other information required to begin the credentialing process; and
- Agree to comply with the terms of Wellcare With Superior HealthPlan's participating Provider Agreement currently in force with the applicant provider's established medical group.

Notification of Network Changes

If a Provider's participation is terminated, Wellcare With Superior HealthPlan will notify affected Members who regularly receive care from that provider. Wellcare With Superior HealthPlan will also notify applicable managed care organizations, health plans, and regulatory entities of any final adverse determination, as required by law. Reporting obligations to State licensure boards and the National Provider Data Bank (NPDB) will be fulfilled in accordance with applicable Federal and State regulations.

Confidentiality and Recordkeeping

Denied applications are maintained in a confidential manner in the Denied Participation file for a period of four years from the date of denial. Denials are kept confidential unless disclosure is required under Federal or State regulations.

Rights to Review and Correct Information

Provider Rights are listed below and are included in the application cover letter.

All Providers participating within the network have the right to review information obtained by Wellcare With Superior HealthPlan to evaluate their credentialing and/or recredentialing application. This includes information obtained from any outside primary source such as the National Provider Data Bank, CAQH, malpractice insurance carriers, and State licensing agencies. Providers have the right to correct any erroneous information submitted by another party (other than references, personal recommendations, or other information that is peer review protected) in the event the Provider believes any of the information used in the credentialing or recredentialing process to be incorrect or should any information gathered as part of the primary source verification process differ from that submitted by the Provider.

Wellcare With Superior HealthPlan will inform Providers in cases where information obtained from primary sources varies from information provided by the Provider. To request release of such information, a written request must be submitted to the Credentialing Department. Upon receipt of this information, the Provider will have 30 days from the initial notification to provide a written explanation detailing the error or the difference in information to the Credentialing Committee. The Wellcare With Superior HealthPlan Credentials Committee will then include this information as part of the credentialing or recredentialing process.

Right to be Informed of Application Status

All practitioners who have applied to join have the right to be informed of the status of their application upon request. To obtain application status, the practitioner should contact the Credentialing Department at credentialing@superiorhealthplan.com. Upon receipt of a written request, Wellcare With Superior HealthPlan will provide written information to the Provider on the status of the application (generally within 15 business days). The information provided will advise of any items pending verification, needing to be verified, any non-response in obtaining verifications, and any discrepancies in verification information received compared with the information submitted by the Provider.

Right to Review Information Submitted

All Providers participating within the Wellcare With Superior HealthPlan network have the right to review certain information obtained by Wellcare With Superior HealthPlan that is used to evaluate their credentialing and/or recredentialing applications. This does not allow a Provider to review peer review-protected information such as references, personal recommendations, or other information.

The Provider may review documentation submitted by them in support of the application/recredentialing application, together with any discrepant information received from professional liability insurance carriers, State licensing agencies, and certification boards, subject to any Wellcare With Superior HealthPlan restrictions.

Right to Appeal or Reconsideration of Adverse Credentialing Decisions

Applicants who are existing Providers and who are denied continued participation due to adverse credentialing determinations (for reasons such as appropriateness of care or liability claims issues) have the right to request an appeal of the decision. Requests for an appeal must be made in writing within 30 days of the date of the notice. New applicants who are declined participation may request a reconsideration within 30 days from the date of the notice. All written requests should include additional supporting documentation in favor of the applicant's appeal or reconsideration for participation in the network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting and/or no later than 60 days from the receipt of the additional documentation in accordance with Federal and State regulations. Written requests to appeal or reconsider adverse credential decisions should be sent to:

Wellcare With Superior HealthPlan
Attn: Credentialing Department
5900 E. Ben White Blvd.
Austin, TX 78741
credentialing@superiorhealthplan.com

Site Inspection Evaluation

Site Inspection Evaluations (SIEs) are conducted in accordance with Federal, State and accreditation requirements. Focusing on quality, safety and accessibility, performance standards and thresholds were established for:

- Office site criteria
- Physical accessibility

- Physical appearance
- Adequacy of waiting room and examination room space
- Medical/treatment record-keeping criteria

SIEs are conducted for:

- Unaccredited facilities
- Initial credentialing requirements
- Recredentialing requirements
- When complaint is received relative to office site criteria

SIEs are conducted for those sites where a Member complaint is received relative to office site criteria listed above. SIEs may be performed for an individual complaint or quality of care concern if the severity of the issue is determined to warrant an onsite review.

Allied Health Professionals

Allied Health Professionals (AHPs), both dependent and independent, are credentialed by Wellcare With Superior HealthPlan. AHPs include, but are not limited to the following:

- Nurse Providers
- Certified nurse midwives
- Physician assistants
- Osteopathic assistants
- Social workers
- Physical therapists
- Occupational therapists
- Audiologists
- Behavioral health Providers

Ancillary Healthcare Delivery Organizations

Ancillary and organizational applicants must complete an application and, as applicable, undergo an SIE if unaccredited. Wellcare With Superior HealthPlan is required to verify accreditation, licensure, Medicare certification (as applicable), regulatory status and liability insurance coverage prior to accepting the applicant as a Wellcare With Superior HealthPlan participating Provider.

Office of Inspector General Medicare/Medicaid Sanctions Report

On a monthly basis, Wellcare With Superior HealthPlan or its designee accesses the listings from the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) report of exclusions and reinstatements, for the most current available information. This information is cross-checked against Wellcare With Superior HealthPlan's network of Providers. If participating Providers are identified as being currently excluded, such Providers are subject to immediate termination, in accordance with Wellcare With Superior HealthPlan policies and procedures and the Agreement.

Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials

On a monthly basis, Wellcare With Superior HealthPlan, or its designee, contacts State licensure agencies to obtain the most current available information on sanctioned Providers. This information is cross-checked against the network of Wellcare With Superior HealthPlan Providers. If a participating Provider is identified as being currently under sanction, appropriate action is taken in accordance with Wellcare With Superior HealthPlan policy and procedure. If the sanction imposed is revocation of license, the Provider is subject to immediate termination. Notifications of termination are given in accordance with contract and Wellcare With Superior HealthPlan policies and procedures.

If a sanction imposes a reprimand or probation, written communication is made to the Provider requesting a full explanation, which is then reviewed by the Credentialing Peer Review Committee. The committee makes a determination as to whether the Provider should continue participation or whether termination should be initiated.

Delegated Entities

All participating Providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a monthly/quarterly basis, and formal audits are conducted annually. Please refer to *Section 20: Delegated Entities* of this manual for further details.

PRIMARY CARE/MANAGED CARE PROGRAM

Wellcare With Superior HealthPlan utilizes a Primary Care Provider (PCP) Member-Centered Medical Home system. In this system, the PCP is responsible for the comprehensive management of each Member's health care. This may include, but is not limited to, ensuring that all medically necessary care is made available and delivered, facilitating the continuity of Member health care, promoting, and delivering the highest quality health care per Wellcare With Superior HealthPlan standards.

Wellcare With Superior HealthPlan Providers are responsible for knowing and complying with all Wellcare With Superior HealthPlan network policies and procedures. Implementation of Wellcare With Superior HealthPlan policies will facilitate the Plan's periodic reporting of HMO data to HHS, the State and the Federal agencies.

Primary Care Provider (PCP) Roles and Responsibilities

Each Wellcare With Superior HealthPlan Member selects a PCP who is responsible for coordinating the Member's total healthcare. All Providers must offer hours of operation that are no less than the hours of

operation offered to commercial Members or comparable to Medicaid Fee-For Service (FFS), if the Provider serves only Medicaid Members.

Female Members will have direct access to women's health specialists to provide women's routine and preventative health care services. This is in addition to the Member's designated source of primary care if that source is not a women's health specialist.

Members also have direct access to self-referral services, including family planning, vision, dental, hearing, and behavioral health.

Except for required direct access benefits or self-referral services, all covered health services are either delivered by the PCP or are referred/approved by the PCP and/or Wellcare With Superior HealthPlan.

PCPs coordinate, monitor and supervise the delivery of primary care services to each Member by doing the following:

- See Members for an initial office visit and assessment within the first 90 days of enrollment in a FIDE SNP plan.
- Ensure Members are aware of the availability of public transportation where applicable.
- Provide access to Wellcare With Superior HealthPlan or its designee to examine thoroughly the primary care offices, books, records and operations of the PCP and any organization that (a) owns or controls the PCP's operation; or (b) has a financial relationship with the PCP or renders services to the PCP's office.
- Submit an encounter to Wellcare With Superior HealthPlan for each visit in which the Provider sees the Member and the Member receives a Healthcare Effectiveness Data and Information Set (HEDIS®) service. For more information on encounters, refer to *Section 12: Billing and Claims* in this manual.
- Ensure Members are referred to participating Providers. For assistance locating a Wellcare With Superior HealthPlan-participating Provider for services required, PCPs should contact Member Services at 1-855-445-3556.
- Implement corrective action and performance improvement plan(s) as required by Wellcare With Superior HealthPlan.

Assignment of Primary Care Provider

Most Members will choose a PCP or will have one assigned to them by Wellcare With Superior HealthPlan.

Resource Access

PCPs participating in Wellcare With Superior HealthPlan's Provider network have access to the following resources:

- Support of Wellcare With Superior HealthPlan's Provider Representatives, Provider Services, and Clinical Services.
- The tools and resources at SuperiorHealthPlan.com/Wellcare.
- Information on Wellcare With Superior HealthPlan-participating Providers for the purposes of referral management and discharge planning.

Annual Wellness Visit

An annual wellness visit should be completed to assess the health status of all Wellcare With Superior HealthPlan Members. The adult Member should receive an appropriate assessment and intervention as indicated or upon request. Please refer to the adult preventive health guidelines and the Member physical screening tool, both located at SuperiorHealthPlan.com/Wellcare.

Telephone Arrangements

PCPs must provide or arrange for coverage of services, consultation, or approval for referrals 24 hours per day, seven days per week. To ensure access and availability, PCPs must provide one of the following after-hours services:

- A 24-hour answering service that connects the Member to someone who can render a clinical decision or reach the PCP
- Answering system with option to page the provider for a return call within a maximum of 30 minutes
- A medical professional who will answer after-hours calls and provide the Member with access to the PCP or on-call provider within a maximum of 30 minutes

Covering Providers

PCPs in solo practice must have a covering Provider who also participates with or is credentialed with Wellcare With Superior HealthPlan. If a PCP's covering Provider is temporarily unavailable, the PCP should make arrangements with another Provider who participates in Wellcare With Superior HealthPlan's FIDE SNP program. In the event of an emergency, Members may seek care from any Provider, regardless of whether the Provider is contracted with Wellcare With Superior HealthPlan.

In non-emergency cases, Providers should contact Wellcare With Superior HealthPlan for approval of any covering Provider who is not contracted with Wellcare With Superior HealthPlan or has not been credentialed by Wellcare With Superior HealthPlan. For more information, refer to the *Quick Reference Guide* at SuperiorHealthPlan.com/Wellcare.

Provider Panels

All Providers have the right to regulate the number of Members they are willing to accept into their practice. Since assignment is based on the Member's choice, Superior does not guarantee that any Provider will receive a set number of Members.

If a Provider declares a specific capacity for their Superior patient panel size and wants to make a change to that capacity, the Provider must:

- Contact Superior's Provider Representatives; and
- Provide notification of the change on or before the 15th of the month for the change to become effective on the first Day of the following month. If the change is requested after the 15th of the month, the change will become effective the first Day of the second month following the request.

When an existing Provider, with an assigned panel, terminates from a group, the group may request in writing to have the patient panel transferred to a participating Provider within the group. This request should be sent

to a Provider Representative. Call Provider Services at **1-855-445-3572** for your Provider Representative contact information or visit Find My Rep.

PCPs are able to access their Panel Reports on Superior's Secure Provider Portal at Provider.SuperiorHealthPlan.com.

Under no circumstance can a Provider take retaliatory action against a Member due to disenrollment from the Provider's panel.

Closing of Provider Panel

When requesting closure of their panel to new Members and/or transferring Wellcare With Superior HealthPlan Members, PCPs must:

- Submit the request in writing at least 60 days (or such other period of time provided in the Agreement) prior to the effective date of closing the panel.
- Keep the panel open for Wellcare With Superior HealthPlan Members who were provided services before the closing of the panel.
- Notify Wellcare With Superior HealthPlan when reopening the panel and provide the effective date.
- Requests may be submitted by contacting your Provider Representative at Find My Rep.

Specialty Care Provider Roles and Responsibilities

Wellcare With Superior HealthPlan recognizes that the specialty Provider is a valuable team Member in delivering care to Wellcare With Superior HealthPlan Members. Key specialty Provider roles and responsibilities include, but are not limited to:

- Rendering services requested by the PCP by referral
- Communicating with the PCP regarding the findings in writing
- Obtaining prior authorization from the PCP and plan before rendering any additional services not specified on the original referral form
- Confirming Member eligibility and benefit level prior to rendering services
- Providing the consultation report to the PCP within 60 days of the consultation date
- Providing the lab or radiology Provider with:
- The PCP and/or corporate prior authorization number
- The Member's ID number

INPATENT NOTIFICATION REQUIREMENTS

Providers, including Facilities, must notify Wellcare With Superior HealthPlan of all emergent admissions no later than the close of the next Business Day. Prior authorization is not required for emergency services, urgent care services and post-stabilization services. All non-emergency, elective inpatient admissions require a prior authorization. Emergent inpatient admissions to any level of acute or sub-acute care, skilled nursing facilities, rehabilitation admission, Behavioral Health and all other inpatient facility type require notification. Phone notifications for inpatient admissions may be completed by contacting Provider Services at **1-855-445-3572**.

Failure to notify an emergent inpatient admission by the next Business Day will result in a late notification denial, unless otherwise stated within a contract with Wellcare With Superior HealthPlan. Once the timely request for authorization is received, the request is screened for eligibility and benefit coverage and an authorization number is provided to the hospital by Wellcare With Superior HealthPlan. Clinical documentation will be obtained through a request to the hospital Care Management department or Utilization Review department.

Wellcare With Superior HealthPlan must make a determination by the close of the next business day following the date of request for authorization. In order to meet State requirements, a receipt is required for the clinical documentation on the day following the request for authorization unless otherwise stated within a contract with Wellcare With Superior HealthPlan. The utilization management clinician will review the clinical documentation to determine medical necessity and appropriateness of services, including setting of care, are met according to InterQual® criteria for medical and behavioral health admissions and 28 T.A.C. §3.8001 for substance use disorders. If medical necessity is not met through InterQual® criteria, clinical policy or 28 T.A.C. §3.8001, a secondary review is completed by a Medical Director (or appointed provider) to make a final determination. A reasonable opportunity for peer-to-peer discussion is offered to the requesting Provider prior to an adverse determination decision.

If approved, a letter will be faxed to the hospital, with approved days and the date of the next review. If denied, a letter is sent to the Provider with instructions regarding the appeal process.

Hospital Roles and Responsibilities

Wellcare With Superior HealthPlan recognizes that the hospital is a valuable team Member in delivering care to Wellcare With Superior HealthPlan Members. Essential hospital responsibilities include, but are not limited to:

- Coordination of discharge planning with Wellcare With Superior HealthPlan Utilization Management staff.
- Coordination of mental health/substance abuse care with the appropriate state agency or Provider.
- Obtaining the required prior authorization from the plan before rendering services.
- Communication of all pertinent patient information to Wellcare With Superior HealthPlan and to the PCP.
- Communication of all hospital admissions to the Wellcare With Superior HealthPlan Utilization Management staff within one business day of admission.
- Issuing all appropriate service denial letters to identified Members.

Ancillary/Organization Provider Roles and Responsibilities

Wellcare With Superior HealthPlan recognizes that the ancillary Provider is another valuable team Member in delivering care to Wellcare With Superior HealthPlan Members. Critical ancillary Provider responsibilities include, but are not limited to:

- Confirming Member eligibility and benefit level before rendering services.

- Being aware of any limitations, exceptions, and/or benefit extensions applicable to Wellcare With Superior HealthPlan Members.
- Obtaining the required prior authorization from the plan before rendering services.
- Communication of all pertinent patient information to Wellcare With Superior HealthPlan and to the PCP.

LTSS PROVIDER ROLES AND RESPONSIBILITIES

LTSS Providers must notify the Member's Service Coordinator whenever there is a change in the Member's physical or mental condition, upon knowledge of an inpatient or nursing facility admissions, all Member complaints or grievances, or if you identify a Member needs services outside the Wellcare With Superior HealthPlan contracted scope of services with the Provider.

In an effort to support our Members and LTSS Providers, contact the Member's Service Coordinator through the Member Services line at **1-855-445-3556** for any questions, concerns, or referrals.

Additionally, the LTSS Provider must notify Wellcare With Superior HealthPlan when services need to be suspended due to any of the following situations:

- The Member temporarily or permanently leaves the contracted service delivery area.
- The Member moves to a location where services cannot be provided under the PHC/PAS Program.
- The Member dies.
- The Member is admitted into any of the following institutions:
    - Hospital.
    - Nursing facility.
    - State school.
    - State hospital.
    - Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions.
    - Corrections facility.

Service Suspensions

In the event the Member's services are suspended the LTSS Provider must notify Wellcare With Superior HealthPlan as soon as they become aware of the need to suspend services but no later than the first Business Day after the Provider suspends services.

The notice must include:

- The date of service suspension.
- The reason(s) for the suspension.
- The duration of the suspension, if known.

Resuming Services After Suspension

An LTSS Provider must resume services after suspension on the earliest of the following:

- Upon the individual's return home, or the date the Provider becomes aware of the individual's return home, if applicable.
- On the date agreed to and specified in writing by Wellcare With Superior HealthPlan.
- The LTSS Provider must send confirmation that services have resumed no later than 7 days after the start date of the resumed services.

ACCESS A MEMBER'S SERVICE COORDINATOR

Service Coordinators provide Members with initial and ongoing assistance with identifying, selecting, obtaining, coordinating and using covered services and other supports to enhance the Member's well-being, independence, and integration in the community. Providers may access assigned Service Coordinator through Member Services by calling 1-855-445-3556.

RESPONSIBILITY OF ALL PROVIDERS

The following is a summary of responsibilities of all Providers who render services to Wellcare With Superior HealthPlan Members:

Advance Directives

Each Member (age 21 years or older and of sound mind) should receive information about Advance Directives. These directives allow the Member to designate another person to make medical decisions on the Member's behalf should the Member become incapacitated.

Information about Advance Directives should be made available in the Provider offices and discussed with the Members. Completed forms should be documented and filed in the Members' medical records.

Providers shall not, as a condition of treatment, require a Member to execute or waive an Advance Directive.

Members with Special Healthcare Needs

A Member with "special healthcare needs" is a Member who has one or more of the following conditions:

- Intellectual disability or related conditions.
- Serious chronic illnesses, such as Human Immunodeficiency Virus (HIV), schizophrenia, or degenerative neurological disorders.
- Disabilities resulting from chronic illness such as arthritis, emphysema or diabetes.
- Environmental risk factors such as homelessness or family problems that may lead to the need for placement in adult foster care.

Providers who render services to Members with special healthcare needs shall:

- Assess Members and develop plans of care for those Members determined to need courses of treatment or regular care.
- Coordinate treatment plans with Members, family and/or specialists caring for Members.

- Develop plans of care that adhere to community standards and any applicable sponsoring government agency quality assurance and utilization review standards.
- Allow Members needing courses of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as appropriate for the Members' conditions or needs.
- Coordinate with Wellcare With Superior HealthPlan, if appropriate, to ensure that each Member has an ongoing source of primary care appropriate to their needs, and a person or entity formally designated as primarily responsible for coordinating the healthcare services furnished.
- Coordinate services with other third-party organizations to prevent duplication of services and share results on identification and assessment of the Member's needs.
- Ensure the Member's privacy is protected as appropriate during the coordination process.

Updates to Provider Contact Information

Providers are required to give prior notice per the terms of their Agreement for any of the following changes. Please contact us at **1-855-445-3572** to report changes to any of the following:

- 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 status (open/closed)

Failure to notify Wellcare With Superior HealthPlan prior to these changes will result in a delay in claims processing and payment.

To maintain the integrity of Provider Directory data, Wellcare With Superior HealthPlan may rely on information independently verified by a third party and may take appropriate actions to remove inaccurate Provider data from the directory.

APPOINTMENT STANDARDS

All participating Providers are required to comply with Wellcare With Superior HealthPlan's standards for appointment availability and in-office wait times. These standards are established to ensure that Members receive timely access to medically necessary services based on the urgency of their clinical needs as specified by CMS, HHSC, and Texas Department of Insurance (TDI). "Day" is defined as "Calendar Day", and the standards are measured from the date of presentation or request, whichever occurs first.

Wellcare With Superior HealthPlan continuously monitors Provider adherence to these standards through various oversight mechanisms. Providers found to be out of compliance may be subject to corrective action plans, up to and including contract review.

Type of Appointment	Access Standard
Specialty Care	
Routine specialty care (e.g., vision, hearing)	Within 6 weeks of request
Acute specialty care (e.g., vision, hearing)	Within 5 business days of request
Dental Services	
Emergency dental services	Available immediately, 24 hours/day, 7 days/week
Urgent dental care	Within 48 hours
Routine dental care	Within 21 business days of request
Preventive dental services	Within 6 weeks of request
Initial dental appointment	Within 8 weeks of request
Durable Medical Equipment (DME)	
Adaptive/enhanced DME and supplies	Within 21 calendar days (large metro, metro, micro areas) Within 28 calendar days (rural/extreme access areas)
Assistive Technology Devices	Within 21 calendar days (large metro, metro, micro areas) Within 28 calendar days (rural/extreme access areas)
Home and Community-Based Services (HCBS)	
Chore services	Within 14 calendar days (large metro, metro, micro areas) Within 21 calendar days (rural/extreme access areas)
Community living supports	Within 7 calendar days (large metro, metro, micro areas)

Type of Appointment	Access Standard
	Within 14 calendar days (rural/extreme access areas)
Home-delivered meals	Within 14 calendar days (large metro, metro, micro areas) Within 21 calendar days (rural/extreme access areas)
Personal care services (non-waiver)	Within 7 calendar days (large metro, metro, micro areas) Within 14 calendar days (rural/extreme access areas)
Personal emergency response systems	Within 30 calendar days (all geographic areas)
Preventive nursing services (agency and non-agency)	Within 7 calendar days (large metro, metro, micro areas) Within 14 calendar days (rural/extreme access areas)
Private duty nursing services (agency and non-agency)	Within 7 calendar days (large metro, metro, micro areas) Within 14 calendar days (rural/extreme access areas)
Respite services	Within 7 calendar days (large metro, metro, micro areas) Within 14 calendar days (rural/extreme access areas)
Respite services – non-waiver (in-home)	Within 7 calendar days (large metro, metro, micro areas) Within 14 calendar days (rural/extreme access areas)
Vehicle modifications	Within 90 calendar days (large metro, metro, micro areas)

Type of Appointment	Access Standard
	Within 120 calendar days (rural/extreme access areas)
Non-Emergency Medical Transportation (NEMT)	
Regularly scheduled services	48–72 hours advance notice required
Urgent services	Same-day or next-day availability
NEMT wait and transport times	- Pickup must not occur more than 15 minutes after scheduled time - Drivers must wait 15 minutes before leaving - Members must not arrive >1 hour early - Drop-off must not occur before the facility opens unless requested - Pickup after appointment must occur within 1 hour of notice if there is no prearranged time - Pickup must not occur >15 minutes after facility closes unless requested

Verifying Member Benefits, Eligibility and Cost-Shares

A Member's eligibility status may change at any time. Therefore, all Providers should verify eligibility, benefits, and cost-sharing prior to each scheduled appointment. Providers should also request Members to present their ID card, along with additional proof of identification such as a photo ID (if applicable), at each encounter. If there are any discrepancies between the Member's ID card and/or the Provider's eligibility report, Providers should contact Provider Services at **1-855-445-3572**.

Providers may do one of the following to verify eligibility:

- Access the Secure Provider Portal at Provider.SuperiorHealthPlan.com.
- Access Wellcare With Superior HealthPlan's Interactive Voice Response (IVR) system.
- Contact Wellcare With Superior HealthPlan's Provider Services Department.

Providers will need their Provider ID number to access Member eligibility through the avenues listed above. Verification is always based on the data available at the time of the request. Since subsequent changes in eligibility may not yet be available, verification of eligibility is not a guarantee of coverage or payment. See the Agreement for additional details.

CONFIDENTIALITY AND ACCURACY OF MEMBER RECORDS

Medical records and other health and enrollment information of a Member must be managed under established procedures that:

- Safeguard the privacy of any information that identifies a particular Member.
- Respect Member rights to access, amend errors in, request confidentiality for, or an accounting of disclosures of the Member's health information.
- Identify when and to whom Member information may be disclosed.
- Safeguard the privacy of any information that identifies a particular Member.
- Secure information through robust controls designed to maintain the confidentiality, integrity, and availability of medical records and to protect against threats or hazards to the security or integrity of such information and any uses or disclosures of such information that could violate the law.
- Maintain such records and information in a manner that is accurate and timely, ensure timely access by Members to the records and information that pertain to them for what purpose(s) the information will be used within the organization, and identify when and to whom Member information may be disclosed.

In addition to the obligation to safeguard the privacy and security of any information that identifies a particular Member, the Plan and all participating Providers are each obligated to abide by all federal and state laws regarding confidentiality and disclosure for mental health records, medical health records and Member information. First tier and downstream Providers must comply with Medicare laws, regulations, and CMS instructions (422.504(i)(4)(v)) and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, within requested time frames, and maintain records a minimum of 10 years.

OBLIGATIONS OF RECIPIENTS OF FEDERAL FUNDS

Providers participating in Wellcare With Superior HealthPlan are paid for their services with federal funds and must comply with all requirements of laws applicable to recipients of federal funds, including but not limited to Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, the False Claims Act, the Anti-Kickback Statute, and HIPAA laws.

At minimum, Wellcare With Superior HealthPlan can check the HHS health professions website monthly for excluded Providers. At minimum, Wellcare With Superior HealthPlan can check the OIG List of Excluded Individual Entities (LEIE), Medicare Exclusion Database (MED), and the System for Awards Management (SAM) [the successor to the Excluded Parties List System (EPLS)] for its Providers at least monthly, before contracting with the Provider, and at the time of a Provider's credentialing and recredentialing. If a Provider is terminated or suspended from the HHS Medicaid Program, Medicare, or another state's Medicaid program, or is the subject of a state or federal licensing action, the Integrated Community Organizations (ICO) shall terminate, suspend, or decline a Provider from its Provider Network as appropriate.

Upon notice from HHS or CMS, Wellcare With Superior HealthPlan cannot authorize any Providers who are terminated or suspended from participation in the Texas Medicaid Program, Medicare, or from another state's Medicaid program, to treat Members and shall deny payment to such Providers for services provided.

Wellcare With Superior HealthPlan must notify CMS and HHS on a quarterly basis when a Provider fails credentialing or recredentialing because of a program integrity reason, or Adverse Action reason, or, an Adverse Benefit Determination reason, and shall provide related and relevant information to CMS and HHS as required by CMS, HHS, or state or federal laws, rules, or regulations.

Wellcare With Superior HealthPlan is prohibited from issuing payment to a Provider or entity that appears in the List of Excluded Individuals/Entities as published by the Department of Health and Human Services Office of the Inspector General or in the List of Debarred Wellcare With Superior HealthPlan as published by the General Services Administration (with the possible exception of payment for emergency services under certain circumstances).

- The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities can be found at http://exclusions.oig.hhs.gov.
- The General Services Administration List of Debarred Wellcare With Superior HealthPlan Providers can be found at www.sam.gov.
- Preclusion List information can be found at CMS Preclusion List

OSHA TRAINING

Employee training and annual in-service education must include:

- Universal precautions
- Proper handling of blood spills
- HBV and HIV transmission and prevention protocol
- Needle stick exposure and management protocol
- Bloodborne pathogen training
- Sharps handling
- Proper disposal of contaminated materials
- Information concerning each employee's at-risk status

At-risk employees must be offered the Hepatitis B vaccination free of charge. Each employee file of an at-risk employee must contain informed consent or informed refusals for Hepatitis B vaccines. Personal protective equipment must be provided to each at-risk employee.

Necessary equipment must be provided for the administration of mouth-to-mouth resuscitation.

Documents to be posted in the facility are:

- Pharmacy Drug Control license issued by the State of Texas if dispensing drugs other than samples
- Section 17757a from the Board of Pharmacy (if dispensing drugs other than samples)

- Controlled Substances License from State of Texas and the Federal DEA
- CLIA certificate or waiver
- Medical Waste Management certificate
- X-ray equipment registration
- R-H 100 notice
- Radiology protection rules

DOMESTIC VIOLENCE AND SUBSTANCE ABUSE SCREENING

Providers are expected to stay current with domestic violence and substance abuse training, as well as follow state laws in regard to serving as mandatory reporters. For adult Members where domestic violence is suspected, or stated by the patient, Providers are expected to provide education and community resources to the patient. In addition, if the adult patient gives consent for law enforcement involvement, the Provider should contact law enforcement officials.

Resources related to substance abuse can be located at SuperiorHealthPlan.com/Wellcare.

SMOKING CESSATION

Providers should direct Members who wish to quit smoking to call Wellcare With Superior HealthPlan's Member Service Department at 1-855-445-3556 and ask to be directed to the Service Coordination Department. A Service Coordinator will educate the Member on national and community resources that offer assistance, as well as smoking-cessation options available to the Member through Wellcare With Superior HealthPlan.

TERMINATION OF A MEMBER

A Provider may not seek or request to terminate his or her relationship with a Member or transfer a Member to another Provider of care based on the Member's medical condition, amount or variety of care required or the cost of covered services required by the Member.

Reasonable efforts should always be made to establish a satisfactory Provider and Member relationship in accordance with practice standards. If a Provider desires to terminate his or her relationship with a Member, the Provider must complete a PCP Request for Transfer of Member form at SuperiorHealthPlan.com/Wellcare and attach documentation of the Member's non-compliance with treatment or uncooperative behavior that is impairing the ability to care for and treat the Member effectively. The form should be faxed or emailed to Wellcare With Superior HealthPlan's Provider Services Department. The Request for transfer of Member form is at SuperiorHealthPlan.com/Wellcare.

Once the form has been submitted, the Provider shall continue to provide medical care for the Member until such time that written notification is received from Wellcare With Superior HealthPlan confirming that the Member has been successfully transferred to another Provider.

PROVIDER TERMINATION

If a Provider decides to leave the Wellcare With Superior HealthPlan network, they must notify Wellcare With Superior HealthPlan within 90 days (180 days, if Provider is a hospital) before terminating your relationship with Wellcare With Superior HealthPlan, unless otherwise agreed to in writing or within your Provider Agreement. This ensures adequate notice may be given to Wellcare With Superior HealthPlan Members regarding Provider's participation status.

All termination requests must be received in writing and include the Provider's Tax Identification Number (TIN), National Provider Identifier (NPI), termination date and reason for the termination. The form is available online: Provider Termination Form.

Please refer to *Section 4: Network and Credentialing* of this manual for specific guidelines regarding rights to appeal a plan termination (if any).

Wellcare With Superior HealthPlan will notify in writing all appropriate agencies and/or Members prior to the termination effective date of a participating PCP, hospital, specialist or significant ancillary Provider within the service area, as required by Medicare and Medicaid program requirements and/or regulations and statutes.

SECTION 4: UTILIZATION MANAGEMENT

The objective of Wellcare With Superior HealthPlan's Utilization Management program is to ensure that the medical services provided to Members are medically necessary and/or appropriate and are in conformance with the health plan benefits. To guide the decision-making process, UM applies systematic evaluations to appropriate medical necessity criteria and considers circumstances unique to the Member.

Access to the Utilization Management Staff

For Utilization Management inquiries, you may call during normal business hours Monday-Friday, 8 a.m. to 5 p.m. at 1-855-445-3572. The Provider Portal is available 24/7 for status on authorization requests and to submit new requests.

UM DECISIONS

Utilization decisions are based on appropriate care and service, as well as the Member's eligibility. Wellcare With Superior HealthPlan does not specifically reward our Providers, associates, consultants, or other individuals for any denials of coverage or care issued, nor do we use incentives to encourage denial of care or service.

Utilization Management clinical staff uses Plan documents for benefit determination and Medical Necessity Coverage Guidelines to support Utilization Management decision-making. All utilization review decisions to deny coverage are made by Wellcare With Superior HealthPlan's medical directors. In certain circumstances, external review of service requests is conducted by qualified, licensed Providers with the appropriate clinical expertise.

Providers should refer directly to coverage policies for information on coverage policies and determinations. The two most common types of coverage policies are National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

National Coverage Determinations (NCDs) and The Centers for Medicare and Medicaid Services (CMS) explain NCDs through program manuals, which are located on the CMS website under Regulations & Guidance/Guidance/Manuals.

Local Coverage Determinations (LCDs) provide guidance to the public and Provider community within a specific geographical area. LCDs supplement a NCD or explain when an item or service will be considered covered if there is no NCD. An LCD cannot contradict a NCD.

If NCDs, LCDs, or other official guidance are unavailable, Wellcare With Superior HealthPlan will base decisions on current clinical literature, InterQual® criteria, and consultation with qualified providers and medical experts. The plan also considers government agency policies, nationally recognized accreditation standards, and internal Medical Management guidelines. When appropriate, Wellcare With Superior HealthPlan may adopt coverage policies from other managed care organizations within the service area to ensure consistency and best practices.

Wellcare With Superior HealthPlan 's Medical Necessity Guidelines are based on current literature review, consultation with practicing Providers and medical experts in their particular field, government agency policies, and standards adopted by national accreditation organizations. It is the responsibility of the attending Provider to make all clinical decisions regarding medical treatment. These decisions should be made consistently with accepted principles of professional medical practice and in consultation with the Member.

Copies of the criteria utilized in decision-making are available free of charge upon request by calling the Utilization Management department at 1-855-445-3572. In certain circumstances, an external review of service requests is conducted by qualified, licensed Providers with the appropriate clinical expertise.

Utilization Management decisions determine the medical necessity of a service and are not a guarantee of payment. Claims payment is determined by the Member's eligibility and benefits at the time the services are rendered.

Previously approved prior authorizations can be updated for changes in dates of service, CPT/HCPCS codes, or provider within 30 days of the original date of service prior to claim denial.

CARE MANAGEMENT PROGRAM

Wellcare With Superior HealthPlan offers comprehensive Care Management services to facilitate Member assessment, planning, education and advocacy, to improve health outcomes for Members with physical, behavioral and/or social determinant of health issues, which may include inadequate access to care, and resources needed to optimize their health. Providers must help coordinate the placement and cost-effective treatment of Members who are eligible for Wellcare With Superior HealthPlan's Care Management Programs.

Wellcare With Superior HealthPlan's Care Management is both comprehensive and Member-centric, dedicated to providing coordination and support services for acute and preventive care; it may or may not lower the cost of care. Care Management is a multi-disciplinary program designed to respond to the needs of Wellcare With Superior HealthPlan Members across the continuum of care.

Disease Management (DM) and Behavioral Health (BH) Management are embedded in the Care Management Program. The program provides Members and/or their caregivers with education, guidance, support and health coaching in an integrated, whole health approach. Members are encouraged to make behavioral changes, which can improve health outcomes, and quality of life, as well as reduce chronic disease progression. The goals and objectives of the behavioral health activities are congruent with the health model and incorporated into the overall Care Management model program description. Case review conferences with Service Coordinators and Medical Directors from both behavioral health and physical health occur on an as needed basis.

Program components include providing coordination through episodic Care Management, including management across transitions that include timely follow-up post hospitalization, emergency department (ED) visits and stays in other institutional settings, symptom and disease management, medication reconciliation and management, and support for exacerbations of chronic illness. For social determinants of health, Members may receive referrals for community and other resources.

Wellcare With Superior HealthPlan's Care Management team is an integrated multidisciplinary team of clinical and nonclinical specialists including, but not limited to, Service Coordinators and support staff. The Service Coordinators assesses the Member's risk factors, develops an individualized care plan, establishes health goals, monitors outcomes, and evaluates the outcome for possible revisions of the care plan. The Service Coordinators work collaboratively with PCPs and other specialists to coordinate care for the Member and expedite access to care and needed services.

Wellcare With Superior HealthPlan's Service Coordinators also serve in a support capacity to the PCP and assist in actively linking the Member to Providers, medical services, residential, social and other support services, as needed. Providers may request Care Management services for any Member.

The Care Management process begins with Member identification and follows the Member until discharge from the program. Members may be identified for Care Management in various ways, including:

- A referral from a Member's PCP.
- Member self-referral.
- Referral from a family member.
- Referral from Wellcare With Superior HealthPlan's internal departments.
- After completing a Health Risk Assessment (HRA).
- Data mining for Members with high utilization.

Wellcare With Superior HealthPlan's philosophy is that the Care Management Program is an integral management tool in providing a continuum of care for Members. Key elements of the Care Management process include:

- Clinical Assessment and Evaluation – A comprehensive assessment of the Member is completed to determine where they are in the health continuum. This assessment gauges the Member's support systems and resources and seeks to align them with appropriate clinical needs.
- Care Planning – Collaboration with the Member and/or caregiver as well as the PCP/Specialist to identify the best ways to fill any identified gaps or barriers to improve access and adherence to the Provider's plan of care. Individual Care Plans (ICPs) are shared with the Member and PCP, and other Members of the care team in accordance with the Model of Care. As a general rule of thumb, Providers can also find their Member's ICP on the Secure Provider Portal.
- Service Facilitation and Coordination – Working with community resources to facilitate Member adherence with the plan of care. Activities may be as simple as reviewing the plan with the Member and/or caregiver or as complex as arranging services, transportation and follow-up.
- Member Advocacy – Advocating on behalf of the Member within the complex labyrinth of the healthcare system. Service Coordinators assist Members with seeking the services to optimize their health. Care Management emphasizes continuity of care for Members through the coordination of care among providers.

Wellcare With Superior HealthPlan uses Member data to stratify and prioritize Care Management outreach. Based on the stratification, Members are identified as having low, moderate, or high risk. The Service

Coordinator assignment process takes into account the risk level and scoring model that was used to assess the Member's score.

Members commonly identified for Wellcare With Superior HealthPlan's Care Management Program may include:

- **Catastrophic Injuries** – Such as head injury, near drowning, burns.
- **Multiple Chronic Conditions** – Multiple comorbidities such as diabetes, chronic obstructive pulmonary disease (COPD), and hypertension, or multiple barriers to quality healthcare (for example, Acquired Immune Deficiency Syndrome [AIDS]).
- **Transplantation** – Organ failure, donor matching, post-transplant follow-up.
- **Complex Discharge Needs** – Members discharged home from acute inpatient or SNFs with multiple service and coordination needs (for example, DME, PT/OT, home health) complicated, non-healing wounds, advanced illness, etc.

Wellcare With Superior HealthPlan staff may work closely with the Provider regarding when to discharge the Member from the Care Management Program, based on the Member's needs. A Member may be discharged from the Care Management Program if they:

- Are meeting primary care plan goals,
- Declined additional Care Management services,
- Disenrolled from Wellcare With Superior HealthPlan, or
- Are unable to be contacted by Wellcare With Superior HealthPlan.

Access to Care Management Programs

Wellcare With Superior HealthPlan's Transition Needs Assessment (TNA) Program assists new Members in their transition from Medicare or another Managed Care Organization (MCO) to Wellcare With Superior HealthPlan. The program involves outreach to these Members prior to their effective date and within the first 30 days of their enrollment.

During this outreach, Members are gauged for their healthcare needs including, but not limited to:

- Their primary and specialist Providers,
- Current prescriptions,
- DME, and
- Home health services.

Members are also screened for eligibility for Wellcare With Superior HealthPlan's Care Management and Disease Management programs, and any additional behavioral healthcare needs.

If a Provider would like to refer an established Member as a potential candidate to Wellcare With Superior HealthPlan's Care Management programs or would like more information, you may contact Provider Services at **1-855-445-3572**. For more information on the Service Coordination, refer to the *Quick Reference Guide* at SuperiorHealthPlan.com/Wellcare.

Classifying Your Prior Authorization Request

Standard Organization Determination (Non-urgent Preservice Request): Standard organization determinations are made as expeditiously as the Member's health condition requires, but no later than 7 calendar days after Wellcare With Superior HealthPlan receives the request for service.

Expedited Organization Determination (Urgent/Expedited Preservice Request): Expedited organization determinations are service requests made when the Member or the Provider believes that waiting for a decision under the standard timeframe could place the Member's life, health, or ability to regain maximum function in serious jeopardy. The determination will be made as expeditiously as the Member's health condition requires, but no later than 72 hours After receiving the Member's or Provider's request. An extension may be granted for an additional 14 calendar days if the Member requests an extension or if Wellcare With Superior HealthPlan justifies a need for additional information and documents how the delay is in the interest of the Member.

Requests for expedited review will require Provider attestation confirming the clinical urgency of the request.

Inpatient Review

Our nurse reviewers are assigned to follow Members at specific acute care facilities to promote collaboration with the facility's review staff and management of the Member across the continuum of care. Wellcare With Superior HealthPlan's nurse reviewers assess the care and services provided in an inpatient setting and the Member's response to the care by applying InterQual® criteria. Together, with the facility's staff, Utilization Management's clinical staff coordinates the Member's discharge needs.

Wellcare With Superior HealthPlan's nurse reviewers' interface with the hospital/facility discharge planners to:

- Obtain the Member's discharge planning needs.
- Identify the Members' discharge planning needs.
- Facilitate the transition of the Member from one level of care to another level of care.
- Obtain clinical information and facilitates the authorization of post discharge services, such as DME, home health services, and outpatient services.

Providers must notify Wellcare With Superior HealthPlan within one business day of admission.

Prior Approval Requirements/ Precertification

Wellcare With Superior HealthPlan offers multiple methods to submit authorization requests. For the most efficient and timely service—use of Wellcare With Superior HealthPlan 's Online Prior Authorization (PA) Form is the preferred method of submitting requests.

1. **Online Submission:** The Wellcare With Superior HealthPlan Online PA Form can be accessed by visiting the secure Provider Portal
2. **Fax Submission**: Refer to Utilization Management's referral type fax numbers. Please include pertinent clinical documentation with the request if indicated

3. **Phone Submission**: Many authorizations cannot be processed via phone, as clinical review and supporting documentation are required. Requests should only be submitted via the phone for services related to pending hospital discharges or expedited pre-certification requests.

Wellcare With Superior HealthPlan	
Type of Request	Fax Number
Inpatient Admissions	1-855-857-2251
Post-Acute Admissions	1-844-409-5557
Pre-Service Standard Requests	1-844-409-5557
Pre-Service Expedited Requests (Phone)	1-855-581-2251
Part B	1-844-235-5090
Part D (prescription drugs)	1-866-226-1093
Behavioral Health Inpatient Admissions*	1-866-535-6974
Behavioral Health Outpatient Services*	1-855-772-7079

When submitting a Prior Authorization request, please include the following information:

- Member's name and date of birth
- Member's identification number
- Requesting Provider & NPI Number
- Servicing Provider & NPI Number
- Servicing Facility & NPI Number
- Place of Service
- Date(s) of service
- Procedure Code(s)
- ICD-10 Diagnosis Code(s)

Decision Timeframes – Prior Authorizations			
Review Type	Make Decision	Written/Verbal Notification	Written Notification (Denials)
Pre-Service Non-urgent	Within 7 days of receipt of the request	Within 7 days of receipt of the request	Within 7 days of receipt of the request
Pre-Service Urgent	Within 72 hours of receipt of the request	Within 72 hours of receipt of the request	Within 72 hours of receipt of the request
Urgent Concurrent	Within 24 hours of receipt of the request, 72 hours if clinical is not	Within 24 hours of receipt of the request, 72 hours if clinical is not included with initial request	Within 72 hours of the decision

Decision Timeframes – Prior Authorizations			
Review Type	Make Decision	Written/Verbal Notification	Written Notification (Denials)
	included with initial request		

CMS INTEROPERABILITY APIS — PROVIDER OVERVIEW

In support of federal CMS interoperability requirements, Wellcare With Superior HealthPlan offers a set of standardized application programming interfaces (APIs) that support improved data sharing between providers, health plans, and members. Two of these - the **Prior Authorization API** and the **Provider Access API** - are designed specifically to reduce administrative burden, streamline clinical workflows, and strengthen care coordination through the secure, electronic exchange of information within participating EHR/EMR systems.

Prior Authorization API

Providers whose EHR/EMR vendor has connected to the Prior Authorization API may be able to check authorization requirements, identify required documentation, submit prior authorization requests, and receive status updates and decisions electronically within their existing clinical workflow. These capabilities bring greater transparency to the process and support more efficient prior authorization processing for medical items and services.

Provider Access API

Providers whose EHR/EMR vendor has connected to the Provider Access API may be able to retrieve eligible patient claims, clinical, and prior authorization information to support treatment and care coordination. Access is generally limited to providers with an active treatment relationship and remains subject to applicable member consent and privacy requirements.

Additional Interoperability APIs

CMS interoperability requirements also include the **Patient Access API**, which allows members to share their health information with third-party applications; the **Payer-to-Payer API**, which supports electronic data exchange when members change plans or are covered by more than one health plan; and the **Provider Directory API**, which makes provider directory information available to third-party applications.

For detailed educational materials, implementation guidance, a list of connected EHR/EMR vendors, and frequently asked questions, providers are encouraged to visit the wellcare.superiorhealthplan.com.

CONCURRENT REVIEW

Wellcare With Superior HealthPlan facilitates the oversight and evaluation of Members when admitted to hospitals, rehabilitation centers and skilled nursing facilities (SNF). This oversight includes reviewing continued acute care stays to promote appropriate utilization of healthcare resources and to promote quality outcomes for Members.

Wellcare With Superior HealthPlan provides oversight when Members receive acute care services in facilities mentioned above to determine the initial/ongoing Medical Necessity, the appropriate level of care and the appropriate length of stay, and the ability to facilitate a timely discharge.

Concurrent review is initiated after Wellcare With Superior HealthPlan is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the Member, complexity, treatment plan and discharge planning activity. The continued length of stay will be reviewed in accordance with appropriate Medical Necessity criteria in order to:

- Promote the delivery of services in a timely and efficient manner.
- Promote meeting established standards of quality care.
- Implement timely and efficient transfer to a lower level of care when clinically indicated and appropriate.
- Complete timely and effective discharge planning.
- Identify referrals appropriate for DM or quality-of-care review.
- Identify cases appropriate for follow up by the CM/service coordinator.
- Concurrent review decisions are made using objective criteria based on sound medical evidence.

These review criteria are used as a guideline. Decisions will take into account the Member's medical condition and comorbidities. The review process is performed under the direction of the Wellcare With Superior HealthPlan Medical Director.

Wellcare With Superior HealthPlan will base the frequency of its on-site and telephonic electronic review on the clinical condition of the Member. The frequency of the reviews for extension of initial determinations is based on the severity/complexity of the patient's condition, necessary treatment and discharge planning activity including possible placement in a different level of care. Wellcare With Superior HealthPlan requests clinical information to support the appropriateness of the admission, continued length of stay, level of care, treatment, and discharge plans.

The treating Provider and the facility utilization review staff can provide review information telephonically, via fax, or through access to electronic records. When a facility determines that a Member no longer needs inpatient care but is unable to obtain the agreement of the Provider, the facility may request a Quality Improvement Organization (QIO) review. Prior to requesting a QIO review, the facility should consult Wellcare With Superior HealthPlan.

CLINICAL INFORMATION

Clinical information should be provided at the time of submission of the request. The Provider or facility is responsible for ensuring services are authorized prior to service delivery. Wellcare With Superior HealthPlan provides a reference number on all authorizations. To ensure a timely decision, make sure all supporting clinical information is included with the initial request:

Clinical information includes relevant and current information regarding the Member's:

- History of presenting problem
- Physical assessment

- Diagnostic results
- Photographs
- Consultations
- Previous and current treatment
- Member's response to treatment

Clinical Practice Guidelines

Wellcare With Superior HealthPlan encourages the use of evidence-based Clinical Practice Guidelines (CPGs) by all participating Providers. These guidelines are available under the Provider section of our website at wellcare.superiorhealthplan.com.

Whenever possible, Wellcare With Superior HealthPlan adopts preventive and clinical practice guidelines that are:

- Published by nationally recognized organizations (e.g., CDC, USPSTF, AHRQ),
- Endorsed by government institutions, or
- Developed through statewide collaboratives or consensus among healthcare professionals in the relevant field.

These guidelines are reviewed and selected with the needs of the Texas FIDE-SNP population in mind. This includes individuals who are dually eligible for Medicare and Medicaid, and who may require:

- Home and community-based services (HCBS),
- Behavioral health support, and
- Management of chronic and complex conditions.

The goal is to support whole-person, integrated care that improves health outcomes, promotes independence, and aligns with the principles of the Model of Care for FIDE-SNPs.

SERVICES REQUIRING PRIOR AUTHORIZATION

The list below provides Wellcare With Superior HealthPlan's general Prior Authorization requirements. This list is not all inclusive and is subject to change. Providers will be given 90-day advance notice to additions to the Prior Authorization list. Please verify requirements at the time of the request.

Wellcare With Superior HealthPlan Utilization Management verifies benefit eligibility and medical necessity for select services at the time of the request and is not a guarantee of coverage or payment. Payment is determined by the Members' eligibility and benefits at the time of service.

Claims payment is also based on the appropriateness, accuracy, and presence of codes submitted on the claim as determined by CMS. Codes that are not listed on the applicable Medicaid fee schedule may not be payable by Wellcare With Superior HealthPlan.

Inpatient Services

- All inpatient admissions (Emergent and Elective)
- Long-Term Acute Care Hospital (LTACH) admissions
- Acute Rehabilitation admissions
- Skilled nursing facilities (SNF) admissions

Durable Medical Equipment (DME)[1]

- DME items are covered according to the HHS Medicaid Fee Schedule and are subject to applicable prior authorization requirements
- Insulin pumps for DM type 1
- Hearing aids

Certain Outpatient Services/Treatments/Procedures

- Chiropractic Services
- Nutritional Counseling
- Hyperbaric oxygen therapy
- Genetic Testing
- Home Health/Skilled Nursing Visits
- Back Surgeries
- Ambulance Transportation Non-Emergent
- Dental Anesthesia in Facility
- Hysterectomy
- Spinal Surgeries
- Varicose Vein Surgery
- Breast Reduction
- Septoplasty
- Rhinoplasty

MENTAL HEALTH OUTPATIENT VISITS FOR MEMBERS WITH MILD-TO-MODERATE BEHAVIORAL HEALTH CARE NEEDS

Wellcare With Superior HealthPlan covers mental health outpatient services for Members with mild to moderate behavioral health conditions. You may contact our Behavioral Health staff at 1-855-445-3556 to assist a Member with the following services:

- Locating a behavioral health Provider

[1] *This list is not all inclusive and is subject to change.*

- Scheduling behavioral health appointments
- Locating community groups and self-help groups

SPECIALTY NETWORK ACCESS TO CARE

Referrals to Specialists may be considered when an appropriate in-network specialist is not available, or when a second opinion is requested following consultation or treatment by an in-network specialist.

As a PCP, you may request a referral to one of the health care public entities via Wellcare With Superior HealthPlan's Provider Portal at Provider.SuperiorHealthPlan.com, or by calling Wellcare With Superior HealthPlan at **1-855-445-3556**. Wellcare With Superior HealthPlan's staff will forward the information and authorization to the central referral office of the public entities. Wellcare With Superior HealthPlan will fax you a copy of the approved referral notification form along with contact information to the public entity.
Services that DO NOT require prior authorization (regardless of contract status) include:

- Emergency services
- Post stabilization services
- Women's Health
- Family Planning & Obstetrical Services
- Child & Adolescent Health Center Services
- Local Health Department (LHD) services
- Long-Acting Reversible Contraception (LARCs)
- School Dental Services
- Other services based on state requirements

You may access the most recent Prior Authorization Requirements on the Online Prior Authorization form under the Prior Authorization Requirements link.

DENIALS AND RECONSIDERATIONS

Denials based on medical necessity may only be issued by a Wellcare With Superior HealthPlan Medical Director. When a denial occurs, the requesting Provider will be notified via phone to discuss the decision.

In addition to verbal communication, a written denial notice is:

- Faxed to the requesting Provider, and
- Mailed to the Member.

The denial notice includes the following:

- The specific reason(s) for the denial,
- A reference to the applicable benefit provision and/or clinical guideline used to make the decision,
- Instructions on how to request a free copy of the benefit provision and/or guideline,

- A clear description of the Members' appeal rights, and
- Step-by-step instructions for submitting an appeal.

MODEL OF CARE OVERVIEW

The Model of Care (MOC) provides the basic framework under which Wellcare With Superior HealthPlan will meet the needs of our Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) Members. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each Member are identified and addressed through the plan's Care Management practices.

Wellcare With Superior HealthPlan identifies, supports, and engages our most vulnerable Members at any point in their healthcare continuum to help them achieve an improved health status. Wellcare With Superior HealthPlan provides services in a Member-centric fashion. Wellcare With Superior HealthPlan's objectives for serving Members with complex and special needs include, but are not limited to:

- Conducting population assessments during Model of Care renewal cycles to identify the needs of the population and subpopulations, so Care Management processes and resources can be updated to address Member needs.
- Promoting preventive health services and the management of chronic diseases through Care Management programs that encourage the use of services to decrease future morbidity and mortality in Members.
- Conducting comprehensive health assessments that identify Member needs and barriers to care.
- Coordinating transitions of care for Members with complex and special needs to assist in navigating the complex healthcare system and accessing Provider, public and private community-based resources.
- Improving access to primary and specialty care for Members with complex health conditions so they receive appropriate services.
- Consulting with appropriate specialized healthcare personnel when needed such as Medical Directors, pharmacists, social workers and behavioral health professionals, etc.
- Ensuring that Members' socioeconomic barriers are addressed.

Effectiveness of the Model of Care Program is evaluated through the identification of objective, measurable, and population-specific quality indicators. Indicator data is collected on a routine and ad hoc basis, outcomes are analyzed, opportunities are identified, interventions are implemented for goal attainment, and reports are generated for ongoing monitoring. Data collection follows protocols established in approved policies and/or program designs. Data sources include administrative data such as claims, survey data, medical record documentation, or a combination of sources. There is a documented systematic step sequence for administrative data collection. Standardized tools are developed for utilization with any manual data collection such as extraction of data from medical records. Statistically valid sampling techniques are used as appropriate.

Wellcare With Superior HealthPlan has established performance outcomes for SNP plans to evaluate and measure the quality of care, quality outcomes, service, and access for Members. For each metric, benchmarks have been established based on evidenced-based medicine found in current literature,

standards, and guidelines. Root cause analysis is conducted, and interventions identified for each indicator that falls below the desired value. The analysis, process improvement plan, implementation of interventions, and improvements are reported to the National Medicare Quality Improvement and Utilization Management Committee (QIUMC) for review, feedback, and approval.

MODEL OF CARE TRAINING

Applicable to participating and non-participating Providers that treat FIDE SNP Members, Wellcare With Superior HealthPlan reviews and updates, as needed, the Model of Care (MOC) training annually at the beginning of each year. Wellcare With Superior HealthPlan offers a printable self-study training guide which can be found at SuperiorHealthPlan.com/Wellcare. If Providers would like to request a copy mailed, they can contact Provider Services at 1-855-445-3572.

SERVICE COORDINATION

Overview

Wellcare With Superior HealthPlan's Service Coordination program offers personalized care management for Members with complex or high-risk conditions. The program is designed to improve health outcomes through proactive care planning and service coordination.

The Wellcare With Superior HealthPlan Service Coordinator (SC) provides a specialized level of care management services that includes, but is not limited to:

- Provide the Service Plan to the Member and the Member's authorized representatives and Providers in the language and format requested. Note: Providers can access Service Plans and ISP documents on the Provider Portal at Provider.SuperiorHealthPlan.com using the Assessment tab.
- Identification of needs, including medical, psychosocial, cognitive, functional and LTSS services for FIDE SNP Members.
- Development of a Service Plan of Care as appropriate to address those identified needs.
- Assistance to ensure timely and a coordinated access to an array of providers and covered services.
- Facilitate communication/care coordination across medical/behavioral/specialists as appropriate to meet Member's unique and holistic needs.
- Coordination of covered services with social and other services delivered outside the benefit plan as necessary and appropriate.
- Conduct mandatory telephonic or face-to-face contacts.

Service Coordination services provided to Members are:

- Review assessments and develop plan of care utilizing input from the Member, family, and Providers.
- Coordinate with the Member's PCP, Specialist, and LTSS Providers to ensure the Member's health and safety needs are met in the least restrictive setting.

- Refer members to support services, such as disease management and community resources.
- Authorize LTSS services.

Service Coordinators may contact Providers to:

- Participate in the Member Integrated Care Team (ICT) meeting.
- Coordinate or update a Member's plan of care.
- Confirm diagnoses or test results.
- Identify care gaps or non-compliance issues.
- Address behavioral health needs or social determinants of health.

Referrals to Service Coordination may be submitted via the secure Wellcare With Superior HealthPlan Secure Provider Portal at Provider.SuperiorHealthPlan.com using the Referrals and Submit button, or by calling 1-855-445-3572.

Program Overview

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) mandate a Health Risk Assessment, care plan, qualifying face-to-face encounter, and an interdisciplinary care team for FIDE SNP Members as well as an evaluation of care effectiveness by Wellcare With Superior HealthPlan. Wellcare With Superior HealthPlan's Model of Care (MOC) is tailored specifically to FIDE SNP Members in an effort to meet the populations' functional, psychosocial and medical needs in a Member-centric fashion.

Health Risk Assessment

Wellcare With Superior HealthPlan's FIDE SNP Service Coordination process begins with the Health Risk Assessment (HRA) for all FIDE SNP Members. The HRA assesses Member risk in the following areas: SDOH, functional, psychosocial, behavioral, cognitive, and medical. Once completed, the HRA is stratified into a risk of low, moderate, or high. The risk level indicates the Member's needs and appropriate level of Service Coordination services. Initial assessments are conducted within 90 days of enrollment and annual reassessments are conducted within one year of the initial assessment.

Comprehensive Assessment

Members identified for enrollment into a Service Coordination program are outreached for engagement and to complete a comprehensive needs assessment. Members are assigned to a Service Coordinator based on their risk level and are telephonically outreached by the Service Coordination Team who conduct a comprehensive needs assessment with the FIDE SNP member and/or caregiver in order to collect additional social, medical, and behavioral information to support the member-centric Individualized Care Plan.

The Comprehensive Needs Assessment (CNA) is based on *Clinical Practice Guidelines* and allows the care plan to be generated using these guidelines.

Individualized Care Plans

Each FIDE SNP Member will receive an Individualized Care Plan (ICP) based on the Member's HRA responses. Once the Member, and/or caregiver completes the health risk assessment, an ICP is generated that reflects the Member's specific problems, prioritized goals, and interventions. The ICP generated tracks dates and goal progress. The frequency of contact will vary depending on the risk level of the Member and specific goal timeframes. The ICP is shared with the Member and their caregiver, the PCP, and as appropriate, other Members of the care team for input and updates. If a Member is Unable to Reach (UTR) or declines to participate in the HRA, the ICP is developed based on a standard care plan consisting of age and gender appropriate goals and interventions for preventative care and may be further tailored using available Member data.

Interdisciplinary Care Team

Providers identified as part of a Member's Interdisciplinary Care Team (ICT) are encouraged to actively participate in the care planning process. The ICT collaborates with the Member and their support team to ensure care is coordinated, person-centered, and aligned with the Member's unique goals, preferences, and needs.

The ICP is shared with the Members of the ICT in an effort to provide feedback and promote collaboration regarding the Member's goals and current health status. The ICT includes the Member, the Member's caregiver (if appropriate), and the Member's PCP at minimum and includes other appropriate supports as appropriate such as a Wellcare With Superior HealthPlan Service Coordinator and/or specialists according to the Member's needs. Other Members of the ICT can include social service supports, behavioral health specialists, state coordinators, and others preferred by the Member. ICT communication is facilitated by the primary coordinator which may include the PCP, Wellcare With Superior HealthPlan Service Coordinator or another appropriate ICT Member. For Members enrolled in a Service Coordination program, the Service Coordinator communicates and coordinates with the Members of the ICT to educate the Member, provide advocacy, and assist them as they navigate the healthcare system.

Face-to-Face Encounters

Wellcare With Superior HealthPlan ensures that Members are provided a face-to-face encounter either in person or virtually within the first 12 months of their enrollment and annually thereafter. The face-to-face encounter is completed for the purpose of delivering healthcare, Service Coordination, or Care Coordination services and can be completed with an in-network treating Provider on the Member's interdisciplinary care team or with Wellcare With Superior HealthPlan Service Coordination/Care Coordination staff. Members who cannot be seen by their Providers within a 12-month period, either in-person or virtually, should contact Wellcare With Superior HealthPlan to schedule a virtual appointment at 1-855-445-3556.

Care Transitions

When Members move from one setting to another, Wellcare With Superior HealthPlan facilitates transitions through communication and coordination with the Member, caregiver, treating Providers, and their primary care practitioner. During this communication with the Member, any changes to the Member's health status and any resulting changes to the care plan are discussed. The Member's primary care Provider will be notified of the transition and informed of any needs to assist with a smoother transition process. All FIDE SNP Members who undergo a transition of care receive:

- Contact by a Wellcare With Superior HealthPlan Utilization Management and/or Service Coordination staff.
- Discharge planning with a concurrent review nurse or discharge planner.
- Post-discharge follow-up from Service Coordination.
- Education on transition and transition prevention.
- If applicable, review of medications with a registered nurse.

Levels of Service Coordination

To provide Service Coordination, we collaborate with the Member, caregiver/family and informal supports desired by the Member, all treating Providers regardless of network status, and community resources.

For each identified Member, the Service Coordination team identifies the appropriate level assignment using the following criteria:

Level One Members:

Defined as a Member with the highest level of utilization of covered services. Level One Members must include those:

- Enrolled in STAR+PLUS HCBS Waiver
- Residing in a nursing facility in the service area
- Who are pregnant
- With end stage renal disease
- With high-cost catastrophic cases or high service utilization (such as a high volume of ER or hospital visits)
- With co-occurring mental health and SUD diagnoses
- With a SPMI diagnosis
- Other Members with complex medical needs

Wellcare With Superior HealthPlan will provide Level One Members with a single identified person as their assigned Service Coordinator.

Level Two Members:

- Members who have not been identified as a Level One Members and who receive LTSS.
- Members in MBCC.
- Members with SUD or non-SPMI behavioral health needs.
- Members who receive services in an ICF/IID or who are enrolled in an IDD Waiver.

- Wellcare With Superior HealthPlan will provide Level Two Members with a single identified person as their assigned Service Coordinator.

Level Three Members:

- Members who do not qualify as a Level One or Level Two Members. This includes Members residing in a nursing facility receiving hospice.
- Members who are provisionally residing in a nursing facility outside of Wellcare With Superior HealthPlan's service area.
- Dual Eligibles who do not meet Level One or Level Two requirements.

Discharge Planning

The Service Coordinator collaborates in concurrent review with Wellcare With Superior HealthPlan's nurses who follow Members while they are in hospital in order to schedule needed assessments and work with the Member, family, attending provider, discharge planner, PCP and other relevant Providers to coordinate services and equipment required at discharge. If a Member was receiving any LTSS prior to admission to a hospital, once a Member is discharged, Service Coordination staff notifies LTSS Providers to resume services. If an LTSS Provider becomes aware of a Member that is admitted to a hospital, the Provider should alert the Service Coordinator when services cease after the admission and resume once the Member returns home from the hospital.

RETROSPECTIVE REVIEW

A retrospective review is any review of care or services that have already been provided to the Member. This includes acute hospital stays when initial notification is received after the Member has been discharged.

Providers must submit a claim for payment. If the claim is denied, the Provider and/or Member will also have the ability to file an appeal. Wellcare With Superior HealthPlan will complete a medical necessity review for reason of lack of medical necessity or when authorization or timely notification to Wellcare With Superior HealthPlan was not obtained due to extenuating circumstances, such as:

- Member was unable to know situations – Member was unconscious or not in right state of mind at presentation.
- Services authorized by another payer who subsequently determined Member was not eligible at the time of service.
- Member did not have their Wellcare With Superior HealthPlan ID card or otherwise indicated other coverage.
- Not enough time situations – the Member requires immediate medical services and prior authorization cannot be completed prior to service delivery.

Participating and non-participating Providers have 95 Days from the first date of service to submit a claim. If a clinical review is warranted due to extenuating circumstances, a decision will be made within 30 Days following receipt of all necessary information.

There are two types of retrospective reviews that Wellcare With Superior HealthPlan may perform:

Initiated by Wellcare With Superior HealthPlan

Wellcare With Superior HealthPlan requires periodic documentation including, but not limited to, the medical record, UB and/or itemized bill to complete an audit of the Provider-submitted coding, treatment, clinical outcome, and diagnosis related to a submitted claim. On request, medical records should be submitted to Wellcare With Superior HealthPlan to support accurate coding and claims submission.

Initiated by Providers

Wellcare With Superior HealthPlan will review post-service requests for authorization of inpatient admissions or outpatient services only if, at the time of treatment, the Member was not eligible but became eligible with Wellcare With Superior HealthPlan retroactively or in cases of emergency treatment and the payer is not known at the time of service.

The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions, and taking into account the Member's needs at the time of service. Wellcare With Superior HealthPlan will also identify quality issues, utilization issues, and the rationale behind failure to follow Wellcare With Superior HealthPlan's prior authorization/pre-certification guidelines.

Wellcare With Superior HealthPlan will give a written notification to the requesting Provider and Member within 30 calendar days of receipt of a request for a UM determination. If Wellcare With Superior HealthPlan is unable to make a decision due to matters beyond its control, it may extend the decision time frame once, for up to 14 calendar days of the post-service request.

Transition Plan

Wellcare With Superior HealthPlan's Continuity of Care Transition Plan ensures consistent, unduplicated care without disruption for all new Members receiving care at the time of enrollment from in-network and out-of-participating Providers including, but not limited to PCPs, specialists, behavioral health (BH), LTSS and home health Providers. We identify new Members receiving care from out-of-participating Providers in multiple ways such as: current service files and information from the transferring MCO or HHS, Provider authorization requests, completed Health Risk Screening (HRS), outreach to LTSS Providers, PCPs, BH and/or other specialty Providers not reflected on transfer files, and other Member or Provider contact or referrals.

Services ordered prior to the Member's enrollment, (e.g., medical equipment or supplies or home modifications approved but not completed prior to enrollment), Wellcare With Superior HealthPlan staff contact the Provider to ensure the Member continues to receive. The Service Coordinator will contact the Member to ensure there are no gaps in services. LTSS Providers should contact Service Coordination for current service authorizations at the time of enrollment with Wellcare With Superior HealthPlan.

Members entering into a nursing facility will receive an assessment within 30 Days of admission by their Service Coordinator. The Service Coordinator works with the Member, family and Providers to develop/implement a transition plan that includes necessary community LTSS and transition services. Members interested in transitioning out of the nursing facility will receive an assessment and education regarding the transition process from the Service Coordinator.

All Members are assigned a Service Coordinator upon enrollment. Any Member or Provider may request a Service Coordinator by calling Member Services at **1-855-445-3556**.

Members are assigned a Service Coordinator and will be provided contact information within five Business Days. Wellcare With Superior HealthPlan will post Service Coordinator assignments to the secure Provider Portal as well as notify the Member of any changes. Wellcare With Superior HealthPlan must notify Members within five Business Days of the name and phone number of their new Service Coordinator, if their Service Coordinator changes.

For Members transferring from another MCO, Wellcare With Superior HealthPlan will honor existing authorizations and service plans for up to 90 Days for Acute Care and 6 months for LTSS after the transition to Wellcare With Superior HealthPlan or until Wellcare With Superior HealthPlan has evaluated and assessed the Member's need.

EVOLENT

Advanced Diagnostic Imaging

As part of a continued commitment to further improve advanced imaging and radiology services, Wellcare With Superior HealthPlan is using Evolent to provide prior authorization services and utilization management for advanced imaging and radiology services. Evolent focuses on radiation awareness designed to assist Providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT/CTA/CCTA
- MRI/MRA
- PET

Key Provisions:

- Emergency room, observation, and inpatient imaging procedures do not require authorization;
- It is the responsibility of the ordering provider to obtain authorization; and
- Providers rendering the above services should verify that the necessary authorization has been obtained; failure to do so may result in denial of all or a portion of the claim.

Evolent provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information or call our Provider Services department.

Cardiac Solutions

Wellcare With Superior HealthPlan in collaboration with Evolent, has launched a cardiac imaging program to promote health care quality for Member's with possible cardiac disease.

Under this program, prior authorization will be required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a Member's diagnosis or treatment - and to recommend

an alternate approach when indicated. By supporting the most efficient diagnosis and management of cardiac disease, Evolent addresses unnecessary procedures and promotes the least invasive, most medically appropriate approach.

Evolent has developed proprietary utilization management guidelines for these cardiac modalities. These consensus-based guidelines draw on current literature, American College of Cardiology (ACC) appropriateness criteria, recommendations from the American Heart Association, and input from our Cardiac Advisory Board and other experts. Their guidelines are transparent and available throughout our programs. Evolent also includes references to the Choosing Wisely campaign by the American Board of Internal Medicine (ABIM) Foundation, which provides specialty society considerations for the selection of appropriate tests.

How does this program improve Member health?

Managing cardiac studies will promote the use of optimal diagnostic methods in the assessment and treatment of cardiac diseases. Based on criteria adapted from the ACC and AMA, this program will minimize Members' radiation exposure by using the most efficient and least invasive testing options available.

Program Components

- Evidence-based clinical guidelines and proprietary algorithms to support clinically appropriate diagnostic options for each Member
- Consultations with cardiologists related to elective cardiac diagnostic imaging, when needed
- Quality assessment of imaging Providers to ensure the highest technical and professional standards

How the Program Works

In addition to the other procedures that currently require prior authorization for Members, prior authorization will be required for the following cardiac procedures:

- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Echocardiography
- Stress Echocardiography

The following services **do not** require authorization through Evolent:

- Inpatient advanced radiology services
- Observation setting advanced radiology services
- Emergency Room radiology services

Evolent provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information.

Physical Medicine Program

To help ensure that physical medicine services (physical and occupational therapy) provided to our Members are consistent with nationally recognized clinical guidelines, Wellcare With Superior HealthPlan has partnered with Evolent to implement a prior authorization program for physical medicine services. Evolent provides utilization management services for outpatient physical, occupational and speech therapy services on behalf of Wellcare With Superior HealthPlan Members.

How the Program Works

Outpatient physical, occupational and speech therapy requests are reviewed by Evolent's peer consultants to determine whether the services meet policy criteria for medically necessary and appropriate care. The medical necessity determinations are based on a review of objective, contemporaneous, and clearly documented clinical records that may be requested to help support the appropriateness of care. Clinical review helps determine whether such services are both medically necessary and eligible for coverage. Although prior authorization for the therapy evaluation alone is not required, additional services provided at the time of the evaluation and for any ongoing care is required through Evolent. Home Health Providers submitting claims using codes other than the designated initial evaluation CPT codes for the initial evaluation should request an authorization within the Wellcare With Superior HealthPlan retro authorization guidelines. There is no need to send patient records in advance. Evolent will contact the Provider via phone and fax if additional clinical information is needed to complete the request. If the clinical documentation fails to establish that care is medically necessary, is not received, or is not received in an appropriate amount of time, it may result in non-certification of the authorization request.

Under the agreement between Wellcare With Superior HealthPlan and Evolent, Wellcare With Superior HealthPlan oversees the Evolent Therapy Management program and continues to be responsible for claims adjudication. If Evolent therapy peer reviewers determine that the care provided fails to meet our criteria for covered therapy services, you and the patient will receive notice of the coverage decision.

Should you have questions, please contact Wellcare With Superior HealthPlan Provider Services at 1-855-445-3572.

Interventional Pain Management

Evolent manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures. It is the responsibility of the ordering provider to obtain authorization for all IPM procedures outlined below. Outpatient IPM procedures requiring prior authorization include:

- Spinal Epidural Injections
- Paravertebral Facet Joint Injections or Blocks
- Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)
- Sacroiliac Joint Injections

Note: A separate prior authorization number is required for each procedure ordered. Prior authorization is not required through Evolent for services performed in the emergency department, on an inpatient basis or in

conjunction with a surgery. Prior authorization and/or notification of admission is still required through Wellcare With Superior HealthPlan. To obtain authorization through Evolent, visit RadMD.com.

Musculoskeletal (MSK) Management Program

The MSK program currently requires prior authorization for non-emergent outpatient, interventional spine pain management services (IPM), and will be expanded to include spinal cord stimulators, and inpatient and outpatient hip, knee, shoulder, lumbar, and cervical spine surgeries for our Members. The decision to implement this latest program is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

Under the terms of this agreement:

- Wellcare With Superior HealthPlan will oversee the MSK program and continue to be responsible for claims adjudication and medical policies.
- Evolent will manage IPM services, and inpatient and outpatient MSK surgeries through the existing contractual relationships with us.

It is the responsibility of the ordering provider to obtain prior authorization for all IPM procedures and MSK surgeries managed by Evolent. Evolent does not manage prior authorization for emergency MSK surgery cases that are admitted through the emergency room or for MSK surgery procedures outside of those procedures listed above. The ordering provider must obtain prior authorization with Evolent prior to performing the surgery/procedure. Facility admissions do not require a separate prior authorization. However, the facility should ensure that an Evolent prior authorization has been obtained prior to scheduling the surgery/procedure.

MSK surgeries other than those outlined above will continue to follow prior authorization requirements for hospital admissions and elective surgeries as outlined for the Wellcare With Superior HealthPlan FIDE-SNP line of business.

Cardiology Surgical Procedures

Wellcare With Superior HealthPlan has partnered with Evolent to launch an innovative Cardiac Surgical Quality and Safety Management Program. The program is designed to work collaboratively with providers to promote patient safety through the practice of high quality and cost-effective care for Wellcare With Superior HealthPlan members undergoing cardiac surgical procedures.

How the Program Works

Cardiology surgical procedures: Prior authorization will be required for the following non-emergent inpatient and outpatient surgeries:

CARDIAC SURGERIES & PROCEDURES

Including all associated partial, total, and revision surgeries

- Coronary Angioplasty/Stenting

- Internal Cardiac Monitoring
- Implantable Cardioverter Defibrillator
- Leadless Pacemaker
- ICD Revision or Removal
- Left Atrial Appendage (LAA) Occluders
- Non-Coronary Angioplasty/Stenting
- Pacemaker
- Pacemaker Revision or Removal
- Peripheral Revascularization
- Percutaneous Transcatheter Closure
- WCD - Wearable Cardiac Defibrillator
- Cardiac Ablation
- Coronary Artery Bypass Grafting

KEY PROVISIONS:

- Emergency related procedures do not require authorization
- It is the responsibility of the ordering provider to obtain authorization
- Providers rendering the above services should verify that the necessary authorization has been obtained; failure to do so may result in non-payment of your claims.

To obtain authorization through Evolent, visit RadMD.com.

TURNINGPOINT HEALTHCARE SOLUTIONS

Ear, Nose and Throat Surgery

Wellcare With Superior HealthPlan has partnered with TurningPoint Healthcare Solutions to implement a prior authorization program for Ear, Nose and Throat (ENT) Surgery. TurningPoint Healthcare Solutions provides prior authorizations services for ENT Surgeries on behalf of Wellcare With Superior HealthPlan Members.

Prior authorization is required for the following ENT surgeries performed in the inpatient, outpatient, provider's office and in-home settings:

- Tonsillectomy with or without adenoidectomy.
- Cochlear implant device.

- Sinus Surgery.
- Tympanostomy and tympanoplasty.
- Rhinoplasty and septoplasty.
- Thyroidectomy and parathyroidectomy.
- Laryngoscopy and laryngoplasty.

For questions regarding prior authorization requirements, or impacted CPT codes, please contact TurningPoint by email at providersupport@turningpoint-healthcare.com or by calling TurningPoint Provider Support at 1-855-336-4391.

Wellcare With Superior HealthPlan will oversee the TurningPoint Healthcare Solutions ENT program and continue to be responsible for claims adjudication and medical policies.

SECTION 5: BILLING AND CLAIMS PAYMENT

OVERVIEW

Wellcare With Superior HealthPlan's Claims Department is structured to ensure accurate and timely processing of Provider claims. A dedicated toll-free telephone number, **1-855-445-3572**, is available for Providers to contact a representative with claims-related inquiries.

CLEAN CLAIM SUBMISSION

Wellcare With Superior HealthPlan only accepts the CMS 1500 (02/12) and CMS 1450 (UB-04) Claim Forms whether filing on paper or electronically. Other claim form types will be upfront rejected and returned to the Provider.

Professional Providers and medical suppliers complete the CMS 1500 (02/12) Claim Form and institutional Providers complete the CMS 1450 (UB-04) Claim Form. Wellcare With Superior HealthPlan does not supply claim forms to Providers. Providers should purchase these from a supplier of their choice. All paper claim forms must be typed with either 10- or 12- point Times New Roman font and on the required original red and white version to ensure clean acceptance and processing. Black and white forms, handwritten forms and nonstandard will be upfront rejected and returned to the Provider. To reduce document handling time, do not use highlights, italics, bold text, or staples for multiple page submissions. If you have questions regarding what type of forms to complete, contact Provider Services at **1-855-445-3572**.

IMPORTANT STEPS TO SUCCESSFUL SUBMISSION OF CLAIMS

The following information must be included on every claim, paper or electronic:

1. Providers must file claims using standard claims forms (CMS 1450 (UB-04) for hospitals and facilities; CMS 1500 for providers or practitioners).
2. Complete all required fields on an original, red CMS 1500 (Version 02/12) or CMS 1450 (UB-04) Claim Form. NOTE: Non-red, nonstandard, and handwritten claim forms will be rejected back to the Provider.
3. Enter the Provider's NPI number in the "Rendering Provider ID#" section of the CMS 1500 form (see box 24J).
4. Providers must include their taxonomy code (e.g., 207Q00000X for Family Practice) and corresponding ID qualifier in this section for correct processing of claims.
5. Ensure all Diagnosis Codes, Procedure Codes, Modifier, Locations (Place of Service); Type of Bill, Type of Admission, and Source of Admission Codes are valid for the date of service.
6. Ensure all Diagnosis and Procedure Codes are appropriate for the age and sex of the Member.
7. Ensure all Diagnosis Codes are coded to their highest number of digits available.

8. Ensure Member is eligible for services during the time which services are provided.
9. Ensure Provider receives authorization to provide services to the eligible Member, when appropriate.

If electronic Claim submission is not possible, all hard copy (CMS-1500, CMS-1450 {UB-04}) claims must be submitted by mail to the address listed below.

Wellcare With Superior HealthPlan
Attn: Claims Center
P.O. Box 9700
Farmington, MO 63640-0700

CLAIMS BILLING REQUIREMENT

Sample forms for the CMS 1500 and the UB-04 forms are provided at the back of the manual. In order to receive reimbursement in a timely manner, please ensure each claim:

1. Uses the data elements of UB-04 (UB-04 Version 050) or CMS 1500 as appropriate http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf
2. If the facility is Medicaid-enrolled ASC, bill using the ASC X12 837 5010 professional claim format when submitting electronic claims. Paper claims must be billed on CMS 1500 paper form.
3. It is submitted within 95 days of the date the service was performed or as specified in your Provider Contract
4. Identifies the patient (Member ID assigned by Wellcare With Superior HealthPlan, address, and date of birth)
5. Identify the plan (plan name and/or Member ID number)
6. Lists the date (mm/dd/yyyy) and place of service
7. If necessary, substantiates the medical necessity and appropriateness of the care or services provided, that includes any applicable authorization number if Wellcare With Superior HealthPlan requires prior authorization
8. Includes additional documentation based upon services rendered as reasonably required by Wellcare With Superior HealthPlan Medical Policies
9. Is certified by Provider that claim:
    - Is true, accurate, prepared with the knowledge and consent of Provider
    - Does not contain untrue, misleading, or deceptive information
    - Identifies each attending, referring, or prescribing Provider, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim
10. Is a claim for which the Provider has verified the Member's eligibility and enrollment in Wellcare With Superior HealthPlan before the claim was submitted
11. It is not a duplicate of a claim submitted within 45 days of the previous submission
12. Is submitted in compliance with all of Wellcare With Superior HealthPlan's prior authorization and claims submission guidelines and procedures

13. Is a claim for which the Provider has exhausted all known other insurance resources for the Medicaid line of business (Medicaid is the payer of last resort)
14. Is submitted electronically if the Provider has the ability to submit claims electronically

Providers may submit and check the status of claims electronically via the secure Wellcare With Superior HealthPlan Provider Portal. To gain access to the Provider Portal, please register with the link provided below.

Submit claims via the Provider Portal at provider.superiorhealthplan.com.

Note: For fastest, most accurate processing, EDI is the preferred method.

Submit all initial claims for payment to:

Wellcare With Superior HealthPlan
Attn: Claims
PO Box 9700
Farmington, MO 63640-0700

TAXONOMY CODES

Taxonomy Codes are designed to categorize the type, classification, and/or specialization of healthcare Providers. Wellcare With Superior HealthPlan requires all claims, both paper and electronic, to include the taxonomy code of the rendering Provider. The taxonomy code included on the claim must also match the taxonomy code Wellcare With Superior HealthPlan has on file for the rendering Provider. To submit or update this information, please complete the Provider enrollment form located on our website.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC)/FREESTANDING RURAL HEALTH CLINIC (RHC)/ENCOUNTER RATE CLINIC (ERC)

FQHCs are important community Providers, and all Wellcare With Superior HealthPlan Members have access to them if the Member resides in a community where FQHC services are available. The Member Handbook outlines the Member's rights to access a FQHC in their service area. Billing requirements for FQHC/RHC for Medicaid is fee-for-service.

FQHC, RHC, and ERC Billing Requirements:

- Claims must be billed using the group National Provider Identifier (NPI).
- Behavioral health (BH) claims must include the appropriate BH modifier.
- All claims must be submitted on a UB-04 claim form.

Billing by Payor Type		
Payor Type	Claim Form	Reimbursement Method
Wellcare With Superior HealthPlan – Medicare Primary	UB-04	Paid at CMS Federal Encounter Rate or Fee Schedule based on services rendered
Wellcare With Superior HealthPlan – Medicaid Primary	UB-04	Paid based on the Texas Medicaid Provider fee schedule
Dual-Eligible Members	UB-04	Medicare pays primary claim; Medicaid processes coinsurance and remaining balance, as applicable

ELECTRONIC CLAIMS SUBMISSION

Providers using electronic submission shall submit all claims to Wellcare With Superior HealthPlan or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 837 electronic format, or a CMS 1500 and/or UB-04, or their successors. Claims shall include the Provider's NPI, tax ID and the valid taxonomy code that most accurately describes the services reported on the claim. The Provider acknowledges and agrees that no reimbursement is due for a covered service and/or no claim is complete for a covered service unless performance of that covered service is fully and accurately documented in the Member's medical record prior to the initial submission of any claim.

In-network Providers may submit claims through Wellcare With Superior HealthPlan Provider Portal at provider.superiorhealthplan.com.

Clearinghouses

The preferred method for submitting claims is electronically. This can be done through clearinghouses or via the online Provider Portal.

If you are re-submitting a claim for a status or a correction, please indicate "Status" or "Claims Correction" on the claim.

Wellcare With Superior HealthPlan is currently accepting electronic claims from the following clearinghouses: *Providers are responsible for ensuring they receive a confirmation file for claims submitted via Electronic Data Interchange (EDI).

Availity Essentials

- **Customer Support: 1-800-282-4548**
- **Claim Types:** Professional/Facility
- **Payer ID:** 68069

Wellcare With Superior HealthPlan may add new clearinghouses partners periodically. Providers should contact Availity Client Services at **1-800-282-4548** to verify whether their current clearinghouse is included in the approved list. It is the Providers' responsibility to ensure receipt of a confirmation file for all claims submitted via EDI.

PAYSPAN® ELECTRONIC PAYMENTS & REMITTANCE

Overview

PaySpan® is Wellcare With Superior HealthPlan's preferred secure electronic payment solution that allows providers to receive claim payments and remittance information electronically. Through PaySpan, providers can access payment details quickly, streamline reimbursement processes, and reduce administrative burden associated with paper checks and mailed EOBs.

Benefits to Providers

- **Faster Payments:** Receive claim payments via EFT (Electronic Funds Transfer), reducing delays associated with paper checks.
- **Convenient Online Access:** View remittance information (835s/EOBs) online, download reports, and reconcile payments in real time.
- **Customizable Preferences:** Choose how and when payments are received, including grouping, notification settings, and reporting formats.
- **Enhanced Security:** EFT reduces risk of lost, stolen, or misdirected checks.
- **Improved Administrative Efficiency:** Streamlined payment workflows allow billing teams to reduce manual posting and improve cash flow management.

Enrollment

Providers who have not yet enrolled in PaySpan must complete the online registration process. During enrollment, providers will:

- Verify TIN/NPI credentials
- Provide banking information for EFT
- Set up user accounts and security preferences (To be tailored per market if needed.)

Providers should have their most recent payment or provider information available to complete registration.

Existing PaySpan providers will be required to add the Wellcare With Superior HealthPlan's line of business to their existing account using their TIN. Failure to register the new line of business may result in providers receiving paper checks.

How to Access PaySpan

Providers may log in to PaySpan's secure portal at: www.payspanhealth.com

Support & Assistance

For enrollment assistance, password resets, or technical questions, providers may contact PaySpan Customer Service:

- **PaySpan Support: 1-877-331-7154**
- **Email:** providersupport@payspanhealth.com

- **Hours:** Monday–Friday, 8 a.m. to 8 p.m. EST

For questions related to claim payment amounts or adjudication decisions (not system access), providers should contact the applicable Provider Services phone number on the member's ID card.

PAPER CLAIMS SUBMISSION

To facilitate processing and to minimize chances for rejection or error in payment, it is required that paper claims be typewritten or computer printed. The recommended font to use for computer generated claims is 12-point Times New Roman font. Do not print in italics, bold or script. Handwritten claims and photocopied claims are not accepted. Paper claims information must be submitted within the confines of each item box.

Claims must be legibly signed and dated in ink by the Provider or his or her authorized representative. Any claim that is not properly signed or that has the certification statement altered will be rejected. A rubber signature stamp or other substitute is not acceptable. An authorized representative may only be a trusted employee over whom the Provider has direct supervision on a daily basis and who is personally responsible on a daily basis to the Provider. Such a representative must be designated specifically and must sign the Provider's name and his or her own initials on each certification statement. This responsibility cannot be delegated to a billing service. It is mandatory that claims for services be submitted only on original billing forms. Photocopies or other facsimile copies cannot be accepted for payment purposes.

TIMELY FILING OF CLAIMS

A claim must be submitted within 95 days from the date the service was performed, or as specified in your Provider Contract.

CORRECTED CLAIMS

A corrected claim should be submitted when a Provider needs to change information on a previously submitted initial claim. All requests for corrected claims or reconsiderations/claim disputes must be received within 180 days from the date of the original explanation of payment or denial.

If you are replacing or voiding/cancelling a UB-04 claim, please use appropriate bill type of 137 or 138. If you are replacing or voiding/cancelling a CMS 1500 claim, please complete box 22. For replacement or corrected claim, enter resubmission code 7 in the left side of item 22 and enter the original claim number of the claim you are replacing in the right side of item 22. If submitting a void/cancel claim, enter resubmission code 8 on the left side of item 22 and enter the original claim number of the paid claim you are voiding/cancelling on the right side of item 22. If you do not follow these corrected claim form submission processes the claim will deny for a duplicate claim submission.

OVERPAYMENTS

Providers are required to promptly notify Wellcare With Superior HealthPlan upon identification of any overpayment. Identified overpayments must be returned to the Plan within sixty (60) calendar days, accompanied by accompanied by the Refund Check Information Sheet (RCIS). Providers submitting a refund check for an overpayment must complete and include the **Refund Check Information Sheet (RCIS)** with their

submission. The RCIS helps ensure refunds are accurately applied to the appropriate claim and member account. The form must be completed in its entirety and should be used only when submitting **one refund check for one claim**. It should not be used for multiple claims. The completed RCIS form should be enclosed with the refund check when mailed for processing.

RETROACTIVE ADJUSTMENTS

Should CMS Risk Adjustment activity retroactively increase or decrease payments, including Risk Adjustment Data Validation (RADV), and for adjustments made by CMS to Health Plan's monthly payments based upon changes in eligibility, capitation payments to Providers shall be retroactively adjusted on a proportional basis.

Wellcare may contract with a vendor to conduct premium enhancing activities. Any fees resulting from premium enhancing activities conducted by Wellcare's vendor will be charged back to Provider during the period when the premium changes are realized. The vendor will sign a HIPAA compliant Business Associate Agreement with Wellcare that allows it to collect PHI on our behalf.

REIMBURSEMENT GUIDELINES, PAYMENT POLICES AND CODING GUIDANCE

Member Billing

Pursuant to Law, Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the State or another payor is responsible for paying such amounts. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization. Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Wellcare With Superior HealthPlan. Providers may not bill Wellcare With Superior HealthPlan Members for covered services, also known as "balance billing," regardless of whether they believe the amount they were paid or will be paid by Wellcare With Superior HealthPlan is appropriate or sufficient. Balance billing a Member for Covered Services is prohibited, except for the Member's applicable Member Liability towards covered Medicaid services such as Nursing Facility. Section 1902(n)(3)(B) of the Social Security Act (42 USC 1396a(n)(3)(b)); 42 CFR §422.504(g)(1)(iii).

Post-Service Provider Appeals

Wellcare With Superior HealthPlan offers a Post-Service claim appeal process for disputes related to denial of payment for services rendered to Wellcare With Superior HealthPlan Members. This process is available to all Providers, regardless of whether they are in or out of network.

What Types of Issues Can Providers Appeal?

The appeals process is in place for two main types of issues:

- **Post-Service Provider Appeal**: An appeal of services that were denied or reduced because they did not meet a specific criteria, policy or guideline and have a denied authorization on file. For example, the Provider disagrees with a determination made by Wellcare With Superior HealthPlan, such as combining two stays as a 15-day readmission. In this case, the Provider should send additional information (such as medical records) that support the Provider's position.

- **Administrative Appeal**: An appeal by a Provider of a claim/service denied for failure to authorize services according to timeframe requirements. In this case, the Provider must explain the circumstances and why the Provider feels an exception is warranted in that specific case.

A Provider's lack of knowledge of a Member's eligibility or insurance coverage is not a valid basis for an appeal. Providers cannot appeal denials due to a Member being ineligible on the date of service or due to non-covered benefits.

How to File a Post-Service Provider Appeal

Providers may submit a post-service appeal in one of three ways:

1. Login to the Provider Portal to submit an appeal. This is the preferred method for a quicker turnaround time.
2. Via mail by filling out the Appeal Cover Letter form and sending documentation to support your position, such as medical records, to the following address:

   Wellcare With Superior HealthPlan
   Attn: Appeals
   P.O. Box 10052
   Van Nuys, CA 91410-0052

3. Via fax by filling out the Appeal Cover Letter form and sending documentation to support your position, such as medical records, to **1-844-273-2671.**

Timeframe for Filing a Post-Service Provider Appeal

Provider appeals must be submitted within 180 days from the date of the EOP.

Response to Post-Service Provider Appeals

Wellcare With Superior HealthPlan typically responds to a Post-Service Provider Appeal within 30 calendar days from the date of receipt. Providers will receive a letter with the decision and rationale.

For Medicare-covered services, there is one level of Provider appeal, and all determinations are final.

For Medicaid-covered services, Providers may have additional appeal rights, including the option to request a State Fair Hearing or review by a Medicaid Independent Review Entity (IRE), depending on the nature of the service and the appeal.

Medical Records

All medical records requested by Wellcare With Superior HealthPlan are to be provided at no cost from the Provider. This includes administrative fees, copying fees, paper fees, and fees delegated from a third-party vendor.

Medical records should be provided to Wellcare With Superior HealthPlan within 10 business days of request, unless otherwise agreed. To help ease the burden on Providers, accommodations can be arranged for

individuals designated by Wellcare With Superior HealthPlan to assist in extracting medical records for this request. Electronic access to medical records should be arranged wherever possible.

Procedure

All practitioners in the network must comply with the following:

1. Medical record documentation must include at least the following elements:
    a. All services provided directly by the practitioner
    b. All ancillary services and diagnostic tests ordered by the practitioner
    c. All diagnostic and therapeutic services for which the Member was referred to by the practitioner (e.g., home health nursing reports, specialty Provider reports, hospital discharge reports and physical therapy reports)
2. The essential documentation elements for the medical record include:
    a. History and physicals
    b. Allergies and adverse reactions, or NKDA, are prominently noted
    c. Problem lists of significant illnesses and medical conditions, with date of onset
    d. Medications (current medications, changes, discontinuation, and reported reactions)
    e. Working diagnoses are consistent with findings
    f. Treatment plans are consistent with diagnoses
    g. Preventive services/risk screenings
    h. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure
3. The Medical Record Keeping standard checks for the following:
    a. Presence of an organized medical record system (i.e., dividers by type of service such as lab reports/test, consults, etc.)
    b. The medical record is a unit record (bound and organized)
    c. Entries in the medical record are legible, signed and dated
    d. The medical record is available to the practitioner (attending and covering) at every visit and retrievable for review for ten years
    e. Member information is kept confidential by ensuring that the records are stored securely, and only authorized personnel have access to the records. Fax machines should be in an area that is not accessible by other patients to ensure confidentiality

f. Acknowledgement of receipt of privacy notice in record (If not in individual records, there is a central file with acknowledgement of receipt of notice)

Note: Corrective action plans are requested of all Providers whose compliance falls below stated levels (80%). Reassessment is subsequently completed within 6 months to verify improved performance and compliance.

A focused medical record review is performed annually as part of the continuous quality improvement activities of Wellcare With Superior HealthPlan. In addition, an individual practitioner medical record review may be performed, when the apparent lack of compliance with the above standards is discovered during a Utilization Management or QI activity.

SECTION 6: REPORTING REQUIREMENTS

CRITICAL INCIDENTS REPORTING

Wellcare With Superior HealthPlan requires participating program Providers to report all Critical Incidents that occur in home and community-based long-term services and supports (HCBS) delivery settings. These settings include assisted-living facilities, community-based residential alternatives, adult day care centers, other HCBS Provider sites, and a Member's home if the incident is related to the provision of HCBS.

Providers will receive Critical Incident education materials and can access additional information on Wellcare With Superior HealthPlan's website. Providers must participate in trainings offered by Wellcare With Superior HealthPlan to ensure accurate and timely reporting of all critical incidents. These trainings may be offered through webinars, online learning, and regional meetings.

Critical incidents include but are not limited to:

- Unanticipated death of a Member
- Any abuse, such as physical, sexual, mental, or emotional
- Theft or financial exploitation of a Member
- Severe injury sustained by a Member
- Medication error involving a Member
- Neglect and/or suspected neglect of a Member
- Suicide ideation/suicide attempt

A Critical Incident Report must be submitted to Wellcare With Superior no later than 24 hours following the discovery of the incident. Providers must cooperate fully in the investigation of reported Critical Incidents, including submitting all requested documentation. If the incident involves an employee or HCBS Provider, the Provider must also submit a written report of the incident including actions taken within 20 calendar days of the incident. To protect the safety of the Member, actions that can be taken immediately include (but are not limited to) the following:

- Contact 911 if the incident poses immediate/severe harm to the Member.
- Removing the worker from the Member's case if the incident involves allegations of improper behavior by that worker.
- Removing the accused worker from servicing all Wellcare With Superior HealthPlan program Members until the investigation is complete, which may take up to 30 calendar days.
- Ordering an immediate drug screen or appropriate testing if the allegation involves theft of drugs or substance use, including alcohol, while on the job.
- Interviewing the involved employee(s) as soon as possible following the incident and having them submit a written account of events. Provider written accounts along with documentation to support completion of pre-employment screenings including background checks, drug screening, and a

statement that the employee did not begin to perform services for Wellcare With Superior HealthPlan program Members until all required pre-employment screenings were completed and verified.

Based on the severity of the incident, any identified trends, or failure on the part of the Provider to cooperate with the investigation, the Provider may be required to submit a written plan of correction to address and rectify any issues related to the critical incident.

When a Provider has reasonable cause to believe that an individual known to them in their professional or official capacity may be abused, neglected, or exploited, they must report the incident to the appropriate State agency. Use the following phone numbers to report suspicions of abuse, neglect, or exploitation.

Incident Reporting

If Wellcare With Superior HealthPlan or a Provider perceives an immediate threat to the Member's life or safety, contact **911**.

Incident Reporting		
Incident Involves	Contact	Timeframe
All adults (including those with disabilities), ages 18–59, living in an institutional setting Cases of suicidal ideation for Members with developmental disabilities (DD) or mental health concerns residing in an institutional setting	Texas Department of Human Services Office of the Inspector General Hotline: **1-800-HHS-TIPS (1-800-447-8477)**	Immediately
Adults with disabilities, ages 18-59, living in a community setting Older adults (60 years of age and older) regardless of residence	Adult Protective Services Hotline: **1-800-252-5400**	Immediately
All adults, ages 18–59, living in a community setting	Local Police Department	Immediately
Nursing facility resident	Department of Public Health's Registry Hotline[2]: **1-888-963-7111**	Immediately
Supportive Living Facility resident	Texas Health and Human Services' SLF Complaint Hotline:	Immediately

[2] The hotline also investigates allegations of actual or potential harm to patients, patients' rights, infection control, and medication errors. Complaints submitted are limited to hospitals, nursing homes, home health agencies, hospices, end-stage renal dialysis units, ambulatory surgical treatment centers, rural health clinics, critical access hospitals, clinical laboratories (CLIA), outpatient physical therapy, portable X-ray services, community mental health centers, accredited mental health centers (only Medicare Certified), comprehensive outpatient rehabilitation facilities, free-standing emergency centers, alternative healthcare delivery, and health maintenance organizations (HMOs).

	1-800-458-9858, Option 5	

For more information, please complete the Critical Incident Training on Wellcare With Superior HealthPlan's website at wellcare.superiorhealthplan.com.

CORPORATE REPORTING REQUIREMENTS

Member encounter information should be reported on submitted claims forms (CMS 1500; UB-04) by stamping or clearly designating on the claims form "ENCOUNTER."

Practices will be monitored for accurate and complete encounter reporting. The data that Wellcare With Superior HealthPlan submits to the State of Texas requires your compliance with this requirement.

Other reporting requirements or data collection may be added, as data collection requirements are dynamic. PCP offices will be notified in writing of any additional reporting requirements.

ENCOUNTER REPORTING REQUIREMENTS

In order to assess the quality of care, determine utilization patterns and access to care for various healthcare services, qualified health plans are required to submit encounter data containing detail for each patient encounter reflecting all services provided by the Providers of Wellcare With Superior HealthPlan. The State will determine the minimum data elements of the encounter reporting. A format consistent with the formats and coding conventions of the CMS 1500 and UB-04 will be used initially. PCPs will submit their encounter data monthly to Wellcare With Superior HealthPlan, who must then submit it to the HHS via an electronic tape. Both Wellcare With Superior HealthPlan and Provider agree that all information related to payment, treatment, or operations will be shared between both parties and all medical information relating to individual Members will be held confidential.

As part of Wellcare With Superior HealthPlan 's contract with Providers, it is required that Provider Preventable Conditions (PPCs) associated with claims be reported to Wellcare With Superior HealthPlan. PPCs address both hospital and non-hospital conditions identified by the State for non-payment. PPCs are broken into two distinct categories: Health Care-Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs). HCACs are conditions/secondary diagnosis codes identified when not present on an inpatient admission. OPPCs are conditions occurring in any healthcare setting that could have been prevented through the application of evidence-based guidelines.

Medicare requires all delegated vendors, delegated Providers, and capitated Providers to submit encounter data to Centene, even if they are reimbursed through a capitated arrangement.

This section is intended to give Providers necessary information to allow them to submit encounter data to Centene. If the encounter data does not meet the requirements set forth in Centene's government contracts for timeliness of submission, completeness or accuracy, federal and state agencies (for example, CMS) have the ability to impose significant financial sanctions on Centene.

ELECTRONIC VISIT VERIFICATION

What is Electronic Visit Verification (EVV)?

Electronic Visit Verification (EVV) is a validation of the date, time, location, type of Personal Care Services (PCS) or Home Health (HH) Care Services provided, and the individual(s) providing and receiving services. The EVV system will electronically capture:

- The type of service performed
- Beneficiary, client, or participant receiving the service
- Date of the service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends

Why was the EVV system implemented?

The 21st Century Cures Act (the Cures Act), enacted by the U.S. Congress in December 2016, added Section 1903(l) to the Social Security Act to require all states to use Electronic Visit Verification (EVV) for Personal Care Services (PCS) and Home Health Care Services (HHCS) provided under a Medicaid State Plan of the Social Security Act or under a waiver of the State Plan.

What services require EVV?

Per CMS, EVV must be used to record all Personal Care Services (PCS) and all Home Health Care Services (HHCS) that require an in-home visit. If the Member receives Medicaid-funded personal care or HHCS, then their service provider must validate those services through an EVV system. Providers must select either the state provided EVV system, HHAeXchange (HHAX), or an EVV proprietary system. Regardless of the EVV system selected, the Provider must have an NPI and be enrolled in Texas Medicaid through the Texas Medicaid & Healthcare Partnership (TMHP). Providers that elect to use an EVV proprietary system must also complete the required PSO onboarding process and receive approval as a Proprietary System Operator (PSO) before using the proprietary system.

EVV REQUIREMENTS

As a part of EVV compliance, Providers must ensure EVV data, including any necessary visit maintenance within 95 Days from the date of service is accurately documented in the EVV system, in order to be properly reimbursed by Wellcare With Superior HealthPlan. EVV compliance and claim submissions are independent processes. EVV data must be captured and confirmed in the EVV system prior to billing.

Providers can verify that their visits have been transmitted to Wellcare With Superior HealthPlan by utilizing the EVV Visit Log in the EVV portal. The EVV Visit Log is used to verify the hours of services delivered by whom and to whom, as well as to verify that all the visits were complete and accurate prior to the submission of a visit for billing. Additional reports are available in the EVV portal to check for unsent transmissions and/or inaccurate visit data.

ADDITIONAL INFORMATION AROUND EVV

For additional details regarding EVV, please visit the Electronic Visit Verification section on our Provider Resources page at SuperiorHealthPlan.com/Wellcare, or refer to *Section 20: Electronic Visit Verification* in our STAR+PLUS Provider Manual, available at SuperiorHealthPlan.com/Wellcare, or HHSC's EVV website at HHS EVV.

SECTION 7: COMPLIANCE AND REGULATORY REQUIREMENTS

FRAUD, WASTE & ABUSE (FWA) PROGRAM

PURPOSE AND COMMITMENT

Wellcare With Superior HealthPlan is committed to the prevention, detection, investigation, and reporting of suspected **fraud, waste, and abuse (FWA)** in accordance with applicable **federal and state laws, regulations, and contractual requirements**. FWA impacts the healthcare system broadly and may result in significant and unnecessary costs to publicly funded programs.

Wellcare With Superior HealthPlan has developed an aggressive, proactive fraud waste and abuse ("FWA") program designed to collect, analyze and evaluate data in order to identify suspected fraud, waste and abuse.

Detection tools have been developed to identify patterns of health care service use, including over utilization, unbundling, up-coding, misuse of modifiers, services not rendered and other common schemes

Through its parent company, **Centene Corporation (Centene)**, Wellcare With Superior HealthPlan maintains a dedicated **Special Investigations Unit (SIU)** and an established FWA program designed to:

- Collect, analyze, and evaluate data to identify potential FWA patterns
- Conduct audits and investigations to assess billing and documentation compliance
- Implement corrective actions, recover overpayments when appropriate, and refer matters to regulatory or law enforcement agencies as required

DEFINITIONS (42 CFR §455.2 AND HHS DEFINITIONS)

For purposes of this manual:

- **Fraud**: An intentional deception or misrepresentation made with knowledge that the deception could result in an unauthorized benefit to the individual or another party. This includes any act that constitutes fraud under applicable federal or state law.
- **Waste**: The overutilization of services or practices that result in unnecessary costs, including consumption or expenditures without adequate return.
- **Abuse**: Provider practices inconsistent with sound fiscal, business, or medical practices that result in unnecessary costs to Medicare and/or Medicaid, reimbursement for services not medically necessary, or services that fail to meet professionally recognized standards of care. Abuse also includes member practices that result in unnecessary program costs.

EXAMPLES OF FWA AND IMPROPER BILLING PRACTICES

Common FWA and improper billing practices may include, but are not limited to:

- Billing for services **not rendered**
- **Duplicate billing** (billing the same service more than once)
- **Unbundling** or fragmenting codes
- **Upcoding** services
- Billing **add-on codes without required primary CPT codes**
- Use of **exclusion codes**
- Misuse of modifiers
- Diagnosis and/or procedure codes **inconsistent with the member's age**
- **Excessive units** or frequency
- **Overutilization** or medically unnecessary services
- Misuse of benefits (including inappropriate use of identification cards)

Providers are cautioned that unbundling, upcoding and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD-CM), Providers' Current Procedural Terminology (CPT) Health Care Common Procedure Coding System, (HCPCS) and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

In addition, providers are reminded that medical records and other documentation must be maintained consistent with contractual and regulatory obligations.

Federal and state regulatory agencies, law enforcement and Wellcare With Superior HealthPlan vigorously investigate incidents of suspected FWA. 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.

PROVIDER RESPONSIBILITIES AND COOPERATION REQUIREMENTS

Reporting

Providers, including Provider employees and /or Provider sub-contractors, must report to Wellcare With Superior HealthPlan any suspected fraud, waste or abuse, misconduct or criminal acts by any Provider, including Provider employees and/or Provider sub-contractors, or by Wellcare With Superior HealthPlan Members. If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the

member may be involuntarily disenrolled from Wellcare With Superior HealthPlan, with appropriate state and regulatory approval.

Cooperation with Audits and Investigations

Participating providers are obligated to cooperate fully with Centene SIU, and applicable oversight agencies. This includes, as required:

- Producing requested medical records and related documentation timely
- Making staff and/or subcontractor personnel available for interviews and consultation
- Making offices and facilities available for onsite visits
- Cooperating with investigative processes, including hearings, trials, and other proceedings when applicable

Documentation Standards

Quality care and appropriate payment depend on **accurate, complete, and legible medical record documentation**. Documentation must support:

- The service(s) billed
- The level of service reported
- Medical necessity, where applicable
- Compliance with all relevant CMS, state, contractual and Wellcare With Superior HealthPlan documentation and billing requirements

SPECIAL INVESTIGATIONS UNIT (SIU)

Our Special Investigations Unit (SIU) proactively monitors for potential FWA and investigates allegations of fraud, waste, and abuse. Staff includes full-time investigators, clinical investigators, data analysts, management support, administrative staff, and legal personnel.

FWA DETECTION AND MONITORING

Wellcare With Superior HealthPlan uses multiple methods to identify potential billing irregularities, including:

- Claims analytics and code editing tools during claims processing
- Pattern recognition for potential overutilization, unbundling, upcoding, and modifier misuse
- Retrospective audits and investigations
- Prepayment Reviews

Reviews may incorporate, as applicable:

- CMS guidelines
- Federal and state regulations/guidance
- Local Coverage Determinations (LCDs)
- National Coverage Determinations (NCDs)
- Specialty-specific billing and coding guidance
- Wellcare With Superior HealthPlan clinical and billing policies
- Contractual requirements

When clinically appropriate, review may include assessment by a clinician of like specialty.

Post-Payment (Post-Processing) Claims Audits/Investigations

Overview

A post-payment audit/investigation is a review of clinical documentation for claims previously submitted. Reviews are conducted to ensure payment is supported by proper documentation, consistent with the services rendered.

Medical Record Requests and Timeframes

Wellcare With Superior HealthPlan will request medical, behavioral health, dental, vision, or pharmacy records to initiate an investigation:

- Medical records will be requested for a defined review period.
- Providers must submit requested records within the timeframe stated in the request.
- If no response is received, a **second and final request** may be issued.
- Records must be received within the timeframe specified in the second request.

As a reminder, HIPAA permits the use or disclosure of protected health information (PHI) for treatment, payment, and health care operations (TPO) without the member's or patient's consent or authorization. See 45 C.F.R. § 164.506.

Failure to Submit Records / Insufficient Documentation

If a provider:

- Fails to respond to the second and final request, **or**
- Submits records that do not document the services billed,

Consistent with applicable law, regulation, and provider agreement terms, Wellcare With Superior HealthPlan may recover all amounts paid for the services in question.

Findings Communication, Overpayments, and Recovery

Findings Results Letter

Upon completion of an investigation, Wellcare With Superior HealthPlan may issue a Proposed Action Letter (PAL) that includes:

- A summary of the review findings and outcome.
- A complete list of the claims reviewed, including the determination for each claim line.
- Documentation of the sources used to make claim-line determinations.
- Any applicable recovery amount and the basis for it.
- Notice of appeal rights

Overpayment Methodology

If documentation does not support the payment, Wellcare With Superior HealthPlan will seek recovery of identified claim payments. Depending on the scope of review, overpayments may be calculated using:

- **Claim-by-claim** review, and/or
- **Extrapolation methodology** may be used to estimate overpayment amounts through statistical sampling, consistent with program integrity methods used in Medicare and Medicaid oversight.

Appeal of Overpayment

Providers may contest the findings, the amount of the overpayment, or the methodology used to identify the overpayment by filing an appeal within 120 calendar days of the date of receipt of the PAL with supporting documentation.

Instructions for filing an appeal are provided in the initial PAL and include:

- A complete and accurate explanation of the issues being refuted. Supporting materials, medical records, or other documentation to challenge the findings.
- An appeal letter as necessary, outlining any contractual, regulatory, factual or other basis of disagreement with the findings and/or overpayment amount.

If the provider does not contest the overpayment, repay the amount due, or contact Wellcare With Superior HealthPlan within thirty calendar days of receiving the PAL to arrange payment, Wellcare With Superior HealthPlan will offset the overpayment against future claims submitted for by the provider.

Required FWA Training and Screening Requirements

Providers and their employees/contractors must comply with applicable CMS rules and regulations related to compliance training and education, including FWA training requirements. Providers and their employees must complete FWA training:

- Within 90 days of contracting, and
- Annually thereafter, as applicable (e.g., consistent with requirements referenced under § 423.504).

Exclusion / Preclusion Screening (Medicare Networks)

For Medicare lines of business, providers are required to check:

- OIG/GSA Exclusion lists, and
- The CMS Preclusion List

Prior to hiring/contracting and monthly thereafter for staff, volunteers, temporary employees, consultants, directors, and contractors who meet applicable requirements, consistent with references including:

- 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/entity.

Reporting Suspected Fraud, Waste, or Abuse

Wellcare With Superior HealthPlan encourages prompt reporting of suspected FWA. Reports may be made anonymously and are treated as confidential to the extent permitted by law.

Fraud, Waste, and Abuse Hotline: **1-866-685-8664**
Corporate Compliance/Ethics Hotline (as applicable): **1-800-345-1642**
Email (if applicable): Special_Investigations_Unit@centene.com

All reports are reviewed and investigated as appropriate.

False Claims Act (Overview)

The False Claims Act establishes liability when a person or entity improperly receives or avoids payment to the federal government. Prohibited conduct includes, but is not limited to:

- Knowingly presenting (or causing to be presented) a false claim for payment or approval
- Knowingly making or using a false record or statement material to a false or fraudulent claim
- Conspiring to violate the False Claims Act
- Knowingly making or using false statements to avoid or decrease an obligation to pay the government

For additional information, providers may reference CMS resources (e.g., www.cms.hhs.gov).

SECTION 8: QUALITY IMPROVEMENT

OVERVIEW

Wellcare With Superior HealthPlan's Quality Improvement (QI) Program is comprehensive, systematic, and continuous. It applies to all Member demographic groups, care settings, and types of services afforded to Medicare Advantage Members, including the Special Needs Plan Membership. The QI Program addresses the quality of clinical care and non-clinical aspects of service. Key areas of focus include, but are not limited to:

- Utilization Management.
- Population Health Management (including Care Management/Disease Management/Chronic Care. Improvement Program, Preventive and Clinical Health and Model of Care).
- Coordination/Continuity of Care.
- Cultural Competency.
- Credentialing.
- Patient Safety and Quality of Care.
- Peer Review.
- Appeals, Grievances and Complaints.
- Member Experience and Retention.
- Provider Experience.
- Components of operational service (including customer service/claims, etc.).
- Contractual, regulatory and accreditation reporting requirements.
- Behavioral Health Services.
- Clinical Indicators and initiatives (including HEDIS®, HOS, and Star Ratings).
- Member Record Review.
- Delegation.
- Pharmacy and Therapeutics.
- Provider Satisfaction.
- Appointment Access and Availability.
- Network Adequacy and Accessibility.
- Confidentiality and Ethics.

The QI Program reflects a Continuous Quality Improvement (CQI) philosophy and mode of action. The QI Program Description, the QI Work Plan, and the National Medicare and SNP QI and UM Program Evaluation are completed at least annually and describe CQI processes and are approved by the applicable committees. The Organization uses the CQI methodology to improve and accomplish identified goals and processes. The QI Program Description defines program structure, accountabilities, scope, responsibilities, and available resources. The Organization uses the Plan-Do-Study-Act (PDSA) method of CQI throughout the organization where multiple indicators of quality of care and service are reviewed and analyzed against benchmarks of quality clinical care, evidence-based medicine, and service delivery. When variations are noted, root cause analysis, action plans, and remeasurement occur to ensure progress toward established goals.

The strategy of PDSA incorporates the continuous tracking and trending of quality indicators to ensure that outcomes are measured and goals attained. Quality of care interventions and outcomes are monitored through nationally recognized quality standards such as HEDIS® performance measures and CAHPS® surveys, while also utilizing current knowledge and clinical experience to monitor external quality review studies, periodic medical record reviews, clinical management, and quality initiatives. Action Plans are issued annually based on market and corporate performance with each measure within the Work Plan.

The National Medicare and SNP QI and UM Work Plan identifies specific activities and initiatives carried out by the Plan and the performance measures for analysis throughout the year. Work Plan activities align with contractual, accreditation, and regulatory requirements and identify measurements to accomplish goals.

The National Medicare and SNP QI and Utilization Management Program Evaluation describes the level of success achieved in realizing set clinical and service performance goals through quantitative and qualitative analysis and trending as appropriate. The Program Evaluation describes the overall effectiveness of the QI Program by including:

- A description of ongoing and completed QI activities and initiatives.
- Trended clinical care and service performance measures as well as the desired outcomes and progress toward achieving goals.
- An analysis and evaluation of the effectiveness of the QI Program and its progress toward influencing the quality of clinical care and service.
- A description of any barriers to accomplishing quality clinical care or achieving desired outcomes
- Current opportunities for improvement with recommendations for interventions.
- Regular follow-up on action items identified in the National Medicare Quality Improvement and Utilization Management Committee (QIUMC) forum.

Network Practitioners and Providers are contractually required to cooperate with all Quality Improvement (QI) activities to improve the quality of care and services and Member experience. This includes the collection and evaluation of performance data and participation in the Wellcare With Superior HealthPlan Health Plan's, under Centene Corporation, QI programs. Practitioner and Provider contracts, or a contract addendum, also require that Practitioners and Providers allow Centene Corporation, of which Wellcare With Superior HealthPlan Health Plan is a part of, use of their performance data for quality improvement activities. To obtain a copy of the National Medicare and SNP Quality Improvement and Utilization Management Program Evaluation contact: MedicareQIProgramOperations@centene.com.

KEY PROGRAM FUNCTIONS, ACTIVITIES, AND INITIATIVES

Wellcare With Superior HealthPlan, continually assesses data and information to improve the level of care provided to its Members.

APPOINTMENT ACCESS AND AVAILABILITY MONITORING

Wellcare With Superior HealthPlan monitors geographic access through the production of reports and maps. Reports are generated using the specific access standards per regulatory agencies and accrediting bodies to ensure compliance and that the needs of all Members are met.

Wellcare With Superior HealthPlan monitors the timeliness of access to care within its Provider networks via appointment accessibility and after-hours telephone surveys per requirements outlined by regulatory agencies, contractual requirements, and accrediting bodies. Wellcare With Superior HealthPlan requires that all participating Providers, both first tier and downstream Providers, offer hours of operation that are no less than the hours of operation offered to commercial and fee-for-service Members.

Maps and accessibility reports are developed and reviewed for targeted lines of business that adhere to regulatory agencies, accrediting bodies, and company requirements. On at least a semi-annual basis, Wellcare With Superior HealthPlan completes analysis to evaluate compliance to geographic access standards and take action as appropriate. Results of the reports are reported into the appropriate committees.

In addition, average speed of answer, service level, and call abandonment rates are monitored on an ongoing basis to ensure adequate access to Wellcare With Superior HealthPlan personnel for Members and Providers. Access and availability are also monitored on an annual basis via the Member satisfaction survey. Network availability data is reported to the National Medicare Quality Improvement and Utilization Management Committee (QIUMC) on a semiannual basis.

APPEALS/CONCERNS/COMPLAINTS/GRIEVANCES

Appeals and Grievance activities are reported to the National Medicare Quality Improvement and Utilization Management Committee (QIUMC).

Within the Appeals and Grievance department, quality goals are outlined and aim to:

- Resolve 95% of complaints within compliance and/or accreditation time frames.
- Improve quality of data to facilitate reporting, tracking and trending, and analysis.
- Achieve acceptable scores on accreditation, and internal and external audits.
- Reduce the volume of appeals.
- Improve compliance and efficiency through automation whenever possible.

Issues are documented in a common database to enable appropriate classification, timely investigation, and accurate reporting of issues to the appropriate Quality committee. Trended data is reviewed on a periodic basis to determine if a need for further action exists, be it Plan, practitioner, or Provider-focused. This data, as well as any identified trends or problem areas, and mitigation strategies to eliminate top reasons for dissatisfaction are reported through the National Medicare Quality Improvement and Utilization Management Committee (QIUMC) on a quarterly basis.

For additional information pertaining to Appeals and Grievances, see *Sections 13 and 14*.

QUALITY OF CARE CONCERNS

The Medical Director is responsible for peer review activities. Peer review is conducted during the investigation of quality of care or service concerns including potential compromises of Member safety. There are multiple reasons such investigations may be initiated, including adverse/sentinel events, Member complaints, over-/under-utilization comparisons, and coordination/continuity of care statistics. The scope of

the review encompasses medical, behavioral, and pharmaceutical services as applicable and determines if there is evidence of poor quality.

MEMBER EXPERIENCE

The Member experience data collected through the CAHPS® survey addresses leading indicators of Member satisfaction including *Getting Needed Care*, *Getting Appointments and Care Quickly*, *Customer Service*, *Care Coordination*, *Rating of Drug Plan*, *Getting Needed Prescription Drugs*, *Flu Vaccination*, *Rating of Healthcare Quality*, and *Rating of Health Plan*. Wellcare With Superior HealthPlan identifies opportunities for improvement based on the information collected through the CAHPS® survey, appeals, and grievances.

Wellcare With Superior HealthPlan contracts with a NCQA-certified survey vendor to conduct the CAHPS® survey on an annual basis, using NCQA-required survey techniques and specifications required by NCQA and CMS. CAHPS® results are presented to the National Medicare Quality Improvement and Utilization Management Committee (QIUMC) for review of the committee including the external Providers that participate.

Member retention analysis and reporting is also a part of the Member experience evaluation process. The Member Experience and Retention Department strives for excellent Member satisfaction and uses voluntary disenrollment performance as the basis for monitoring success and performing root cause analyses for continual improvement of Member satisfaction.

Please refer to *Section 9: Medicare Star Ratings* for additional information regarding CAHPS®.

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

PROVIDER EXPERIENCE

The Provider network is formally surveyed by a certified vendor on an annual basis to assess Provider satisfaction with the Plan. Results are analyzed and an action plan is developed and implemented to address the areas identified as needing improvement. The results and action plan are presented to the National Medicare Quality Improvement and Utilization Management Committee (QIUMC) for approval and recommendations.

SECTION 9: MEDICARE STAR RATING

OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the healthcare system. This rating system applies to Medicare Advantage plans that cover both health services and prescription drugs (MA-PD).

The ratings are posted on the CMS consumer website, https://www.medicare.gov/, to help beneficiaries when choosing an MA and MA-PD plan offered in their area. The Star Rating program is designed to promote improvement in quality and recognize Providers for demonstrating an increase in performance measures over a defined period of time.

The goal of Star Rating is to improve the quality of care and general health status for Medicare beneficiaries and support the efforts of CMS to improve the level of accountability for the care provided by providers, hospitals and other providers. Wellcare With Superior HealthPlan supports these goals, and the organization strives for the highest rating of five stars in all domains. The Quality Improvement Committee receives Star rating results annually.

CMS's Star Rating program is based on measures in nine different domains:

PART C

1. Staying healthy: screenings, tests and vaccines.
2. Managing chronic (long-term) conditions.
3. Member experience with the health plan.
4. Member complaints, problems getting services and improvement in the health plan's performance.
5. Health plan customer service.

PART D

1. Drug plan customer service.
2. Member complaints and changes in the drug plan's performance.
3. Member experience with the drug plan.
4. Drug safety and accuracy of drug pricing.

How can Providers help improve Star ratings?

- Continue to encourage their Members to obtain preventive screenings annually or as recommended, including but not limited to:
    - Breast and/or colon cancer screening.
    - Annual flu vaccine.
- Continue to monitor and assess the well-being of those Members with chronic conditions in various ways, including:

  - Diabetes care.
  - Retinal eye exam.
  - Routine monitoring to ensure HbA1c control (<9).
  - Ensure members remain adherent to their diabetic medications and receive necessary statin therapy.
  - Controlling high blood pressure (<140/90).
  - Ensure Members remain adherent to their hypertension medications (RAS antagonists).
  - Statin therapy for Members with cardiovascular disease.
  - Ensure members remain adherent to their cholesterol medications (statin therapy).
- Provide timely osteoporosis management for women who have had a fracture through one of the following (within six months of the fracture):
  - Bone mineral density test.
  - Medication therapy to treat osteoporosis.
- Continue talking to your Members and document interventions regarding topics such as improving or maintaining mental and physical health, issues with bladder control and fall prevention.
- Create office practices to identify noncompliant Members at the time of their appointments.
- Submit complete and correct encounters/claims with appropriate codes and properly document medical chart for all members.
- Review the gap-in-care files listing Members with open gaps, which is available on our secure portal.
- Follow up with Members within 14 days post-hospitalization and complete post-hospitalization medication reconciliation.
- Identify opportunities for you or your office to have impact Member gaps in care.

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 uses 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 driven by quality, HEDIS® rates are becoming more important, not only to the health plan, but also to the individual Provider.

HEDIS® Rate Calculations

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), 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 hemoglobin A1c control for Members with diabetes (results including HbA1c, nephropathy, dilated retinal eye exams and

blood pressures) and colorectal cancer screening (colonoscopy, sigmoidoscopy, FOBT, CT, colonography or FIT-DNA test). Medication review post-hospitalization and controlling blood pressure (blood pressure results <140/90 for members with high blood pressure).

Electronic Clinical Data System (ECDS) measures are a reporting method for health plans that use digital clinical data from sources like electronic health records (EHRs) and health information exchanges (HIEs) to calculate quality metrics. These measures include screenings and follow-up for cancer (breast and colorectal) and depression, adult and prenatal immunizations.

Who conducts medical record reviews (MRR)?

Wellcare With Superior HealthPlan may contract with an independent national Medical Record Review (MRR) vendor to conduct the HEDIS® MRR on its behalf. Medical record review audits for HEDIS® can occur anytime throughout the year but are usually conducted March through May. Prompt cooperation with the MRR process is greatly needed and appreciated.

As a reminder, sharing of protected health information (PHI) used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Wellcare With Superior HealthPlan that allows it to collect PHI on our behalf.

How can Providers improve their HEDIS® scores?

- Understand the specifications established for each HEDIS® measure.
- Submit claims and encounter data for each and every service rendered. All Providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Wellcare With Superior HealthPlan. 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.
- Contact the quality improvement department with questions, comments or concerns related to the annual HEDIS® project or the medical record reviews.

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDER SYSTEMS (CAHPS®) SURVEY

The CAHPS® survey is a Member satisfaction survey that is included as a part of the Star ratings system. It is a standardized survey administered annually to Members by CMS's certified survey vendor. The survey provides information on the experiences of Members with Medicare Advantage Organization (MAO) and practitioner services and gives a general indication of how well Providers and the MAO is meeting the Members' expectations. Member responses to the CAHPS® survey are used in various aspects of the Star rating program

including monitoring of practitioner access and availability. CAHPS® survey material that may reflect on the service of Providers includes:

- Whether the Member received an annual flu vaccine.
- Whether Members perceive they are getting needed care, tests or treatment needed, including specialist appointments and prescriptions.
- Whether the Member's personal Provider's office followed up to give the member test results.
- Whether the Member's personal Provider is informed and up to date on care received from specialist.

Wellcare With Superior HealthPlan uses information regarding Member experiences to measure Member satisfaction with their healthcare. Sources of data used to evaluate experience include the annual Consumer Assessment of Health Providers and Systems (CAHPS) survey, the annual Experience of Care and Behavioral Health Outcomes (ECHO®), grievances and appeals.

MEDICARE HEALTH OUTCOMES SURVEY (HOS)

The Medicare HOS is a Member-reported outcomes measure used in the Medicare Star ratings program. The goal of the Medicare HOS is to gather data to help target quality improvement. The HOS assesses Providers' and a Medicare Advantage Organization's (MAO) ability to maintain or improve the physical and mental health of the MAO's Medicare Members over time. Wellcare With Superior HealthPlan HOS questions that may reflect on the service of Providers includes:

- Whether the Member perceives their physical or mental health is maintained or improving.
- Look for opportunities to discuss and address concerns regarding the following:
    - Mobility: Address potential needs for assistive devices.
    - Physical activity: Discuss starting, increasing or maintaining Members' level of physical activity.
    - Mental health: Address social interactions and other behavioral health needs that may require further follow-up if Provider has discussed fall risks and bladder control with the Member by considering the following:
        - Fall risk prevention: Educate Members on fall risk prevention by addressing any needs for assistive devices and reviewing any potential high-risk medications that could increase their fall risk.
        - Bladder Control: Assess the need for bladder control education and potential treatment.

SECTION 10: DEFINITIONS AND ACRONYMS

DEFINITIONS

The following terms as used in this manual shall be construed and/or interpreted as follows, unless otherwise defined in the Agreement.

Agreement means the contract under which Provider participates in Wellcare With Superior HealthPlan network.

Appeal means a request for review of some action taken by or on behalf of Wellcare With Superior HealthPlan.

Benefit Plan means a health benefit policy or other health benefit contract or coverage document (a) issued by Wellcare With Superior HealthPlan or (b) administered by Wellcare With Superior HealthPlan, pursuant to a government contract. Benefit Plans and their designs are subject to change periodically. This manual applies only to Benefit Plans issued under the Medicare Advantage program.

Centers for Medicare and Medicaid Services (CMS) means the United States Federal agency that administers Medicare, Medicaid, and Marketplace.

Clean Claim means a claim for covered services provided to a Member that (a) is received timely by Wellcare With Superior HealthPlan, (b) has no defect, impropriety, or lack of substantiating documentation from the Member's medical record regarding the covered services, (c) is not subject to coordination of benefits or subrogation issues, (d) is on a completed, legible CMS 1500 form or UB-04 form or electronic equivalent that follows current HIPAA Administrative Simplification ASC X12 837 standards and additional Wellcare With Superior HealthPlan-specific requirements in the *Wellcare With Superior HealthPlan Companion Guide*, including all current guidelines regarding coding and inclusive code sets, and (e) includes all relevant information necessary for Wellcare With Superior HealthPlan to (1) meet requirements of laws and program requirements for reporting of covered services provided to Members, and (2) determine payer liability, and ensure timely processing and payment by Wellcare With Superior HealthPlan. A Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim that is under review for Medical Necessity.

Co-Surgeon means one of multiple surgeons who work together as primary surgeons performing distinct part(s) of a surgical procedure.

Covered services means Medically Necessary healthcare items and services covered under a Benefit Plan.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant individual, the health of the individual or their unborn child.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part

Encounter Data means encounter information, data and reports for covered services provided to a Member that meets the requirements for Clean Claims.

Full Benefit Dual Eligible (FBDE) means Members who are eligible to have full Medicaid and full Medicare benefits.

Grievance means any complaint or dispute, other than one that involves a Wellcare With Superior HealthPlan determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of Wellcare With Superior HealthPlan, regardless of whether remedial action can be taken. Grievances may include, but are not limited to, complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item and may only be brought on behalf of a Member.

Ineligible Person means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may be identified in the list of excluded individuals/entities maintained by the Office of the Inspector General of the U.S. Department of Texas Health and Human Services (OIG), or (ii) Federal procurement or non-procurement programs, as may be identified in the excluded parties list system maintained by the U.S. General Services Administration, (b) has been convicted of a criminal offense subject to OIG's mandatory exclusion authority for Federal Health Care Programs described in Section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in state medical assistance programs, including Medicaid or CHIP, or state procurement or non-procurement programs as determined by a state governmental authority.

Medically Necessary or **Medical Necessity** means those healthcare items or services that are (i) necessary to protect life, prevent significant illness or significant disability or to alleviate severe pain, (ii) individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the Member's needs, (iii) consistent with generally accepted professional medical standards and not experimental or investigational, (iv) reflective of the level of service that can be provided safely and for which no equally effective and more conservative or less costly treatment is available statewide, (v) provided in a manner not primarily intended for the convenience of the Member, the Member's caretaker or the healthcare Provider, and (vi) not custodial care as defined by CMS. For healthcare items and services provided in a hospital on an inpatient basis, "Medically Necessary" also means that such items and services cannot, consistent with the provisions of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient facility of a different type. The fact that a healthcare Provider has prescribed, recommended or approved healthcare items or services does not, in itself, make such items or services Medically Necessary.

Member means an individual properly enrolled in a Benefit Plan and eligible to receive covered services at the time such services are rendered.

Member Expenses means copayments, coinsurance, deductibles, or other cost-share amounts, if any, that a Member is required to pay for covered services under a Benefit Plan.

Organization Determination means any determination made by a Wellcare With Superior HealthPlan with respect to the following:

- Payment for temporarily out-of-the-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.
- Payment for any other health services furnished by a Provider other than the Wellcare With Superior HealthPlan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for or reimbursed by the Wellcare With Superior HealthPlan.
- The Wellcare With Superior HealthPlan's refusal to provide or pay for services, in whole or in part, including the type or level of services that the enrollee believes should be furnished or arranged for by the Wellcare With Superior HealthPlan.
- Reduction or premature discontinuation of a previously authorized ongoing course of treatment.
- Failure of the Wellcare With Superior HealthPlan to approve, furnish, arrange for, or provide payment for healthcare services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

Primary Care Provider (PCP) means a licensed medical doctor (MD) or doctor of osteopathy (DO) or certain other licensed medical practitioners who, within the scope of practice and in accordance with state certification licensure requirements, standards, and practices, is responsible for providing all required primary care services to Members. A PCP shall include general/family practitioners, pediatricians, internists, physician assistants, CNMs or NP-Cs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with licensure requirements.

Provider means an individual or entity that has contracted, directly or indirectly, with Wellcare With Superior HealthPlan to provide or arrange for the provision of covered services to Members under a Benefit Plan as a participant in Wellcare With Superior HealthPlan's network.

QMB+ means Qualified Medicare Beneficiary whose income is up to 100% of the Federal Poverty Level. These individuals are considered a zero-cost-share dual-eligible Member since Medicaid pays both the Medicare Parts A and B premiums and Medicare Parts A and B cost-share. These Members have full Medicaid benefits.

SLMB+ means Specified Low-Income Medicare Beneficiary whose income is up to 120% of the Federal Poverty Level. These individuals are considered a zero cost-share dual-eligible Member since Medicaid pays the Medicare Part B premiums and Medicare Parts A and B cost-share. These Members have full Medicaid benefits.

Wellcare With Superior HealthPlan Companion Guide means the transaction guide that sets forth data requirements and electronic transaction requirements for Clean Claims and encounter data submitted to Wellcare With Superior HealthPlan or its affiliates, as amended from time to time.

Zero Cost-Share Dual-Eligible Member means a dual-eligible Member who is not responsible for paying any Medicare Part A or Part B cost-share amounts.

ABBREVIATIONS

ACS – American College of Surgeons
AEP – Annual enrollment period
AHP – Allied health professional
AIDS – Acquired Immune Deficiency Syndrome
ALJ – Administrative law judge
AMA – American Medical Association
ARNP – Advanced Registered Nurse Practitioner
CAD – Coronary artery disease
CAHPS® – Consumer Assessment of Healthcare Providers and Systems
CDS – Controlled Dangerous Substance
CHF – Congestive heart failure
CIA – Corporate Integrity Agreement
CLAS – Culturally and linguistically appropriate services
CMS – Centers for Medicare & Medicaid Services
CNM – Certified Nurse Midwife
COB – Coordination of benefits
COPD – Chronic obstructive pulmonary disease
CORF – Comprehensive outpatient rehabilitation facility
CPT-4 – *Physician's Current Procedural Terminology, 4th Edition*
C-SNP – Chronic Special Needs Plan
CSR – Controlled Substance Registration
DDE – Direct data entry
DEA – Drug Enforcement Agency
DM – Disease Management
DME – Durable medical equipment
DOC – Delegation Oversight Committee
DSM-IV – *Diagnostic and Statistical manual of Mental Disorders, 4th Edition*
D-SNP – Dual-Eligible Special Needs Plan
EDI – Electronic data interchange
EOB – Explanation of Benefits
EOP – Explanation of Payment
ESRD – End-stage renal disease
FBDE – Full Benefit Dual-Eligible Members
FDA – Food and Drug Administration
FFS – Fee-for-service
FWA – Fraud, waste and abuse
HEDIS® – Healthcare Effectiveness Data and Information Set
HHA – Home health agency
HHS – U.S. Department of Health and Human Services
HIPAA – Health Insurance Portability and Accountability Act of 1996
HIV – Human Immunodeficiency Virus
HMO – Health maintenance organization
HMO-POS – Health maintenance organization with point-of-service option
HOS – Medicare Health Outcomes Survey

HRA – Health Risk Assessment
HTN – Hypertension
ICD-10-CM – *International Classification of Diseases, 10th Revision, Clinical Modification*
ICP – Individualized Care Plan
ICT – Interdisciplinary Care Team
INR – Inpatient nursing rehabilitation facility
IPA – Independent physician association
IRE – Independent Review Entity
IVR – Interactive voice response
JNC – Joint National Committee
LCSW – Licensed Clinical Social Worker
LTAC – Long-term acute care facility
MA – Medicare Advantage
MAC – Medicare Appeals Council
MIPPA – Medicare Improvements for Members and Providers Act of 2008
MOC – Model of Care
MOOP – Maximum out-of-pocket
MSP – Medicare Savings Program
NCCI – National Correct Coding Initiative
NCQA – National Committee for Quality Assurance
NDC – National Drug Codes
NIH – National Institutes of Health
NPI – National Provider Identifier
NPP – Notice of Privacy Practices
OA – Osteopathic Assistant
OB – Obstetric/obstetrical/obstetrician
OIG – Office of Inspector General
OT – Occupational therapy
OTC – Over the counter
P&T – Pharmacy and Therapeutics Committee
PA – Physician Assistant
PCP – Primary Care Provider
PHI – Protected health information
POS – Point-of-service
PPC – Provider-preventable condition
Provider ID – Provider identification number
PT– Physical therapy
QDWI – Qualified Disabled Working Individual
QI – Qualifying Individual
QI Program – Quality Improvement Program (*also referred to as* QIP)
QIO – Quality Improvement Organization
QIUMC -- Quality Improvement and Utilization Management Committee
QMB – Qualified Medicare Beneficiary
QMB+ – Qualified Medicare Beneficiary Plus
RN – Registered Nurse

SFTP – Secure file transfer protocol
SIE – Site inspection evaluation
SLMB – Specified Low-Income Medicare Beneficiary
SLMB+ – Specified Low-Income Medicare Beneficiary Plus
SNF – Skilled nursing facility
SNIP – Strategic National Implementation Process
SSN – Social Security Number
ST – Speech therapy
Tax ID/TIN – tax identification number
TNA – Transition Needs Assessment
TOC – Transition of care
UM – Utilization management
WEDI™ – Workgroup for Electronic Data Interchange

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