Wellpoint Massachusetts

# Provider Manual

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wellpoint.com

Wellpoint

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Wellpoint is a health benefits company providing health benefits exclusively to people insured through the Group Insurance Commission (GIC). Administrative services for the plan are provided by Wellpoint Life & Health Insurance Company, a wholly owned subsidiary of Wellpoint Corporation, whose parent company is Elevance Health, Inc.

The Commonwealth of Massachusetts is solely responsible for the determination of eligibility and payment of any amounts due under the plan.



Wellpoint retains the right to add to, delete from, and otherwise modify this provider manual. Contracted providers must acknowledge this provider manual and any other written materials provided by Wellpoint as proprietary and confidential.

**Please note:** The material in this provider manual is subject to change. For the most up-to-date information, please visit wellpoint.com.

**About the GIC**

The Group Insurance Commission of Massachusetts – the GIC – is the state agency responsible for Wellpoint's plan design and for payment of all benefits. Funding and insurance for Wellpoint plan members are provided by the Commonwealth of Massachusetts. Wellpoint provides administrative services such as claims processing, member services, and utilization management for the GIC.

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# Introduction

Wellpoint is committed to working together with our Providers and Facilities to make a real impact on health for their patients – our Members. That's why we continue our focus to streamline our processes to help make it easier for care provider partners to find and use the information they need for their business interactions with us. With this collaboration, it's one more way that we're working to ensure Members have access to high-quality, affordable healthcare.

This Provider Manual (Manual) contains important information regarding key administrative requirements, policies, and procedures. While the Manual covers a wide array of policies, procedures, forms, and other useful information that can be found and maintained on our website at **wellpoint.com**, a few key topics are:

- Claims submission
- Reimbursement and administrative policies and requirements
- Utilization management
- Quality improvement

As participants in our diverse network, our Providers and Facilities agree to comply with Wellpoint policies and procedures, including those contained in this Manual. Payment may be denied, in full or in part, should Providers or Facilities fail to comply with the Manual. However, in the event of an inconsistency between the Agreement and this Manual, the Agreement will govern.

**Provider/Facility**

This Manual is intended to support all entities and individuals who have executed a Provider or Facility agreement with Wellpoint. The use of Provider within this Manual refers to entities and individuals contracted with Wellpoint who submit professional Claims. They may also be referred to as Professional Providers in some instances. The use of Facility within this manual refers to entities contracted with Wellpoint who submit institutional Claims, such as Acute General Hospitals and Skilled Nursing Facilities. General references to provider website and similar terms apply to both Providers and Facilities.

Capitalized terminology shown in this Manual is the same capitalized terminology shown in the Wellpoint Facility Agreement or Wellpoint Provider Agreement, referred to in this Manual as Agreement.

**Updates to the Provider Manual**

This Manual may be updated at any time and is subject to change. If there is a material change to this Manual, Wellpoint will make reasonable efforts to notify Providers and Facilities in advance of such change through web-posted newsletters or email communications. In such cases, the most recently published information will supersede all previous information and be considered the current directive.

**Important disclaimer**

Please note that this Manual is not intended to be a complete catalog of all Wellpoint policies and procedures. Other policies and procedures not included in this Manual may be posted on the Wellpoint website or published in specially targeted communications, including but not limited to bulletins and newsletters. This Manual does not contain legal, tax or medical advice. Providers and Facilities should consult their advisors for advice on these topics.

# Professional and Respectful Communication Standards

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

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

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

# Legal and Administrative Requirements

## Affiliates

Affiliates are an important concept in Wellpoint's Provider and Facility Agreements, as these entities access the rates, terms, or conditions of the agreements. An Affiliate is defined as any entity that is: (i) owned or controlled, either directly or through a parent or subsidiary entity, by Wellpoint, or any entity which controls or is under common control with Wellpoint, and/or (ii) that is identified as an Affiliate on a designated web site as referenced in the provider manual(s).

## Clinical Data Sharing

When requested by Wellpoint, Providers are required to submit clinical data (such as discharge summaries, consult notes, and medication lists) and admission, discharge, and transfer (ADT) data to Wellpoint for certain healthcare operations functions. We collect this data to improve the quality and efficiency of healthcare delivery to our Members. Providers are required to submit:

- Facilities must provide Wellpoint with, at a minimum, Health Level Seven International (HL7) Admission, Discharge and Transfer (ADT) messaging data for all Members on a near real-time basis, including all standard HL7 message events pertaining to ADT as published by HL7. Facility will transfer required message data segments according to the standard HL7 format, or as requested by Wellpoint. For purposes of this section, "near real-time basis" means no later than twenty-four (24) hours from admission, discharge, or transfer of any Members.
- Clinical data for a Member on a daily, weekly, or monthly basis, in a mutually agreeable format and method based on the Provider's electronic medical record (EMR) or other electronic data sharing capabilities, e.g., industry-standard CCDA clinical data format.

Wellpoint's permitted uses of the data with respect to clinical data requests include utilization management, case management, identification of gaps in care, conducting clinical quality improvement, risk adjustment, documentation in support of HEDIS® and other regulatory and accrediting reporting requirements, and for any other purpose permitted under HIPAA.

Wellpoint has determined the data requested is the minimum necessary for Wellpoint to accomplish its intended purposes. The data will be provided in accordance with data layout and format requirements defined by Wellpoint.

## Coordination of Benefits

If a Member or eligible dependent is covered by more than one Health Benefit Plan, the carriers involved work together to prevent duplicate payments for any services. This cooperative effort is called Coordination of Benefits ("COB"), a provision in most Health Benefit Plans.

If a Plan is other than the primary payor, any further compensation to the Provider or Facility from the Plan or the Member will be determined in accordance with the Agreement, the applicable Health Benefit Plan, and any applicable Plan written policies and procedures for coordinating benefits. Such compensation from the Plan as a secondary payer, plus the amounts owed by all other sources, including the Member, shall add up to one hundred percent (100%) of the Plan rate.

Notwithstanding the foregoing, in no event shall Plan or the Member be required to pay more than they would have paid had the Plan been the primary payor. Providers and Facilities will not collect any amount from the Member if such amount, when added to the amounts collected from the primary and

secondary payors, would cause total reimbursement to the Provider or Facility for the Covered Service to exceed the amount allowed for the Covered Service under the Agreement. Further, this provision shall not be construed to require Providers or Facilities to waive Cost Share in contravention of any Medicare rule or regulation, nor shall this provision be construed to supersede any other Medicare rule or regulation. If, under this Section, Providers and Facilities are permitted to seek payment from other sources by reason of the existence of other group coverage in addition to Plan's Health Benefit Plan. Providers and Facilities may seek payment from other sources on a basis other than the Plan rate.

**Make the most of Electronic Coordination of Benefits (COB) submissions**

Availity is Wellpoint's designated electronic data interchange (EDI) gateway. To learn more, contact the EDI vendor.

**When filing Coordination of Benefits Claims on paper submission**

Include an Explanation of Benefit (EOB) from the primary insurance carrier with coordination of benefits (COB) Claims submitted for secondary payment.

## Dispute Resolution, Mediation, and Arbitration

The substantive rights and obligations of Wellpoint, Providers, and Facilities with respect to resolving disputes are set forth in the Wellpoint Provider Agreement (the "Agreement") or the Wellpoint Facility Agreement (the "Agreement"). All administrative remedies set forth in the Agreement shall be exhausted prior to filing an arbitration demand. The following provisions set forth the procedures and processes that must be followed during the exercise of the Dispute Resolution and Arbitration Provisions in the Agreement. To the extent possible, the language of the Agreement and the Provider Manual should be read together and harmonized if there are details in one not addressed in the other.

A. Fees and Costs

   All fees and costs associated with neutrals, logistics, and administration of confidential non-binding mediation and confidential binding arbitration (i.e., mediator travel and fee, arbitrator(s) travel and fee(s), arbitration association administrative costs, etc.) shall be shared equally between the parties. Each party shall be responsible for the payment of its own fees and costs that the party incurs (i.e., attorney fees, experts, depositions, document production, e-discovery, etc.). Notwithstanding this provision, the arbitrator or panel of arbitrators may issue an order in accordance with Federal Rule of Civil Procedure Rule 11 or the respective state rule counterpart, awarding a party its fees if that party requested fees under Rule 11, or the respective state court counterpart rules in its initial pleadings. Notwithstanding this provision, the arbitrator or panel of arbitrators may issue an order in conjunction with a party's offer of judgment in accordance with Federal Rule of Civil Procedure Rule 68.

B. Location of the Arbitration

   The arbitration hearing will be held in the city and state in which the Wellpoint office, identified in the address block on the signature page to the Agreement, is located except that if there is no address block on the signature page, then the arbitration hearing will be held in the city and state in which the Wellpoint Plan identified in the Agreement has its principal place of business. Notwithstanding the foregoing, both parties can agree in writing to hold the arbitration hearing in some other location.

C. Pre-Arbitration Mediation and Selection and Replacement of Arbitrator(s)

Refer to the Agreement for invoking dispute resolution requirements, monetary thresholds of disputes (exclusive of interest, costs or attorney fees) that require a meeting to discuss and in effort to resolve or that require pre-arbitration mediation and selection of the mediator. In the event of a dispute where the dispute resolution provision is invoked, the first step is for the complaining entity to provide written notice containing a detailed description of the dispute, all relevant underlying facts, a detailed description of the amount(s) in dispute and how they have been calculated and any other information in this Provider Manual describing the policy, procedure, process and so on that is being disputed.

Refer to the Agreement for governing arbitration rules, monetary thresholds (exclusive of interest, costs or attorney fees) as applicable, selection of a single arbitrator or panel of three arbitrators, and replacement of an arbitrator.

D. Consolidation

The arbitrator or panel of arbitrators does not have the authority to consolidate separately filed arbitrations, for discovery or otherwise, without written consent and agreement by the parties. The arbitrator or panel of arbitrators does not have the authority to permit Providers or Facilities under separate Agreements with Wellpoint to bring one arbitration action without written consent and agreement by the parties. Rather, each Provider or Facility with separate Agreements should file for separate arbitration in its own name, unless there is written consent and agreement by the parties to consolidate the action, in some fashion.

E. Discovery

The parties recognize that litigation in state and federal courts can be costly and burdensome. One of the parties' goals in providing for disputes to be mediated and arbitrated instead of litigated is to reduce the costs and burdens associated with resolving disputes. Accordingly, the parties expressly agree that discovery shall be conducted with strict adherence to the rules and procedures established by the mediation or arbitration administrator identified in the Agreement, except that the parties will be entitled to serve requests for production of documents and data, which shall be governed by Federal Rules of Civil Procedure 26 and 34. The parties shall confer and draft an Order Regarding Procedures for Production Format and Electronic Discovery, which shall be presented to the arbitrator or panel of arbitrators for review, approval, and entry.

F. Decision of Arbitrator(s)

The decision of the arbitrator, if a single arbitrator is used, or the majority decision of the arbitrators, if a panel is used, shall be binding upon the parties. The arbitrator(s) may construe or interpret, but shall not vary or ignore, the provisions of the Agreement and shall be bound by and follow controlling law. The arbitrator(s) shall not toll or modify any applicable statute of limitations set forth in the Agreement or controlling law if the Agreement is silent. If there is a dispute regarding the applicability or enforcement of the class waiver provisions found in the Agreement, that dispute shall only be decided by a court of competent jurisdiction and shall not be decided by the arbitrator(s). Either party may request either a reasoned award or decision, or findings of facts and conclusions of law, and if either party makes such a request, the arbitrator(s) shall issue such an award or decision setting forth the factual and legal basis for the decision.

The arbitrator(s) may consider and decide the merits of the dispute or any issue in the dispute on a motion for summary disposition. In ruling on a motion for summary disposition, the arbitrator(s) shall apply the standards applicable to motions for summary judgment under Federal Rule of Civil Procedure 56.

Judgment upon the award rendered by the arbitrator(s) may be confirmed and enforced in any court of competent jurisdiction. Without limiting the foregoing, the parties hereby consent to the jurisdiction of the courts in the State(s) in which Wellpoint is located, as identified in the address block on the signature page to the Agreement, and of the United States District Courts sitting in the State(s) in which Wellpoint is located, as identified in the address block on the signature page to the Agreement, for confirmation, specific enforcement, or other relief in furtherance of the arbitration proceedings or to enforce judgment of the award in such arbitration proceeding.

If a party files an interim award, award, or judgment with a state or federal district court, then all documents must be filed under seal to ensure confidentiality as outlined below, and only the portions outlining the specific relief or specific enforcement, or performance shall be filed, and the remainder of the opinion or decision shall be redacted.

Refer to the Agreement for monetary thresholds (inclusive of interest, costs, and attorney fees) as applicable for the right to appeal the decision of the arbitrator or panel of arbitrators. A decision that has been appealed shall not be enforceable while the appeal is pending.

G. Interest

Providers or Facilities agree that the state's statutory pre-judgment interest statute is inapplicable to Dispute Resolution and Arbitration. Should the arbitrator(s) determine that pre-judgment interest is appropriate and issue an award including it, pre-judgment shall be simple, not compounded, at an annual percentage rate no more than five percent (5%) or the interest applied for "clean claims", whichever is less. If an award is issued and it includes post-judgment interest, it will not begin accruing until thirty (30) business days after the date of the award to allow time for payment. If an appeal is taken by either side, the obligation to pay any damages and/or interest awarded shall be tolled until a decision is reached as the result of the appeal.

H. Confidentiality

Subject to any disclosures that may be required or requested under state or federal law, all statements made, materials generated or exchanged, and conduct occurring during the arbitration process including, but not limited to, materials produced during discovery, arbitration statements filed with the arbitrator(s), and the decision of the arbitrator(s), are confidential and shall not be disclosed in any manner to any person who is not a director, officer, or employee of a party or an arbitrator or used for any purpose outside the arbitration. If either party files an action in federal or state court arising from or relating to a mediation or arbitration, all documents must be filed under seal to ensure that confidentiality is maintained. Nothing in this provision, however, shall preclude Wellpoint or its parent company from disclosing any such details regarding the arbitration to its accountants, auditors, brokers, insurers, reinsurers, retrocessionaires, or affiliates and Other Payors whose Claims have been at issue in the arbitration, including Administrative Services Only (ASO) groups.

## Financial Institution/Merchant Fees

Providers and Facilities are responsible for any fees or expenses charged to them by their own financial institution or payment service provider.

## Insurance Requirements

Providers and Facilities shall self-insure or maintain insurance in types and amounts reasonably determined by Providers and Facilities, or as required under applicable licensing or regulatory requirements.

## Misrouted Protected Health Information (PHI)

Providers and Facilities are required to review all Member information received from Wellpoint to ensure no misrouted PHI is included. Misrouted PHI includes information about Members that a Provider or Facility is not currently treating. PHI can be misrouted to Providers and Facilities by mail, fax, email, or electronic remittance. Providers and Facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are Providers or Facilities permitted to misuse or re-disclose misrouted PHI. If Providers or Facilities cannot destroy or safeguard misrouted PHI, Providers and Facilities must contact Provider Services to report receipt of misrouted PHI.

## Open Practice

Providers shall give Wellpoint sixty (60) days prior written notice when Provider no longer accepts new patients.

## Provider and Facility Data Verification Required

Massachusetts Regulation 211 CMR 52.15 mandates accurate provider and facility data to enhance the Online Provider Directory.Providers and Facilities are required to review and verify the accuracy to any of the following every ninety (90) days:

- Provider/facility name
- Address
- Specialty
- Phone number
- Digital contact information

## Provider and Facility Digital Engagement

Wellpoint expects Providers and Facilities will utilize digital tools unless otherwise prohibited by law or other legal requirements for transactions such as filing Claims, prior authorizations, verifying eligibility and benefits, paperless payments, etc. Providers and Facilities should refer to the guidance included throughout this Manual where digital tools are available. For a complete list of digital tools, refer to the *Digital Applications* section and *Provider and Facility Digital Guidelines* subsection in this Manual.

## Provider and Facility Notification Requirements

Providers and Facilities are responsible for notifying Wellpoint when changes occur within the Provider practice or Facility. All changes must be approved by Wellpoint. Providers and Facilities should reference their Agreement for specific timeframes associated with change notifications.

Examples of these changes include, but are not limited to:

- Adding new or removing practitioners to the group
- Change in ownership
- Change in tax identification number
- Making changes to demographic information or adding new locations
- Selling or transferring control to any third party
- Acquiring other medical practice or entity

- Change in accreditation
- Change in affiliation
- Change in licensure or eligibility status
- Change in operations, business, or corporation

## Referring to Non-Participating Providers

Wellpoint's mission is to provide affordable quality health care benefits to its Members. Members access their highest level of health care benefits from Network/Participating Providers and Facilities. Providers and Facilities put Members at risk of higher out-of-pocket expenses when they refer to non-participating providers in non-emergent situations or without Wellpoint's prior approval. Wellpoint has established Maximum Allowed Amounts for services rendered by non-participating providers. Once Wellpoint determines the appropriate Maximum Allowed Amount for services provided by a non-participating provider, the payment will be remitted to the Member in most situations rather than the non-participating provider; and Members may be balance-billed by non-participating providers for the difference between the amount they charge for the service and the amount paid to that non-participating provider. Wellpoint's Group Indemnity Plan covers Massachusetts Group Insurance Commission (GIC) members. Massachusetts law prohibits any Massachusetts-based provider, including non-participating ones, from balance billing GIC members. (M.G.L. c. 32A, § 20). Providers and Facilities are reminded that pursuant to their Agreement with Wellpoint, they are generally required to refer Members to other Network/Participating Providers and Facilities. Providers and Facilities that establish a pattern of referring Members to non-participating providers may be subject to disciplinary action, up to and including termination from the Network. Wellpoint understands that there may be instances in which Providers and Facilities must refer to a non-participating provider. For additional information on in-network and out-of-network referrals, Providers and Facilities should refer to the applicable sections of their Agreement with Wellpoint.

## Risk Adjustments

### Compliance with Federal Laws, Audits, and Record Retention Requirements

Medical records and other health and enrollment information of Members must be handled under established procedures that:

- Safeguard the privacy of any information that identifies a particular Member;
- Maintain such records and information in a manner that is accurate and timely; and
- Identify when and to whom Member information may be disclosed.

In addition to the obligation to safeguard the privacy of any information that identifies a Member, Wellpoint, Providers, and Facilities are obligated to abide by all Federal and state laws regarding confidentiality and disclosure for medical health records (including mental health records) and enrollee information.

# Digital Applications

## Provider Website

The Wellpoint website is a public website. **wellpoint.com**

Wellpoint designed the provider public website to make navigation easy and more useful for Providers and Facilities. The website holds timely and important information to assist providers when working with Wellpoint. Go to the **Wellpoint Provider webpage** and from the menu **For Providers,** choose content available.

- Provider Overview
    - Claims & reimbursement
        - File claims and check eligibility with Availity
        - Reimbursement and administrative policies
        - Filing electronic claims
    - Medical policies & guidelines
    - Preapproval & preauthorization
    - Enhanced Personal Health Care (EPHC)
    - Forms & documents
        - Provider reference / notification requirements
        - HCAS Provider Enrollment Form
        - Provider Information Change Form
        - Wellpoint member ID cards
        - Member and Provider Urgent Appeals
- Support
    - About us
    - Contact us
    - Provider News

## E-mail Communications

Wellpoint produces a monthly newsletter, *Provider News*, designed to notify Providers, Facilities, and their staff about updates, events, and changes in processes and policies. Providers and Facilities can sign up for email communications to be notified when a newsletter is published and receive other notifications from Wellpoint. To sign up for our email communications, go to our ***Provider News* website** and select the **Subscribe to Email** button.

*Note: Provider News* emails will come from ProviderCommunications@email.**wellpoint**.com. Add this to your browser's sender/recipient list to ensure our emails are received.

## Online Provider Directory and Demographic Data Integrity

Providers and Facilities are able to confirm their Network participation status by using the **Find Care** tool. A search can be done on a specific provider name or by viewing a list of local in-network Providers and Facilities using search features such as provider specialty, zip code, and plan type.

### Online Provider Directory

Accessing the Online Provider Directory:

- Go to the **Wellpoint Provider webpage**
- Select the **Find Care** link at the top right of the page.

Before directing a Member to another Provider or Facility, verify that the Provider or Facility is participating in the Member's specific network. ***Note***: The Member's Network Name should be on the front of the Member's ID card.

To help ensure Members are directed to Providers and Facilities within their specific Network, utilize the online provider directory in one of the following ways:

  - **Search as a Member**: Search by entering the Member's ID number (including the three-character prefix), or simply enter the three-character prefix by itself.
  - Select **Basic Search as Guest**.

Providers and Facilities who have questions on their participation status listed in the online directory should contact the number on the back of the Member's ID card.

### Updating Demographic Data with Wellpoint

It is critical that Members receive accurate and current data related to Provider availability. Providers and Facilities must notify Wellpoint of any demographic changes.

All requests must be received sixty (60) days **prior** to the change/update. Any requests received with less than sixty (60) days' notice may be assigned a future effective date. Contractual terms may supersede effective date requests.

**Important:** If updates are not submitted sixty (60) days prior to the change, Claims submitted for Members may be the responsibility of the Provider or Facility.

Types of demographic data updates can include, but are not limited to:

- Accepting new patients
- Address additions, terminations, updates (including physical and billing locations)
- Areas of expertise (behavioral health only)
- Email address
- Handicapped accessibility
- Hospital affiliation and admitting privileges
- Languages spoken
- License number
- Name change (provider/organization or practice)
- National provider identifier (NPI)
- Network participation
- Office hours/days of operation

- Patient age/gender preference
- Phone/fax number
- Provider leaving group, retiring, or joining another practice*
- Specialty
- Tax identification number (TIN) (must be accompanied by a W-9 to be valid)
- Termination of provider participation agreement**
- Web address

Visit the **Wellpoint Provider Forms and Documents webpage** for provider enrollment and demographic change information.

* To request participation for a new provider or practitioner, even if joining an existing practice, providers or practitioners, email us at **WellpointProviderRelations@wellpoint.com**.

**For notices of termination from a Wellpoint network, Providers and Facilities should refer to the termination clause in the Agreement for specific notification requirements. Allow the number of days' notice of termination from Wellpoint's network as required by the Agreement (e.g., 90 days, 120 days, etc.).

## Availity Essentials

We offer digital solutions that will enhance collaboration and streamline your interactions, helping to eliminate complexities and improve transparency, traceability, and the entire experience for you and our Members.

**Availity Essentials is available to all Provider and Facilities**

- **Multi-payer access:** Users can access data from Wellpoint Medicare, Medicaid and other Commercial insurers (See **Availity.com** for a full list of payers.)
- **No charge:** Wellpoint transactions are available at no charge to providers.
- **Standard responses:** Responses from multiple payers returned in the same format and screen layout, providing users with consistency across payers.
- **Compliance:** Availity Essentials is compliant with all Health Insurance Portability and Accountability Act (HIPAA) regulations.
- **Accessibility:** Availity Essentials functions are available 24/7 from any computer with Internet access.

**Availity Essentials simplifies the way we work together through these and other applications and processes:**

- **Eligibility and Benefits application** – get current patient coverage and benefits information. Access Member's digital ID cards. Use the Patient Registration tab to access Eligibility and Benefits
- **Submit Claims** – use the Claims & Payments application or through the EDI gateway
- **Claims Status application** – monitor Claim status, submit documents, and file Claims disputes online. Access Claims Status from the Claims & Payments tab.

- **Authorizations** – submit for medical or behavioral health inpatient or outpatient services. File appeals and track authorization cases. Access the Authorization from the Patient Registration tab
- **Remittance Advice** – view, print, or save a copy of your remittance advice through the Claims Status application or through Remittance Inquiry in Payer Spaces
- **Clinical Documentation Lookup Application** – searches our Medical Policies by CPT code and returns a list of documents needed to process your Claim.

**Additional digital methods of engagement include:**

- **Carelon Medical Benefits Management:** Access link to precertification requests and inquiries for specific services and access the OptiNet Survey when applicable at providerportal.com.
- **Claims Attachments:** Submit supporting Claims documentation for initial, pended, or denied Claims through Availity.com using the Attachments – New, Attachments Dashboard, or Claims Status applications. For Providers registered in Medical Attachments through Availity.com, receive digital notifications about additional documents needed for Claims processing through Digital RFAI for faster Claims processing. Use the Medical Attachments functions to submit documentation electronically through the EDI 275 transaction.
- **Member Certificate Booklet:** View a Member's certificate of coverage, online, where available. From Availity.com, select the Patient Registration tab to access Eligibility and Benefits. The Certificate of Coverage link will be at the top of the page of a successful eligibility and benefits transaction if available in your market.
- **Secure Messaging**: Secure messaging is an alternate way to receive claim status when you did not receive the information you need through self-service and a Claims Status inquiry. From a successful Claim status transaction, select the Secure Messaging link to submit a question about the Claim. From Availity.com, go to Payer Spaces, select the payer then use the Resources Tab to access Secure Messaging responses.

**Payer Spaces**

To access WellPoint-specific applications, use **Payer Spaces** from Availity.com:

- **Clinical Documentation Lookup Tool:** Use this new application to learn what documents you should submit with your prior authorization or Claim based on our Medical Policies and UM Guidelines.
- **Custom Learning Center:** Access payer-specific training and educational videos.
- **Provider Digital RFAI Progress Dashboard:** For Providers who are enrolled in Medical Attachments and using the Attachments Dashboard to receive digital notifications when additional documentation is needed to process their Claims, use this Dashboard to show your organization's attachment performance.
- **Provider Online Reporting**: access proprietary Provider-specific reports such as Member rosters and Provider Contract and Fee Schedule notifications.
- **Remittance Inquiry**: Eliminate paper remittances by using the Remittance Inquiry application to view an imaged copy of the Wellpoint remittance advice for up to fifteen (15) months in the past.
- **Total Member View (TMV)**: A robust picture of a Member's health and treatment history, including gaps in care and care reminders.

### Getting Started and Availity Essentials Training

To register for access to Availity Essentials, go to **Availity.com/providers/registration-details/**. For additional assistance in getting registered, contact Availity Client Services at **1-800-AVAILITY (282-4548)**.

After logging into Availity Essentials, Providers and Facilities have access to many resources to help jumpstart learning, including free and on-demand training, frequently asked questions, comprehensive help topics and other resources to help ensure Providers and Facilities get the most out of the Availity Essentials experience. Availity Essentials also offers onboarding modules for new Administrators and Users.

From Availity.com, select **Help & Training** (from the top navigation menu on the Availity Essentials home page), **Get Trained**, and type "*onboarding*" in the search catalog field.

### Availity Essentials Training for Wellpoint-specific tools

Learn about Wellpoint-specific applications through the Custom Learning Center. From **Payer Spaces,** select **Applications** to access the Custom Learning Center for presentations and reference guides. Find additional learning opportunities through the Provider Learning Hub. To visit the Wellpoint version of the Provider Learning Hub, go to your public provider site and select the Provider Learning Hub link located with Availity information.

### Organization Maintenance

To update Administrator or Organization information:

- To replace the Administrator currently on record with Availity Essentials, call Availity Client Services at **1-800-AVAILITY (282-4548)**.
- An Administrator can use the Maintain Organization feature on Availity.com to maintain the organization's demographic information, including address, phone number, tax ID, and NPI updates. Any changes made to this information automatically apply to all Users associated with the organization and affect only the registration information on Availity Essentials.

### Support

Submit a support ticket for additional help or technical difficulties through Availity Essentials:

1. Log onto Availity.com
2. Select **Help & Training** to access **Availity Support**
3. Select organization, then **Continue**
4. Select **Contact Support** from the top menu bar, then **Create Case**

## Provider and Facility Digital Guidelines

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

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

The Digital Guidelines establish the standards for using secure digital Provider platforms (websites) and applications when transacting business with Wellpoint. These platforms and applications are accessible to both participating and nonparticipating Providers and Facilities and encompass

Availity.com, electronic data interchange (EDI), electronic medical records (EMR) connections and business-to-business (B2B) desktop integration.

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

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

Digital functionality available through Availity Essentials includes:

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

Additional digital applications available to Providers and Facilities include:

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

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

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

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

**Section 1: Accepting digital ID cards**

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

**Section 2: Eligibility and benefits inquiry and response**

Providers and Facilities should leverage these Availity clearinghouse-hosted channels for electronic eligibility and benefit inquiry and response:

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

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

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

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

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

<u>Claim submissions status and Claims payment disputes</u>

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

- EDI transaction: X12 837 – professional, institutional, and dental Claim submission (version 5010):
    - Wellpoint supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.
    - 837 Claim batch upload through EDI allows Providers and Facilities to upload a batch/file of Claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – Claim status inquiry and response:
    - Wellpoint supports the industry standard X12 276/277 transaction set for Claim status inquiry and response as mandated by HIPAA.
- Availity Essentials – Claims & Payments application
    - The Claims & Payments application enables Providers and Facilities to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.
- The Claim Status application enables Providers and Facilities to access online Claim status. Access the Claim payment dispute tool from Claim Status. Claims Status also enables online Claim payment disputes in most markets and for most Claims. Provider desktop integration via B2B APIs:
    - Wellpoint has also enabled real-time access to Claim status via APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software, and some EMR software. Contact Availity for available vendor integration.

Claim attachments

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

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

**Section 5: Electronic remittance advice and electronic Claims payment**

Electronic remittance advice

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

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

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

To stop receiving ERAs for Claims, contact Availity Client Services at **1-800-AVAILITY** (282-4548).

To re-enable receiving paper remittances, contact Provider Services.

Electronic Claims payment

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

- **Electronic Funds Transfer (EFT)**

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

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

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

- **Virtual Credit Card (VCC)**

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

  Note that Wellpoint may receive revenue for issuing a VCC.

  **Opting out of virtual credit card payment**. Providers and Facilities are entitled to opt out of electronic payment. To opt out of virtual credit card payment, there are two (2) options:

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

    OR

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

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

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

Note that Wellpoint may receive revenue for issuing ZPN.

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

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

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

  OR

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

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

# Credentialing

Credentialing is the process Wellpoint uses to evaluate healthcare practitioners and health delivery organizations (HDOs) to provide care to Members to help ensure Wellpoint's standards of professional conduct and competence are met. Wellpoint's Credentialing Program Summary includes a complete list of the provider types within Wellpoint's credentialing scope. The credentials of healthcare practitioners and HDOs are evaluated according to Wellpoint's criteria, standards, and requirements as set forth in our Program Summary and applicable state and federal laws, regulatory, and accreditation requirements. Wellpoint retains discretion to amend, change or suspend any aspect of Wellpoint's Credentialing Program, and the Program Summary is not intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to Members. Wellpoint further retains the right to approve, suspend, or terminate individual practitioners and HDOs in those instances where it has delegated credentialing decision-making.

Wellpoint's Credentialing Program Summary also includes the recredentialing process which incorporates re-verification and the identification of changes in the practitioner's or HDO's credentials that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Wellpoint credentialing standards. All applicable practitioners and HDOs in Wellpoint's network within the scope of the Credentialing Program are required to be recredentialed at least every three (3) years unless otherwise required by applicable state contract or state regulations.

The Wellpoint Credentialing Program Summary is below.

## Wellpoint Credentialing Program Summary

### Wellpoint's Discretion

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

### Credentialing Scope

Credentialing requirements apply to the following:

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

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

- Individual or group practices
- Locum tenens:
    - Provisional Credentialing is required if these practitioners work less than 60 calendar days.

    - Full Credentialing is required if these practitioners work 60 calendar days or more.
    - Covering practitioners (e.g., locum tenens) who do not have an independent relationship with the Company are not included in the Credentialing scope.
- Facilities
- Rental networks:
    - That are part of Wellpoint's primary Network and include Wellpoint Members who reside in the rental network area.
    - That are specifically for out-of-area care and Members may see only those practitioners or are given an incentive to see rental network practitioners; and
- Telemedicine
- PPO network:
    - If an organization contracts with a PPO network to provide health services to members who need care outside its service area, and if it encourages members to obtain care from that network when they are outside the network, NCQA considers this to be an independent relationship if:
        - Information about the network is included in member materials or on an ID card that directs members to the network (e.g., network name, phone number, logo), *or*
        - There are incentives for members to see the PPO's practitioners.
    - In this type of contractual arrangement, the organization must credential the practitioners or delegate credentialing to the PPO network.

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

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors
- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan, including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral health care specialists who provide treatment services under the Health Benefit Plan
- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dietitians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process, including verification of licensure by the applicable state licensing board, to independently provide

behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

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

Wellpoint credentials the following Health Delivery Organizations (HDOs):

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

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

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
- End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission
- Portable X-ray Suppliers (CMS Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)
- Orthotics and Prosthetics Suppliers (American Board for Certification in Orthotics and Prosthetics (ABCOP) or Board of Certification/Accreditation (BOC), or The National Examining Board of Ocularists (NEBO))

**Credentials Committee**

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

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated. In states or regions where a Wellpoint-affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or a Wellpoint medical director designee, and the vice-chair must be a lead medical officer or a Wellpoint medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (e.g., nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region, as per the chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (e.g., Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

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

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

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Wellpoint's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of their right to correct erroneous information or provide additional details regarding the issue, and will include the process for submission of this additional information. Depending on the nature of the issue, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date.  All communication on the issue, including copies of the correspondence or a detailed

record of phone calls, will be documented in the practitioner's or HDO's credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Upon request, the practitioner or HDO will be provided with the status of their credentialing or re-credentialing application.

Wellpoint may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

**Nondiscrimination Policy**

Wellpoint will not discriminate against any applicant for participation in its programs or provider network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Wellpoint is required to include fields for the collection of practitioner race, ethnicity, and language on the application. However, Wellpoint does not use such reported to discriminate against a practitioner, and the application includes a statement indicating the provision of such information is optional. Additionally, Wellpoint will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Determinations as to which practitioners and providers require additional individual review by the Credentials Committee are made according to predetermined criteria related to professional conduct and competence. Credentials Committee decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Wellpoint will review denials and terms for consistency and lack of discrimination annually to identify discriminatory practices in the selection of practitioners. These reviews are documented in a report summary format by reason for the denial or term for initial denials, recredentialing, terminations, and off-cycle terminations. The reasons for denial or term include: not board certified, license/board action, malpractice, education/training, hospital privileges, criminal conviction, DEA, hospital action, insurance, work history gap, and federal sanctions. In addition, audits of practitioner complaints about credentialing shall be reviewed annually for evidence of alleged discrimination. Should discriminatory practices be identified through annual review or through other means, Wellpoint will take appropriate action(s) to track and eliminate those practices.

**Initial Credentialing**

Each practitioner or HDO must complete a standard application form deemed acceptable by Wellpoint when applying for initial participation in one or more of Wellpoint's networks or plan programs. For practitioners, the Council for Affordable Quality Healthcare (CAQH) ProView system is utilized. To learn more about CAQH, visit their website at CAQH.org.

Wellpoint will verify those elements related to an applicant's legal authority to practice, relevant training, experience, and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 120-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards. The application attestation, including work history verification, must be dated and verified within 180 calendar days prior to the Credentials Committee decision.

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

A. Practitioners

Verification Elements

- License to practice in the state(s) in which the practitioner will be treating Members.
- Hospital admitting privileges at a TJC, DNV NIAHO, CIHQ, or ACHC-accredited hospital, or a Network hospital previously approved by the committee.
- DEA/CDS and state-controlled substance registrations
    - The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.
- Malpractice insurance
- Malpractice claims history
- Board certification or the highest level of medical training or education
- Work history
- State or Federal license sanctions, exclusions or limitations
- Medicare, Medicaid, or FEHBP sanctions and exclusions
- National Practitioner Data Bank report
- State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Elements

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

**Re-credentialing**

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

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

**Health Delivery Organizations**

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

oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

### Ongoing Sanction Monitoring

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

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

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

### Appeals Process

Wellpoint has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Wellpoint's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Wellpoint may wish to terminate practitioners or HDOs. Wellpoint also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Wellpoint's Networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB).

Additionally, Wellpoint will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions that may have led to such denial (informal/ reconsideration only). It is Wellpoint's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Wellpoint's Networks or Plan Programs, and those denials of requests for initial participation that are reported to the NPDB that were based on professional conduct and competence considerations.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation, or revocation, if a practitioner or HDO has been sanctioned, debarred, or excluded from the Medicare, Medicaid, or FEHB programs, has a criminal conviction, or Wellpoint's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network

participation has been terminated due to sanction, debarment, or exclusion from the Medicare, Medicaid, or FEHB are not eligible for informal review/reconsideration or formal appeal.

**Reporting Requirements**

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

**Wellpoint Credentialing Program Standards**

Eligibility Criteria

A. Health care practitioners:

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

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

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

1. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.
2. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
3. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
4. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.
    a. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
        i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty

for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;

ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or

iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Wellpoint's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

b. Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Wellpoint education, training, and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Wellpoint review and approval. Reports submitted by delegates to Wellpoint must contain sufficient documentation to support the above alternatives, as determined by Wellpoint.

5. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (DNV NIAHO), Center for Improvement in Healthcare Quality (CIHQ), an Accreditation Commission for Health Care (ACHC) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may, at its discretion, deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.
6. For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.
7. For Registered Dieticians (RD), the applicant must have completed a bachelor's degree at a US regionally accredited university or college and coursework accredited or approved by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics. Completion of an ACEND-accredited supervised practice program at a healthcare facility, community agency, or a food services corporation, or combined with undergraduate or graduate studies. Typically, a practice program will run six (6) to twelve (12) months in length. Must have passed a national examination administered by the Commission on Dietetic Registration (CDR).

<u>Criteria for Selecting Practitioners</u>

New Applicants (Credentialing):

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3. Primary source verifications within acceptable timeframes of the date of submission to the

CC for a vote, as deemed by appropriate accrediting agencies.

4. No evidence of potential material omission(s) on application.
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members.
6. No current license action.
7. No history of licensing board action in any state.
8. No current federal sanction or exclusion and no history of federal sanctions or exclusions (per System for Award Management (SAM), OIG, and OPM report, nor on NPDB report).
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one state must have a valid DEA/CDS registration for each applicable state.
10. Initial applicants who voluntarily have no DEA/CDS registration, the exception listed below may apply, or if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:
    a. It can be verified that this application is pending.
    b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber.
    c. The applicant agrees to notify Wellpoint upon receipt of the required DEA/CDS registration.
    d. Wellpoint will verify the appropriate DEA/CDS registration via standard sources.
        i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar-day timeframe will result in termination from the Network.

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

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

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

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

11. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for Practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating Practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.
12. No history of or current use of illegal drugs or history of or current substance use disorder.
13. No impairment or other condition that would negatively impact the ability to perform the essential functions in their professional field.
14. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.
15. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
16. A minimum of the past 10 years of malpractice claims history is reviewed.
17. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Wellpoint's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs, and board certification criteria for DPMs, and oral and maxillofacial surgeons;
18. No involuntary terminations from an HMO or PPO.
19. No "yes" answers to attestation/disclosure questions on the application form, with the exception of the following:
    a. Investment or business interest in ancillary services, equipment, or supplies;
    b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. Voluntary surrender of state license related to relocation or nonuse of said license;
    d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    f. Previous failure of a certification exam by a practitioner who is currently board

certified or who remains in the five-year post-residency training window.

g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
h. History of a licensing board, hospital, or other professional entity investigation that was closed without any action or sanction.

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

Participation Criteria and Exceptions for Non-Physician Credentialing.

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

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type based on state licensing regulations:
    a. Master or doctoral degree in social work.
    b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a doctor of social work will be viewed as acceptable.
    c. Licensure to practice independently.
2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC), or other master level license type based on state licensing regulations:
    a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family, and child counseling, or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
    b. Master or doctoral degrees in divinity, masters in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
    c. Practitioners with PhD training as a clinical psychologist can be reviewed.
    d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
    e. Licensure to practice independently or in states without licensure or certification:
        i. Marriage & Family Therapists with a master's degree or higher:
            a. Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).
        ii. Mental Health Counselors with a master's degree or higher:
            a. Provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) (proof of NBCC certification required) or meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).
3. Pastoral Counselors:
    a. Master's or doctoral degree in a mental health discipline.
    b. Licensed as another recognized behavioral health provider type (e.g., MD/DO, PsyD, SW, RNCS, ARNP, and MFT, OR LPC) at the highest level of independent

practice in the state where the practice is to occur OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.

c. A fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) OR meet all requirements to become a fellow or diplomat member of the ACPE [documentation of eligibility of ACPE required].

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

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

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

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

8. Process, requirements and Verification – Nurse Practitioners:
    a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the licensing agency does not verify highest level of education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Wellpoint procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
    e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
        i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
        ii. American Academy of Nurse Practitioners – Certification Program;
        iii. National Certification Corporation;
        iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner);
        v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
        vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.
    f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ,

TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.

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

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

        This certification must be active. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.
    f. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee, or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.

g. The CNM applicant will undergo the standard credentialing process outlined in Wellpoint's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies, including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the Network.

10. Process, Requirements, and Verifications – Physician's Assistants (PA):
    a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Wellpoint procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
    e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Wellpoint Health Plan and submitted for individual review by the CC.
    f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
    g. The PA applicant will undergo the standard credentialing process outlined in Wellpoint's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

<u>Currently Participating Applicants (Re-credentialing)</u>

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred, or excluded from participation in any of the following programs: Medicare, Medicaid, or FEHBP. If, once a practitioner

participates in Wellpoint's Plan programs or provider Networks, federal sanction, debarment or exclusion from the Medicare, Medicaid, or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Wellpoint's other credentialed provider Networks.

4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction or exclusion and no new (since prior credentialing review) history of federal sanctions or exclusions (per SAM, OIG, and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or substance use disorder;
10. No impairment or other condition that would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO.
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    b. Voluntary surrender of state license related to relocation or nonuse of said license;
    c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;
    f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
15. No quality improvement data or other performance data including complaints above the set threshold.

16. Re-credentialed at least every three years to assess the practitioner's continued compliance with Wellpoint standards.

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

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

B. HDO Eligibility Criteria

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

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

HDO Type and Wellpoint Approved Accrediting Agent(s)

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

| Facility Type (Medical Care) | Acceptable Accrediting Agencies |
|---|---|
| Skilled Nursing Facilities/Nursing Homes | CARF, TJC |
| Durable Medical Equipment Suppliers | TJC, CHAP, TCT, ACHC, BOC, HQAA |

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

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

## Standards of Participation for Non-Credentialed Providers and Facilities

Wellpoint contracts with many types of providers that do not require credentialing as described on **Wellpoint Provider webpage**. However, to become a Network/Participating Provider or Facility, certain standards of participation still must be met. In addition to the insurance requirements listed in the Legal and Administrative Requirements section of this Manual, and standards of participation and accreditation requirements outlined in the Provider Agreement, the chart below outlines requirements that must be met in order to be considered for contracting as a Network/Participating Provider or Facility in one of these specialties.

*Note: This is only a representative listing of provider types that do not require formal credentialing. For questions about whether a Provider or Facility is subject to the formal credentialing process or the applicable standards of participation, contact Network Management.

| Provider/Facility | Standards of Participation |
|---|---|
| Ambulance (Air & Ground) | Medicare Certification/State Licensure |
| Ambulatory Event Monitoring | Medicare Certification |
| Convenient Care Centers (CCCs)/ Retail Health Clinics (RHC) | DNV/NIAHO, UCAOA, TJC |
| Hearing Aid Supplier | State Licensure |
| Intermediate Care Facilities | CTEAM |
| Immunization Clinic | CDC Certification Pharmacy License, Medicare Certification |
| Private Duty Nursing | TJC, CHAP, CTEAM, ACHC, or DNV/NIAHO |
| Urgent Care Center (UCC) | AAAHC, IMQ, NUCCA (formerly ABUCM), TJC, UCAOA |

# Claims Submission

## Electronic Claims Submissions

Providers and Facilities are expected to submit Claims electronically whenever possible. Claims must be submitted within the timely filing timeframe specified in the Provider or Facility Agreement. Refer to the Electronic Data Interchange (EDI) section in this Manual for more details about electronic submissions, and to learn more about how EDI can work for Providers and Facilities.

For instructions on connecting and submitting to the Availity Essentials EDI Gateway, review the **Availity Essentials Batch Companion Guide**.

## Claim Submission Filing Tips

Eliminate processing delays and unnecessary correspondence with these Claim filing tips:

### Ambulatory Surgical Centers

When billing revenue codes, always include the CPT or HCPCS code for the surgery being performed. This code is required to determine the procedure, and including it on the Claim helps Wellpoint process the Claim correctly and more quickly. Ambulatory surgical Claims must be billed on a CMS-1500 (Form 1500 (02-12)) or CMS-1450 (UB04), as indicated in the Agreement.

### Ambulance Claims

- Include the Point of Pickup (POP) ZIP Code for all ambulance (including air ambulance) Claims, both institutional outpatient, and professional.
- Air Ambulance providers contracted through a facility should submit services on UB-04 CMS 1450 (facility claim forms).
- The POP (Point of Pick-up) ZIP Code should be submitted as follows:
    - *Professional Claims* – for CMS-1500 submitters: the POP ZIP code is reported in field 23 or 54
    - *Institutional outpatient Claims* – for UB submitters: the Value Code of ‘A0’ (zero), and the related ZIP Code of the geographic location from which the beneficiary was placed on board the ambulance, should be reported in the Value Code Amount field and billed with the appropriate revenue 54x codes.

### Independent Clinical Laboratory Claims

- Independent lab Claims are determined by the place of service 81.
- Unless exempted by state or other legal guidelines, Wellpoint requires the CLIA number to be included on each Claim billed for laboratory services by any Provider or Facility performing tests covered by CLIA. Wellpoint requires the CLIA identification number to be submitted based on the applicable method below:
    - ASC X12 837 professional Claim
    - Claim format REF segment as REF02, with qualifier of “X4” in REF01 or
    - Field 23 of the paper CMS-1500

### CPT Coding

The most current version of the CPT® Professional Edition manual is considered by Wellpoint as the industry standard for accurate CPT and modifier coding.

### Duplicate Claims

Providers and Facilities should refrain from submitting a Claim multiple times to avoid potential duplicate denials. Providers or Facilities can check the status of Claims via Availity Essentials.

### Maternity Delivery Claims

Delivery procedure codes reported on a professional Claim are required to submit with the appropriate Z3A diagnosis code indicating the baby's gestational age.

Procedure codes on a professional Claim:

- 59400 through 59430 for vaginal delivery.
- 59510 through 59525 for cesarean section delivery.

Revenue codes on a facility Claim:

- 0720 through 0729

An inpatient facility billed as a healthy newborn may be combined to the mother's delivery claim depending on the state guidelines.

Stays beyond the first forty-eight (48) / ninety-six (96) hours require authorization for healthy newborns.

All NICU will need to be authorized for appropriate level of care.

### National Drug Codes (NDC)

See separate subsection titled *National Drug Codes*.

### Negative Charges

When filing Claims for procedures with negative charges, don't include these lines on the Claim. Negative charges often result in an out-of-balance Claim that must be returned to the provider for additional clarification.

### Not Otherwise Classified ("NOC") Codes

- When submitting Not Otherwise Classified (NOC) codes, follow these guidelines to avoid possible Claim processing delays**. Wellpoint must have a clear description of the item/service billed with a NOC code for review**.
    - If the NOC is for a drug, include the drug's name, dosage, NDC number, and number of units.
    - If the NOC is not a drug, include a specific description of the procedure, service or item.
    - If the item is durable medical equipment, include the manufacturer's description, model number, and purchase price if rental equipment.
    - If the service is a medical or surgical procedure, include a description on the Claim and submit medical record/and the operative report (if surgical) that support the use of an NOC and medical necessity for the procedure.

- If the NOC is for a laboratory test, include the specific name of the laboratory test(s) and/or a short descriptor of the test(s)

NOTE: NOC codes should only be used if there are no appropriate listed codes available for the item or service. Descriptions should be included in the shaded area for item 24 on professional Claim forms, or locator 43 on facility Claim forms.

**Occurrence Dates**

When billing facility Claims make sure the surgery date is within the service from and to dates on the Claim. Claims that include a surgical procedure date that falls outside the service from and to dates will be returned to the provider.

**Other Insurance Coverage**

When filing Claims with other insurance coverage ensure the following fields are completed and that a legible copy of the Explanation of Benefits (EOB) from the other insurance coverage is attached to the Claim:

- CMS-1500 Fields:
  - Field 9: Other insured's name
  - Field 9a: Other insured's policy or group number
  - Field 9b: Other insured's date of birth
  - Field 9c: Employer's name or school name (not required in EDI)
  - Field 9d: Insurance plan name or program name (not required in EDI)
- UB-04 CMS-1450 Fields:
  - Field 50a-c: Payer Name
  - Field 54a-c: Prior payments (if applicable)

**Including Explanation of Medicare Benefits (EOMB) or other payer Explanation of Benefits (EOB)**

When submitting a CMS Form 1500 (02-12) or CMS-1450 (UB-04) Claim form with an Explanation of Medicare Benefits (EOMB) attached, the EOMB should indicate Medicare's Assignment. When submitting a CMS Form 1500 (02-12) or CMS-1450 (UB-04) Claim form with an Explanation of Medicare Benefits (EOMB) or other payer Explanation of Benefits (EOB) attached, the EOMB or EOB should match each service line and each service line charge submitted on the CMS Form 1500 (02-12) or CMS-1450 (UB-04).

**Preventive Colonoscopy – correct coding**

Wellpoint allows for preventive colonoscopy in accordance with state mandates. Colonoscopies, which are undertaken as a SCREENING colonoscopy, during which a polyp/tumor or other procedure due to an abnormality is discovered, should be covered under benefits for Preventive Services. This has been an area of much confusion in billing by Providers and Facilities of services. Frequently, the Provider or Facility will bill for the CPT code with an ICD-10 diagnosis code corresponding to the pathology found, rather than the "Special screening for malignant neoplasms, of the colon."

CMS has issued guidance on correct coding for this situation and states that the ICD-10 diagnosis code Z12.11 (**Encounter for screening for malignant neoplasm of colon**) should be entered as the

primary diagnosis and that the ICD-10 diagnosis code for any discovered pathology should be entered as the secondary diagnosis on all subsequent Claim lines.

Wellpoint endorses this solution for this coding issue as the appropriate method of coding to ensure that the Provider or Facility receives the correct reimbursement for services rendered and that Members receive the correct benefit coverage for this important service.

**Type of Billing Codes**

When billing facility Claims ensure the type of bill coincides with the revenue code(s) billed on the Claim. For example, if billing an outpatient revenue code, the type of bill must be for outpatient services.

## Claim Inquiry/Adjustment Filing Tips

The different types of Claim inquiries should be handled in separate ways depending on what is being requested. Here are some examples:

- **Claim Inquiry:** A question about a Claim or Claim payment is called an inquiry. Claim Inquiries do not result in changes to Claim payments, but the outcome of the Claim Inquiry may result in the initiation of the Claim Payment Dispute. In other words, once the Provider or Facility receives the answer to the Claim Inquiry, the Provider or Facility may opt to begin the Claim Payment Dispute process.

  Providers and Facilities can Chat with Payer or send a Secure Message through Availity Essentials. If Providers or Facilities are unable to utilize Availity Essentials for the inquiry they can call the number on the back of the Member ID Card and select the *Claims* prompt. For further details on Secure Messaging, reference the *Availity Essentials* section in this Manual.
- **Claim Correspondence:** Claim Correspondence is when Wellpoint requires more information to finalize a Claim. Typically, Wellpoint makes the request for this information through the Explanation of Payment (EOP) or through Availity for Digital RFAI. The Claim or part of the Claim may be denied, but it is only because more information is required to process the Claim. Once the information is received, Wellpoint will use it to finalize the Claim. To upload the requested documentation from Availity.com, select the Claims & Payments tab to access Claims Status. Enter the necessary information to locate the claim and use the Submit Attachments button to upload requested documentation. For Digital RFAI, you may also attach through your Dashboard.
- **Clinical/Medical Necessity Appeals:** Information about an appeal regarding a clinical decision denial, such as an authorization or Claim that has been denied as not medically necessary, experimental/investigational, is located in the *Clinical Appeals* section within the Provider Manual.
- **Claim Payment Disputes:** Refer to the *Claim Payment Dispute* section for further details.
- **Precertification/Prior Authorization Disputes:** Precertification/Prior Authorization disputes should be handled via the process detailed in the letter received from the precertification department. If Providers or Facilities disagree with a clinical decision follow the directions detailed in the letter. A Precertification/Prior Authorization appeal can be submitted through the digital prior authorization application on Availity.com. Select the Patient Registration tab to access Authorizations & Referrals. Sending precertification/predetermination requests or appeals to the provider correspondence address may delay responses.

- **Corrected Claims:** Submit a corrected claim only when updating information on the Claim form. Access your claim on Availity.com through the Claims & Payments tab. If the inquiry is about the way the Claim processed, refer to the prior sections. If Providers or Facilities have corrections to the claim, submit them according to the Corrected Claim Guidance below.

**Proof of Timely Filing**

Claims must be submitted within the two-year (2) timely filing. All additional information reasonably required by Wellpoint to verify and confirm the services and charges must be provided on request. ***Claims submitted after the timely filing period expires will be denied, unless proof of timely filing can be demonstrated according to the guidelines listed below.***

Waiver of the timely filing requirement is only permitted when Wellpoint has received documentation indicating the Member, Provider, or Facility originally submitted the Claim within the applicable timely filing period. The documentation submitted **must** indicate the Claim was originally submitted before the timely filing period expired.

**Acceptable documentation includes the following:**

1. A copy of the Claim with a **computer-printed filing date** (a handwritten date isn't acceptable)
2. An original fax confirmation specifying the Claim in question and including the following information: date of service, amount billed, Member name, original date filed with Wellpoint and description of the service
3. The Provider or Facility's billing system printout showing the following information: date of service, amount billed, Member name, original date filed with Wellpoint and description of the service
    - If the Provider or Facility doesn't have an electronic billing system, approved documentation is a copy of the Member's chart indicating the billed date and/or a copy of the billing records indicating the billed date, and the information listed above.
4. If the Claim was originally filed electronically, a copy of Wellpoint's electronic Level 2 or the respective clearinghouse's acceptance/rejection Claims report is required; a copy can be obtained from the Provider or Facility's EDI vendor, EDI representative or clearinghouse representative. The Provider or Facility also must demonstrate that the Claim and the Member's name are on the original acceptance/rejection report. Note: When referencing the acceptance/reject report, the Claim must show as accepted to qualify for proof of timely filing. Any rejected Claims must be corrected and resubmitted within the timely filing period.
5. A copy of the Wellpoint letter requesting additional Claim information showing the date information was requested.

Appeals for Claims denied for failing to meet the timely filing requirements must be submitted to Wellpoint **in writing**. Wellpoint doesn't accept appeals over the phone.

**Corrected Claim Guidance**

When submitting a correction to a previously submitted Claim, submit the entire Claim as a replacement Claim if Providers or Facilities have omitted charges or changed Claim information (i.e., diagnosis codes, procedure codes, dates of service, etc.), including all previous information and any corrected or additional information. To correct a Claim that was billed to Wellpoint in error, submit the entire Claim as a void/cancel of the prior Claim. If there is a zero Member, Provider, or Facility liability, then a new Claim is needed instead of a corrected Claim.

**Regarding paper claims:** Claims originally filed on paper are accessible through Availity.com. Submit replacement, void/canceled claims through Availity.com following the instructions below for digital submission. Do not use the paper submission process unless there is a specific reason for filing a paper claim correction.

| Type | Professional Claim | Institutional Claim |
|---|---|---|
| **EDI** | To indicate the Claim is a replacement Claim:<br>• In element CLM05-3 “Claim Frequency Type Code”<br>• Use Claim Frequency Type 7 | To indicate the Claim is a replacement Claim:<br>• In element CLM05-3 “Claim Frequency Type Code”<br>• Use Claim Frequency Type 7 |
| | To confirm the Claim that is being replaced:<br>• In Segment “REF – Payer Claim Control Number”<br>• Use F8 in REF01 and list the original payer Claim number is REF02 | To confirm the Claim that is being replaced:<br>• In Segment “REF – Payer Claim Control Number”<br>• Use F8 in REF01 and list the original payer Claim number is REF02 |
| | To indicate the Claim was billed in error (Void/Cancel):<br>• In element CLM05-3 “Claim Frequency Type Code”<br>• Use Claim Frequency Type 8 | To indicate the Claim was billed in error (Void/Cancel):<br>• In element CLM05-3 “Claim Frequency Type Code”<br>• Use Claim Frequency Type 8 |
| | To confirm the Claim which is being void/cancelled:<br>• In Segment “REF – Payer Claim Control Number”<br>• Use F8 in REF01 and list the original payer Claim number is REF02 | To confirm the Claim which is being void/cancelled:<br>• In Segment “REF – Payer Claim Control Number”<br>• Use F8 in REF01 and list the original payer Claim number is REF02 |
| **Digital** | Submit replacement, void/cancel claims through **Availity.com** | Submit replacement, void/cancel claims through **Availity.com** |
| | Select the Claims & Payments tab and click Professional Claim | Select the Claims & Payments tab and click Facility Claim |
| | Enter the clam information and set the billing frequency and payer control number as follows:<br>• Select **Replacement of Prior Claim** or **Void/Cancel of Prior Claim** for the **Billing Frequency** (or **Frequency Type**) field, in the **Claim Information**<br>• Set the **Payer Control Number** (ICN/DCN) (or **Payer Claim Control Number**) field to the claim number assigned to the claim by the payer. You can obtain this number from the 835, if available. | Enter the clam information and set the billing frequency and payer control number as follows:<br>• Select **Replacement of Prior Claim** or **Void/Cancel of Prior Claim** for the **Billing Frequency** (or **Frequency Type**) field, in the **Claim Information**<br>• Set the **Payer Control Number (ICN / DCN)** (or **Payer Claim Control Number**) field to the claim number assigned to the claim by the payer. You can obtain this number from the 835, if available. |
| **Paper** | To indicate the Claim is a replacement Claim:<br>• In Item Number 22: “Resubmission and/or Original Reference Number”<br>• Use Claim Frequency Type 7 under “Resubmission Code” | To indicate the Claim is a replacement Claim:<br>• In Form Locator 04: “Type of Bill”<br>• Use Claim Frequency Type 7 |
| | To confirm the Claim that is being replaced:<br>In the right-hand side of Item Number 22 under “Original Ref. No.”, list the original payer Claim number for the resubmitted Claim. | To confirm the Claim that is being replaced:<br>In Form Locator 64: “Document Control Number (DCN)” list the original payer Claim number for the resubmitted Claim. |

| Type | Professional Claim | Institutional Claim |
|---|---|---|
| | To indicate the Claim is a void/cancel of a prior Claim:<br>• In Item Number 22: “Resubmission and/or Original Reference Number”<br>• Use Claim Frequency Type 8 under “Resubmission Code” | To indicate the Claim is a void/cancel of a prior Claim:<br>• In Form Locator 04: “Type of Bill”<br>• Use Claim Frequency Type 8 |
| | To confirm the Claim which is being void/cancelled:<br>In the right-hand side of Item Number 22 under “Original Ref. No.” list the original payer Claim number for the void/cancelled Claim. | To confirm the Claim which is being void/cancelled:<br>In Form Locator 64: “Document Control Number (DCN)” list the original payer Claim number for the void/cancelled Claim. |

For additional information on provider complaints and appeals, refer to the *Claim Payment Dispute* and *Clinical Appeals* sections.

## National Drug Codes (NDC)

All practitioners and providers are required to supply the 11-digit NDC when billing for injections and other drug items on the CMS1500 and UB04 Claim forms as well as on the 837 electronic transactions.

Line items on a Claim regarding drugs administered in a physician office or outpatient facility setting for all drug categories will deny if they do not include the following:

- Applicable HCPCS code or CPT code
- Number of HCPCS code or CPT code units
- The valid 11-digit NDC, including the N4 qualifier
- Unit of measure qualifier (F2, GR, ML, UN, ME)
- NDC Units dispensed (must be greater than 0)

**Unit of Measurement Requirements**

The unit of measurement codes are also required to be submitted. The codes to be used for all Claim forms are:

- F2 – International unit
- GR – Gram
- ML – Milliliter
- UN – Unit
- ME – Milligram

**Location of the NDC**

The NDC is found on the label of a prescription drug item and must be included on the CMS-1500 or UB04 Claim form or in 837 electronic transactions. The NDC is a universal number that identifies a drug or related drug item.

| NDC Number Section | Description |
|---|---|
| 1 (five digits) | Vendor/distributor identification |
| 2 (four digits) | Generic entity, strength, and dosage information |
| 3 (two digits) | Package code indicating the package size |

### Correcting Omission of a Leading Zero

Providers and Facilities may encounter NDCs with fewer than 11 digits. In order to submit a Claim, Providers and Facilities will need to convert the NDC to an 11-digit number. Sometimes the NDC is printed on a drug item, and a leading zero has been omitted in one of the segments. Instead of the digits and hyphens being in a 5-4-2 format, the NDC might be printed in a 4-4-1 format (example, 1234-1234-1), a 5-3-2 format (example, 12345-123-12), or a 5-4-1 format (example, 12345-1234-1).

- If this occurs, when entering the NDC on the Claim form, it will be required to add a leading zero to the beginning of the segment(s) that are missing the zero.
- Do not enter any of the hyphens on Claim forms.

See the examples that follow:

| If the NDC appears as… | Then the NDC… | And it is reported as … |
|---|---|---|
| NDC 12345-1234-12<br>(5-4-2 format) | Is complete | 12345123412 |
| NDC 1234-1234-1<br>(4-4-1 format) | Needs a leading zero placed at the beginning of the first segment and the last segment | 01234123401 |
| NDC 12345-123-12<br>(5-3-2 format) | Needs a leading zero placed at the beginning of the second segment | 12345012312 |
| NDC 12345-1234-1<br>(5-4-1 format) | Needs a leading zero placed at the beginning of the third segment | 12345123401 |

### Process for Multiple NDC numbers for Single HCPC Codes

- If there is more than one NDC within the HCPCS code, Providers and Facilities must submit each applicable NDC as a separate Claim line. Each drug code submitted must have a corresponding NDC on each Claim line.
- If the drug administered is comprised of more than one ingredient (i.e., compound or same drug with different strength, etc.), Providers and Facilities must represent each NDC on a Claim line using the same drug code.
- Standard HCPCs billing accepts the use of modifiers to determine when more than one NDC is billed for a service code. They are:
    - KO – Single drug unit dose formulation
    - KP – First drug of a multiple drug unit dose formulation
    - KQ – Second or subsequent drug of a multiple drug unit dose formulation
    - JW – Drug amount discarded /not administered to the patient

### How/Where to Place the NDC on a Claim Form

### 837 Reporting Fields

Providers and Facilities will need to notify billing or software vendors that the NDC is to be reported in the following fields in the 837 format.

| Loop | Segment | Element Name | Information | Sample |
|---|---|---|---|---|
| 2410 | LIN02 | Product or Service ID Qualifier | Enter product or NDC qualifier N4 | LIN**__**N4**__***01234567891~ |
| 2410 | LIN03 | Product or Service ID | Enter the NDC | LIN**N4*01234567891~ |
| 2410 | CTP04 | Quantity | Enter quantity billed | CTP******__**2**__***UN~ |
| 2410 | CTP05-1 | Unit of Basis for Measurement Code | Enter the NDC unit of measurement code:<br>F2: International unit<br>GR: Gram<br>ML: Milliliter<br>UN: Unit<br>ME: Milligram | CTP******2*__**UN**__~ |
| 2410 | REF01 | Reference ID Qualifier (used to report Prescription # **or** Link Sequence Number when reporting components for a Compound Drug) | VY: Link Sequence Number<br>XZ: Prescription Number | REF01*__**XZ**__*123456~ |
| 2410 | REF02 | Reference Identification | Prescription Number **or** Link Sequence Number | REF01*XZ*__**123456**__~ |

**Digital submission through Availity.com:**

- From Availity.com, select the Claims & Payments tab, then select Professional Claim or Facility Claim.
- Enter the NDC code in the NDC Code field that is associated with the procedure code/service line.
- In the NDC Quantity field, you can enter a maximum of 13 numbers before the decimal point and a maximum of two numbers after the decimal point.
- Convert the NDC to 11-digits following the instructions noted above.

For more information about how to submit an electronic claim, including the NDC Code field using Availity Essentials, log onto Availity.com, select the Help & Training tab, and enter Professional or Facility Claim in the search bar.

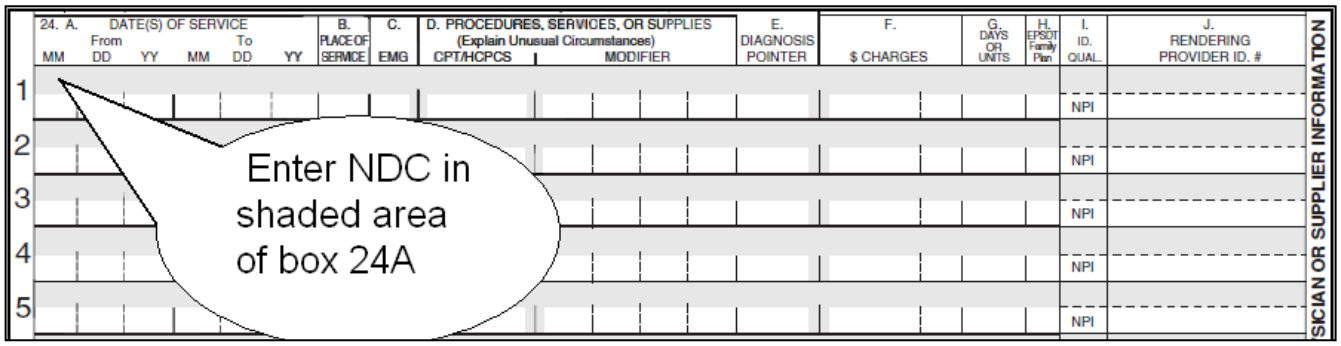
**CMS 1500 Claim Form:**

- Reporting the NDC requires using the upper **and** lower rows on a Claim line. Be certain to line up information accurately so all characters fall within the proper box and row.
- DO NOT bill more than one NDC per Claim line.

- Even though an NDC is entered, a valid HCPCS or CPT code must also be entered in the Claim form.
- If the NDC billed does not have a specific HCPCS or CPT code assigned, the appropriate miscellaneous code should be assigned per Correct Coding Guidelines.
- The unit of service for the HCPCS or CPT code is very important. Units for injections must be billed consistent with the HCPCS or CPT description of the code.

The following table provides elements of a proper NDC entry on a CMS-1500 Claim form. **All Elements are REQUIRED:**

| How | Example | Where |
|---|---|---|
| Enter a valid NDC code including the N4 qualifier | NDC 00054352763 is entered as N400054352763 | Beginning at the left edge, enter NDC in the **shaded area** of box 24A |
| Enter one (1) of five (5) units of measure qualifiers;<br>F2 – International Unit<br>GR – Gram<br>ML – Milliliter<br>UN – Units<br>ME – Milligrams<br>and quantity, including a decimal point for correct reporting | GR0.045<br>ML1.0<br>UN1.000 | In the **shaded area** immediately following the 11-digit NDC, enter three (3) spaces, followed by one (1) of five (5) units of measure qualifiers, followed immediately by the quantity |
| Enter a valid HCPCS or CPT code | J0610 “Injection Calcium Gluconate, per 10 ml” is billed as one (1) unit for each 10 ml ampul used | Non-shaded area of box 24D |



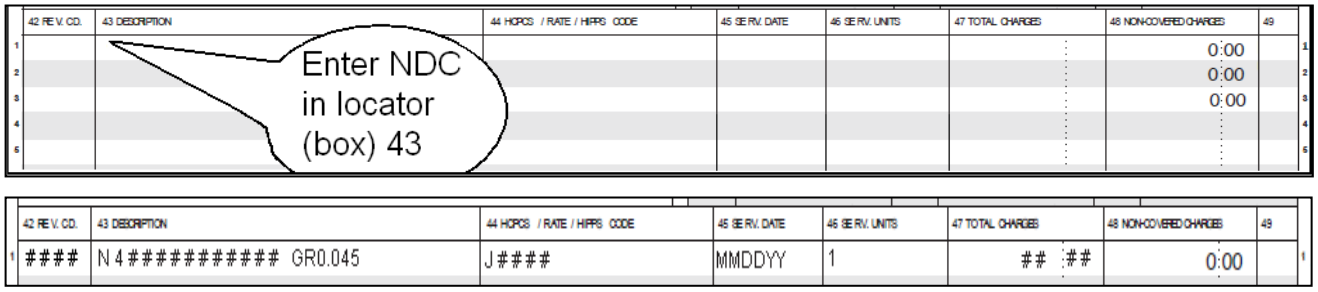

**UB-04 Claim Form:**

- Even though an NDC is entered, a valid HCPCS or CPT code must also be entered in the Claim form.
- If the NDC billed does not have a specific HCPCS or CPT code assigned, the appropriate miscellaneous code should be assigned per Correct Coding Guidelines.
- DO NOT bill more than one NDC per Claim line.
- The unit of service for the HCPCS or CPT code is very important. Units for injections must be billed consistent with the HCPCS or CPT description of the code.

The following table provides elements of a proper NDC entry on a UB04 Claim form. **All Elements are REQUIRED:**

| How | Example | Where |
|---|---|---|
| Enter a valid revenue code | Pharmacy Revenue Code 0252 | Form locator (box) 42 |
| Enter 11-digit NDC, including the N4 qualifier | NDC 00054352763 is entered as N400054352763 | Beginning at left edge, enter NDC In locator (box) 43, currently labeled as “Description” |
| Enter one (1) of five (5) units of measure qualifiers;<br>F2 – International Unit<br>GR – Gram<br>ML – Milliliter<br>UN – Units<br>ME – Milligrams<br>and quantity, including a decimal point for correct reporting | GR0.045<br>ML1.0<br>UN1.000 | Immediately following the 11-digit NDC, enter three (3) spaces followed by one (1) of five (5) units of measure qualifiers, followed immediately by the quantity. |
| Enter a valid HCPCS or CPT Code | J0610 “injection Calcium, per 10ML” is billed as one (1) unit for each 10ML ampul used | Form locator (box 44) |

Sample Images of the UB-04 Claim Form




## Paper Claims Submissions

Digital claim submission, either through the claim submission applications on Availity.com or through EDI, are the preferred method for receiving claims. Filing paper claims can cause delays due to errors associated with using this manual claim submission process. If Providers or Facilities file a paper Claim, failure to submit them on the most current CMS-1500 (Form 1500 (02-12)) or CMS-1450 (UB-04) will cause Claims to be rejected and returned to the Provider or Facility. More information and the most current forms can be found at **cms.gov.**

- Submit all paper Claims using the current standard RED CMS Form 1500 (02-12) for professional Claims and the UB-04 (CMS-1450) for Facility Claims.
- If Providers or Facilities are submitting a multiple-page Claim, the word “continued” should be noted in the total charge field, with the total charge submitted on the last page of the Claim.
- When submitting a multiple-page document, do not staple over pertinent information.
- Complete all mandatory fields.

- Do not highlight any fields.
- Check the printing of Claims from time to time to help ensure proper alignment and that characters are legible.
- Ensure all characters are inside the appropriate fields and do not overlap.
- Change the printer cartridge regularly and do not use a DOT matrix printer.
- Submit a valid Member identification number including three-digit prefix or R+8 numeric for Federal Employee Program® (FEP®) Members on all pages.
- Claims must be submitted with complete provider information, including referring, rendering, and billing NPI; tax identification number; name; and servicing and billing addresses on all pages.

**Recommended CMS Form 1500 (02-12)**

A sample form and instructions are available on the **CMS website.**

**UB-04 (CMS-1450)**

A sample form is available on the **CMS website: CMS Forms | CMS along with instructions on how to complete the paper claim form**

## Medical Records Submission

When submitting documentation in response to Wellpoint's request, the recommended method is to submit them electronically via the 275 transaction or digitally through the Attachments Dashboard. To attach requested documentation, navigate to Availity Essentials Claim Status, locate your Claim and use the Send Attachment link to upload your documents.

**Always include a copy of the request letter as part of your attachment**. The documentation should be formatted as a .tiff, .jpg, or .pdf file. Providers and Facilities should submit medical records within ten (10) calendar days of Wellpoint's request, or sooner, depending upon the urgency of the matter and or as required by state or federal law, statute, or regulation. Providers and Facilities can view the status of submitted documentation in Availity Essentials Attachment New.

A Provider or Facility organization's Availity Essentials administrator should complete the following set-up steps to authorize user access to the Medical Attachments New tool:

From My Providers, select Enrollments Center > Medical Attachments Setup, follow the prompts, and complete the following sections:

1. Select Application > Choose Medical Attachments Registration
2. Provider Management > Select **Organization** from the drop-down.
    - Add billing NPIs and Tax IDs. (both are recommended)
    - Multiples can be added, separated by spaces or semi-colons.
3. Assign user access by checking the box in front of the user's name. Users may be removed by unchecking their name.

If Availity Essentials set-up has not been completed and medical records must be sent via mail or fax, send them to the appropriate department as directed in the notification from Wellpoint. **Do not** place a copy of the Claim on top of the records.

If Providers or Facilities are submitting X-rays, pictures, or dental molds, remember to include a valid and complete Member Identification number on page one (1) of the material sent with these items.

**Medical Records Submission with Initial Claim**

Providers and Facilities can expedite Claim processing by sending medical records with the 837 Claim submission or Direct Data Entry.

To determine what medical records or portion of the medical records may be required, refer to the applicable Wellpoint Medical Policy, Wellpoint Clinical Guidelines, Carelon Clinical Criteria, or MCG on the **Wellpoint Provider webpage**. Review the Position Statement section of the Wellpoint Medical Policies, the Clinical Indications section of the applicable Wellpoint Clinical Guidelines, or the Clinical Criteria section of Carelon to determine what medical records are needed. Refer to the *Medical Policies*, *Clinical Guidelines*, and *Carelon Medical Benefits Management* sections of the Provider Manual for details on accessing this information.

When submitting medical records that are not requested by Wellpoint, include a clear description of the billed code to help ensure prompt processing of the Claim for all miscellaneous, not otherwise classified (NOC), not otherwise specified (NOS), and unlisted HCPCS and CPT codes.

A Provider or Facility organization's Availity Essentials administrator should complete the set-up steps listed above in the Medical Records Submission section to authorize user access to the Medical Attachments tool.

Submit an EDI 837 (claim) batch, which includes a PWK segment containing the attachment control number in loops 2300/2400; this detail links the electronic claim and the documentation. The attachment control number can be assigned by the Provider organization or vendor and must be unique.

- Log in to Availity Essentials portal
- Select **Claims & Payments** to access **Attachments – New**
- From the Attachments Dashboard **Inbox**, locate the appropriate Claim
- Add files with supporting documentation
- When a PWK segment is submitted with the claim, an intake with the attachment control number will display in the Attachment Dashboard inbox for seven (7) calendar days.
- If the document is not received within the seven (7) calendar day requirement, documentation can be uploaded using Claim Status by locating your Claim and attaching the document.

**Digital Request for Additional Information (RFAI)**

Providers and Facilities registered for the Medical Attachments application will receive digital notifications when additional documentation is needed to process your Claim. Digital notifications will be posted to your Attachments Dashboard daily when additional documentation is needed. Claims will pend for up to thirty (30) days. After the thirty (30)-day pend period, the Claim will deny and you will receive the explanation of payment. An additional digital notification will be posted to your Dashboard for an additional forty-five (45) days.

Digital RFAI notifications reduce the amount of time it takes for Wellpoint to receive needed documentation to process your Claims. This reduces Claims processing time and Claims are paid faster.

Visit the **Availity, EMR and Digital Solutions** webpage on **wellpoint.com** for more information about Digital RFAI.

### Types of Claims Documentation Required

Claims documentation may be needed to determine the medical necessity of a billed code. To follow are examples of the types of records we may need to make the determination. Only submit the records requested for that specific claim, procedure, and date of service. Do not send more records than requested or required:

- History and physical, office visit/clinical notes, treatment records, and response
- Chemotherapy regimens, oncology drugs, and records
- Medications list (current and prior)
- Radiology, diagnostic imaging, or diagnostic testing reports
- Therapy/rehabilitation records
- Laboratory reports, pathology reports
- Exact description of NOC/NOS code
- Operative/procedure report
- Inpatient admission, history & physical, discharge summary, physician progress notes, operative/procedure report, CT/MRI report

### Wellpoint May Request Additional Documentation

Some situations may require medical records in addition to what was submitted with the Claim. Although these situations may not have specific rules and guidelines, Wellpoint will make every effort to make these requests explicit and limited to what is minimally necessary to render a decision. Examples include, but are not limited to, the following situations:

- Review and investigation of Claims (e.g., pre-existing conditions [for grandfathered policies of the Affordable Care Act], lifetime benefit exclusions)
- Medical review and evaluation
- Requests for retro authorizations
- Medical management review (utilization review) and evaluation
- Underwriting review and evaluation
- Adjustments
- Appeals
- Quality management (quality of care concerns)
- Records documenting prolonged services
- Provider audits
- Pre-pay review program
- Fraud, waste, and abuse

### Medical Record Appeals

When a request for additional information is received in support of the resolution of a grievance or appeal, Providers and Facilities should respond within ten (10) calendar days of the request, or sooner, depending upon the urgency of the matter or as required by state or federal law, statute or regulation.

### HIPAA Privacy Rule – Minimum Necessary

Wellpoint complies with HIPAA Privacy Rules and will request the minimum necessary information needed to determine benefits and/or coverage associated with Claim processing. Providers and Facilities are also required under the Minimum Necessary rule to submit only those records requested.

## Electronic Data Interchange (EDI)

Wellpoint uses Availity as our EDI gateway for managing all electronic data interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835). Electronic Funds Transfers (EFT) allow for a faster, more efficient, and cost-effective way to work together.

### Payer IDs

Payer IDs route EDI transactions to the appropriate payer. The **Availity Essentials Payer ID list** is available on Availity.com. If a provider or facility uses a clearinghouse, billing service, or vendor, work with them directly to determine the payer ID.

### Advantages of Electronic Data Interchange (EDI)

- Faster claims processing that allows submissions of corrected claims, primary payment detail, and offers choices for submitting documentation to support your claims.
- Reduce overhead and administrative costs by eliminating paper claim submissions

Use Availity for the following EDI transactions

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Claim: Dental (837D)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Electronic Remittance Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

### How Providers and Facilities Can Efficiently Use the Availity EDI Gateway

Availity EDI submission options:

- Availity EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software)

- Or use the provider or facility's existing clearinghouse or billing vendor. Requires the vendor to have a connection to the Availity EDI Gateway.

**Electronic Data Interchange Trading Partner**

Trading partners connect with Availity's EDI gateway to send and receive EDI transmissions. A trading partner can be a provider organization using software to submit direct transmissions, a billing company, or a clearinghouse vendor.

To become an EDI trading partner, visit **Availity.com.**

Select **Login** if already an Availity Essentials user, choose My providers < Transaction Enrollment or choose **Register** if new to Availity Essentials.

**EDI Response Reports**

Claims submitted electronically will return response reports that may contain rejections. If using a Clearinghouse or Billing Vendor, please work with them to ensure you are receiving all reports.

It's important to review the response reports as rejections will require correction and resubmission. For questions on electronic response reports, contact your clearinghouse, billing vendor, or Availity if you submit directly using your practice management software at **800-AVAILITY (800-282-4548)**.

**Electronic Funds Transfer (EFT)**

Electronic claims payment through electronic funds transfer (EFT) is a safe, secure, and fast way to receive payment. There is no charge for the deposit, and EFT reduces administrative time related to posting and reconciling payments. EFT deposits are assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

To register or manage Electronic Funds Transfer (EFT), use EnrollSafe at **enrollsafe.payeehub.org** to register and manage EFT account changes.

**Virtual Credit Cards (VCCs)**

For Providers and Facilities who don't enroll in EFT, and in lieu of paper checks, Wellpoint is shifting some reimbursements to virtual credit cards (VCCs). VCCs allow Providers and Facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply. For detailed information, refer to the *Provider and Facility Digital Guidelines* section of this Manual.

**Electronic Remittance Advice (ERA) 835**

The 835 electronic remittance advice (ERA) eliminates the need for paper remittance reconciliation. Use Availity Essentials to register and manage ERA account changes:

1. Log onto Availity.com
2. Select My Providers
3. Click on Enrollment Center and select Transaction Enrollment

Note: If you use a clearinghouse or vendor, work with them for ERA registration and receiving your ERAs.

**Use EDI to submit corrected claims**

For corrected electronic claims, use one of the following frequency codes:

- 7 – Replacement of Prior Claim

- 8 – Void/Cancel Prior Claim

EDI segments required:

- Loop 2300 – CLM – Claim frequency code
- Loop 2300 – REF – Original claim number

Work with your vendor on how to submit corrected claims or contact Availity.

**Contact Availity Essentials**

Contact Availity Client Services with any questions at 1-800-Availity (282-4548).

**Useful EDI Documentation**

- **Availity EDI Connection Guide** – This guide includes information to get started with submitting Electronic Data Interchange (EDI) transactions to Availity Essentials, from registration to ongoing support.
- **Availity EDI Companion Guide** – This Availity Essentials EDI Guide supplements the HIPAA TR3s and describes the Availity Essentials Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity Essentials.
- **Availity Essentials Registration Page** – Availity Essentials registration page for users new to Availity Essentials.
- **X12 External Code Listing** – X12 code descriptions used on EDI transactions.

## Overpayments

Wellpoint's Program Integrity department reviews Claims for accuracy and requests refunds if Claims are overpaid or paid in error. Some common reasons for overpayment are:

- Paid wrong Provider/Member
- Coordination of Benefits
- Allowance overpayments
- Late credits
- Billed in error
- Duplicate
- Non-covered services
- Claims editing
- Terminated Members
- Total charge overpaid
- Paid wrong Member/ Provider number

Wellpoint's Program Integrity department also requests refunds for overpayments identified by other divisions of Wellpoint, such as Complex and Clinical Audit (CCA) or the Special Investigations Unit (SIU).

**Wellpoint Identified Overpayment (aka "Solicited")**

When refunding Wellpoint for a Claim overpayment that Wellpoint has requested, use the payment coupon included on the request letter and supply the following information with the payment:

- The payment coupon
- Member ID number
- Member's name
- Claim number
- Date of service
- Reason for the refund as indicated in the refund request letter

As indicated in the Wellpoint refund request letter and in accordance with provider contractual language, and state regulations, provider overpayment refunds not received and applied within the timeframe indicated will result in Claim recoupment from any Claim the Provider or Facility submits to Wellpoint.

Providers and Facilities may direct disputes of amounts indicated on a Wellpoint refund request letter to the address indicated on the letter.

**Provider and Facility Identified Overpayments (aka "voluntary" or "unsolicited")**

If Wellpoint is due a refund because of an overpayment discovered by a Provider or Facility, refunds can be made by submitting a refund check with supporting documentation.

When voluntarily refunding Wellpoint on a Claim overpayment, include the following information:

- All documents supporting the overpayment including EOBs from Wellpoint and other carriers as appropriate
- Member ID number
- Member's name
- Claim number
- Date of service
- Reason for the refund as indicated in the list above of common overpayment reasons
- Amount to apply for each Claim

If overpayments are being submitted for multiple Claims, be sure the total of the amounts to apply for each Claim equals the total check amount.

Be sure the copy of the provider remittance advice is legible and the Member information that relates to the refund is circled. By providing this critical information, Wellpoint will be able to expedite the process, resulting in improved service and timeliness to Providers and Facilities.

**Important Note:** If a Provider or Facility is refunding Wellpoint due to coordination of benefits and the Provider or Facility believes Wellpoint is the secondary payer, **refund the full amount paid**. Upon receipt and insurance primacy verification, the Claim will be reprocessed and paid appropriately.

Use the correct address noted below to return payment:

| Make Check Payable To: | Regular Mailing Address: | Overnight Delivery Address: |
|---|---|---|
| Wellpoint | Wellpoint<br>PO Box 73651<br>Cleveland, OH 44193-1177 | Wellpoint<br>Lockbox 73651<br>4100 West 150th Street<br>Cleveland, OH 44135 |

## Medicare Crossover

### Claims Handling for Medicare Crossover

Wellpoint participates in the Medicare crossover Claims process. This results in automatic submission of Medicare Claims by Medicare to Wellpoint as the secondary payer to eliminate the need for Provider or Facilities or their billing service to submit an additional Claim to the secondary carrier.

When a Medicare Claim has crossed over, Providers and Facilities must wait thirty (30) calendar days from the Medicare remittance date before submitting the Claim to Wellpoint if the charges have still not been considered by the Member's plan.

To avoid the submissions of duplicate Claims, use the 276/277 health care Claims status inquiries to verify Claim and adjudication status prior to re-submission of electronic Claims.

The Claims Providers and Facilities submit to the Medicare intermediary will be crossed over to Wellpoint only after they have been processed by the Medicare intermediary. This process may take approximately fourteen (14) days to occur. This means that the Medicare intermediary will be releasing the Claim to Wellpoint for processing about the same time Provider or Facility receives the Medicare remittance advice. As a result, upon receipt of the remittance advice from Medicare, it may take up to thirty (30) additional calendar days for Providers or Facilities to receive payment or instructions from Wellpoint.

Providers and Facilities should continue to submit services that are covered by Medicare directly to Medicare. Even if Medicare may exhaust or has exhausted, continue to submit Claims to Medicare to allow for the crossover process to occur and for the Member's benefit policy to be applied.

Medicare primary Claims, including those with Medicare exhaust services, that have crossed over and are received within thirty (30) calendar days of the Medicare remittance date or with no Medicare remittance date, will be rejected by Wellpoint.

Wellpoint will reject Medicare primary Provider submitted Claims with the following conditions:

- Medicare remittance advice remark codes MA18 or N89 that Medicare crossover has occurred
    - MA18 Alert: The Claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
    - N89 Alert: Payment information for this Claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.
- Claim received from Provider or Facility within thirty (30) calendar days of Medicare remittance date
- Claim received from Provider or Facility with no Medicare remittance date
- Claim received with GY modifier on some lines but not all

- A GY modifier is used by Providers and outpatient Facilities when billing to indicate that an item or service is statutorily excluded and is not covered by Medicare. Examples of statutorily excluded services include hearing aids and home infusion therapy.

When these types of Claims are rejected, Wellpoint will also remind the Provider or Facility to allow thirty (30) days for the crossover process to occur or instruct the Provider or Facility to submit the Claim with only GY modifier service lines indicating the Claim only contains statutorily excluded services.

**Medicare statutorily excluded services – just file once to Wellpoint**

There are certain types of services that Medicare never or seldom covers, but a secondary payer, such as Wellpoint, may cover all or a portion of those services. These are statutorily excluded services. For services that Medicare does not allow, such as home infusion, Providers and outpatient Facilities need only file statutorily excluded services directly to Wellpoint using the GY modifier and will no longer have to submit to Medicare for consideration. These services must be billed with only statutorily excluded services on the Claim and will not be accepted with some lines containing the GY modifier and some lines without.

For Claims submitted directly to Medicare with a crossover arrangement where Medicare makes no allowance, Providers and Facilities can expect the Member's benefit plan to reject the Claim advising the Provider or Facility to submit to Wellpoint when the services rendered are considered eligible for benefit. These Claims should be resubmitted as a fresh Claim to Wellpoint with the Explanation of Medicare Benefits (EOMB) to take advantage of Provider or Facility contracts. Since the services are not statutorily excluded as defined by CMS, no GY modifier is required. However, the submission of the Medicare EOMB is required. This will help ensure the Claims process consistent with the Provider's or Facility's contractual agreement.

- Providers or outpatient Facilities who render statutorily excluded services should indicate these services by using GY modifier at the service line level of the Claim.
- Providers or Facilities will be required to submit only statutorily excluded service lines on a Claim (cannot combine with other services like Medicare exhaust services or other Medicare covered services)
- Wellpoint will not require Medicare EOMB for statutorily excluded services submitted with a GY Modifier.

If Providers or outpatient Facilities submit combined line Claims (some lines with GY, some without) to Wellpoint, the Claim will be denied, instructing the Provider or outpatient Facility to split the Claim and resubmit.

**Original Medicare** – The GY modifier *should* be used when service is being rendered to a Medicare primary Member for statutorily excluded service and the Member has Wellpoint secondary coverage. The value in the SBR01 field should not be "P" to denote primary.

**Medicare Advantage** – Ensure SBR01 denotes "P" for primary payer within the 837 electronic Claim file. This helps ensure accurate processing on Claims submitted with a GY modifier.

The GY modifier *should <u>not</u>* be used when submitting:

- Federal Employee Program Claims
- Inpatient institutional Claims. Use the appropriate condition code to denote statutorily excluded services.

These processes align Wellpoint with industry standards and will result in less administrative work, accurate payments and fewer rejected Claims. Because the Claim will process with a consistent application of pricing, Members will also see a decrease in health care costs as the new crossover process eliminates or reduces balance billing to the Member.

**Medicare Crossover Claims FAQs**

1. **How do Providers and Facilities handle traditional Medicare-related Claims?**
    - When Medicare is primary payer, submit Claims to the local Medicare intermediary.
    - Wellpoint is set up to automatically cross over (or forward) to the Member's plan after being adjudicated by the Medicare intermediary.
2. **How do Providers and Facilities submit Medicare primary / Wellpoint secondary Claims?**
    - For Members with Medicare primary coverage and Wellpoint secondary coverage, submit Claims to the Medicare intermediary and/or Medicare carrier.
    - When submitting the Claim, it is essential that Providers and Facilities enter Wellpoint as the secondary carrier. Check the Member's ID card for additional verification.
    - When Providers and Facilities receive the remittance advice from the Medicare intermediary, look to see if the Claim has been automatically forwarded (crossed over) to Wellpoint.
        - If the remittance advice indicates that the Claim was crossed over, Medicare has forwarded the Claim on behalf of the Provider or Facility to Wellpoint, and the Claim is in process. ***DO NOT*** resubmit that Claim to Wellpoint; duplicate Claims will result in processing and payment delays.
        - If the remittance advice indicates that the Claim was not crossed over, submit the Claim to Wellpoint with the Medicare remittance advice.
    - In some cases, the Member identification card may contain a Coordination of Benefits Agreement (COBA)* ID number. If so, be certain to include that number on the Claim.
    - For Claim status inquiries, contact Wellpoint.
3. **Who do Providers and Facilities contact with Claims questions?**

    Contact Wellpoint for Claims questions.

    For Medicare Claims questions, Providers can submit Claim status inquiries via the **Medicare Administrative Contractors' provider Internet-based portals**.
4. **How do Providers and Facilities handle calls from Members and others with Claims questions?**
    - If a Member contacts a Provider or Facility, tell them to contact Wellpoint. Refer them to the front or back of their ID card for a customer service number.
5. **Where can Providers and Facilities find more information?**

    For more information, contact Wellpoint.

*The Coordination of Benefits Agreement (COBA) program is a standard processing methodology used by the national Medicare community. The COBA allows greater efficiency and simplification via consolidation of the claim's crossover process. The COBA allows other insurers and benefit programs to send eligibility information to CMS and receive Medicare paid claims data, along with other coordination of benefits data, from one source, the BCRC.

# Claim Payment Disputes

## Provider and Facility Claim Payment Dispute Process

If a Provider or Facility disagrees with the outcome of a Claim, the Provider or Facility may begin the Wellpoint Claim Payment Dispute process. The simplest way to define a Claim Payment Dispute is when the Claim is finalized, but a Provider or Facility disagrees with the outcome. Providers and Facilities must complete the Claim Payment Reconsideration and Claim Payment Appeal processes set forth in this Provider Manual before they can initiate the dispute resolution and arbitration process set forth in your Provider or Facility Agreement.

A Claim Payment Dispute may be submitted for multiple reasons, including:

- Contractual payment issues
- Disagreements over reduced or zero-paid Claims
- Claim code editing issues
- Duplicate Claim issues
- Retro-eligibility issues
- Claim data issues
- Claims that are denied for no authorization when an authorization was obtained, a Claim Payment Dispute may be submitted as long as the authorized services match the Claim details.
- Timely filing issues*
- Disputes of prepayment itemized bill review findings

*Wellpoint will consider reimbursement of a Claim that has been denied due to failure to meet timely filing if the Provider or Facility can: 1) provide documentation the Claim was submitted within the timely filing requirements, or 2) demonstrate good cause exists. See “Proof of Timely Filing” in the *Claims Inquiry/Adjustment Filing Tips* subsection of the Manual for more information.

**Please note**: The Claim Payment Dispute process described in this section does not apply to appeals regarding a clinical decision denial, such as a utilization management authorization or a Claim that has been denied as not medically necessary or experimental/investigational. For more information on Clinical/Medical Necessity Appeals, refer to the *Clinical Appeals* section within the Provider Manual.

There are other Claim-related matters that are **not** considered Claim Payment Disputes. To avoid confusion with Claim Payment Disputes, they are defined briefly here:

- **Claim Inquiry:** A question about a Claim or Claim payment is called an inquiry. Claim Inquiries do not result in changes to Claim payments, but the outcome of the Claim Inquiry may result in the initiation of the Claim Payment Dispute. In other words, once the Provider or Facility receives the answer to the Claim Inquiry, the Provider or Facility may opt to begin the Claim Payment Dispute process. Providers and Facilities can Chat with Payer or send a Secure Message through Availity Essentials. If Providers or Facilities are unable to utilize Availity Essentials for the inquiry they can call the number on the back of the Member ID Card and select the *Claims* prompt. For further details on Secure Messaging reference *Availity Essentials* section in this Manual.

- **Claim Correspondence:** Claim Correspondence is when Wellpoint requires more information to finalize a Claim. Wellpoint can request this information through the Explanation of Payment (EOP), a digital notification if the provider is registered for Medical Attachments and is using the Digital RFAI process, or through paper mail. The Claim or part of the Claim may be denied, but it is only because more information is required to process the Claim. Once the information is received, Wellpoint will use it to finalize the Claim.
- **Clinical/Medical Necessity Appeals**: An appeal regarding a clinical decision denial, such as an authorization or Claim that has been denied as not medically necessary, experimental/ investigational. For more information on Clinical/Medical Necessity Appeals, refer to the *Clinical Appeals* section within the Manual.

Reference the *Claims Submission Filing Tips* section for additional information.

The Wellpoint Claim Payment Dispute process consists of **two steps: Claim Payment Reconsideration and Claim Payment Appeal**. Providers and Facilities will **not** be penalized for filing a Claim Payment Dispute, and no action is required by the Member.

**Step 1: Claim Payment Reconsideration**

The first step in the Wellpoint Claim Payment Dispute process is called the Claim Payment Reconsideration. It is the Provider or Facility's initial request to investigate the outcome of a finalized Claim. Wellpoint cannot process a Claim Payment Reconsideration without a finalized Claim on file. Most issues are resolved at the Claim Payment Reconsideration step.

Claim Payment Reconsiderations can be submitted via phone, Availity Essentials, or in writing. Providers and Facilities have one hundred eighty (180) calendar days from the issue date of the EOP, unless otherwise required by State law or such time period set forth in the Provider or Facility Agreement.

A determination will be made, and the initial adjudication of the Claim will either be upheld or overturned. If the Provider or Facility is satisfied with this determination, the process will end. If the Provider or Facility disagrees with the determination of the Reconsideration, they can proceed with Step 2 and file a Claim Payment Appeal. Providers and Facilities cannot submit another Claim Payment Reconsideration request.

When submitting Claim Payment Reconsiderations, Providers and Facilities should include as much information as possible to help Wellpoint understand why the Provider or Facility believes the Claim was not paid as expected. If a Claim Payment Reconsideration requires clinical expertise, it will be reviewed by the appropriate Wellpoint clinical professionals.

If the decision results in a Claim adjustment, the payment and EOP will be sent separately.

Except in cases where the Provider or Facility presents evidence of an extenuating circumstance, Wellpoint will not accept Claim Payment Reconsiderations that are not submitted timely according to the procedures set forth above. If a Provider or Facility submits a request for a Claim Payment Reconsideration more than 180 calendar days from the issue date of the EOP without evidence of an extenuating circumstance, the request is deemed ineligible, and requests for payment will be denied. In such cases, Providers or Facilities will not be permitted to bill Wellpoint, Plan, or the Covered Individual for those services for which payment was denied.

Provider and Facilities will be notified of the Claims Payment Reconsideration determination in writing or through an EOP.

**Step 2: Claim Payment Appeal**

A Claim Payment Appeal is the second step in the Claim Payment Dispute process. If a Provider or Facility is dissatisfied with the outcome of a Claim Payment Reconsideration determination, Providers and Facilities may submit a Claim Payment Appeal through Availity Essentials or in writing. Providers and Facilities must submit a Claim Payment Reconsideration before submitting a Claim Payment Appeal. In addition, Providers and Facilities must submit Claims Payment Appeals within ninety (90) days from the date of the determination of the Claims Payment Reconsideration.

Except in cases where the Provider or Facility presents evidence of an extenuating circumstance, Wellpoint will not accept Claim Payment Appeals that are not submitted timely according to the procedures set forth above. If a Provider or Facility submits a request for a Claim Payment Appeal more than ninety (90) calendar days from the date of the Claims Payment Reconsideration determination without evidence of an extenuating circumstance, the request is deemed ineligible, and requests for payment will be denied. In such cases, Providers or Facilities will not be permitted to bill Wellpoint, Plan, or the Covered Individual for those services for which payment was denied.

When submitting a Claim Payment Appeal, Providers and Facilities should include as much information as possible to help Wellpoint understand why the Provider or Facility believes the Claim Payment Reconsideration determination was in error. If a Claim Payment Appeal requires clinical expertise, it will be reviewed by appropriate Wellpoint clinical professionals.

Provider and Facilities will be notified of the Claims Payment Appeal determination in writing or through an EOP.

## Required Documentation for Claim Payment Disputes

Wellpoint requires the following information when submitting a Claim Payment Dispute (Claim Payment Reconsideration or Claim Payment Appeal):

- The Provider or Facility position statement explaining the nature of the dispute
- Provider or Facility name, address, phone number, email, and either NPI or TIN
- The Member's name and Wellpoint ID number
- A listing of disputed Claims, which should include the Wellpoint Claim number and the date(s) of service(s)
- All supporting statements and documentation

**How to Submit a Claim Payment Dispute**

There are several options to file a Claim Payment Dispute:

- Online through Availity Essentials Claim Status Application (preferred method where available)
- Mail all required documentation, including the claim dispute form, to:

  Wellpoint Claim Disputes
  PO Box 4095
  Woburn, MA 01888-4095

- Call the Number on the back of the Member ID Card

# Clinical Appeals

Clinical appeals refer to a situation in which an authorization or Claim for a service was denied as not medically necessary or experimental/investigational. Medical necessity appeals/prior authorization appeals are different than Claim Payment Disputes and should be submitted in accordance with the Clinical appeal process.

For questions regarding non-clinical decisions, refer to the Claim Payment Dispute section. Examples of non-clinical items that fall under Claim Payment Disputes include:

- Contractual payment issues
- Disagreements over reduced or zero-paid Claims
- Claim code editing issues
- Duplicate Claim issues
- Retro-eligibility issues
- Claim data issues
- Claims that are denied for no authorization when an authorization was obtained, a Claim dispute may be submitted as long as the authorized services match the Claim details.
- Timely filing issues
- Disputes of Prepayment Itemized Bill Review Findings

Clinical Appeals can be used if Providers or Facilities disagree with clinical decisions. Clinical Appeals are requests to change decisions based on whether services or supplies are Medically Necessary or experimental/ investigative. UM program Clinical Appeals involve certification decisions, Claims, or predetermination decisions evaluated on these bases. Clinical Appeals can be made through Availity.com using the Authorizations & Referrals application, where available, verbally, or in writing, for appeals regarding prior authorization clinical adverse decisions.

Wellpoint Members may designate a representative to exercise their complaint and appeal rights. When a Provider or Facility is acting on behalf of a Member as the designated representative, the complaint or appeal may be directed to Provider Customer Service, using the phone number on the back of the Member ID card. These types of issues are reviewed according to Wellpoint's Member Complaint and Appeal Procedures for each applicable state. Provider Services will help Providers and Facilities determine what action must be taken and if a Designation Of An Authorized Representative form is needed.

The *Designation of an Authorized Representative* form (DOR) can be found online at **wellpoint.com**. go to the **Wellpoint Provider webpage** and from the horizontal menu under **Provider Resources**, select **Forms & Guides**, then select **Designation of an Authorized Representative (DOR)**.]

**Guidelines and Timeframes for Submitting Clinical Appeals**

- Providers and Facilities have one hundred eighty (180) calendar days to file a clinical appeal from the date they receive notice of Wellpoint's initial decision.
- All standard post-service clinical appeals will be resolved within a reasonable period of time appropriate to the medical circumstances, but not later than sixty (60) calendar days from the receipt of the appeal request by Wellpoint.

- For clinical appeals, there are three (3) types of review: expedited and standard.
    1. *Expedited Appeal:* Wellpoint offers an expedited appeal for decisions meeting the expedited criteria. Requests to handle a review as “expedited” are always handled as a Member appeal. Both standard and expedited appeals are reviewed by a person who did not make the initial decision. Unless the Member, on his or her own behalf, or another Provider or Facility has already filed an expedited appeal on the service at issue in the appeal, a Provider or Facility that requests an expedited appeal will be deemed to be the Member’s designated representative for the limited purpose of filing the expedited appeal. As a result, the expedited appeal will be handled pursuant to the Wellpoint Member Appeal Procedures exclusively.

       When a request for information is received in support of the resolution of a clinical appeal, the provider is required to respond within seven days of the request or sooner dependent upon the clinical urgency of the case in accordance with the state or federal law, statute, or regulation.
    2. *Standard Appeal:* A standard appeal is available following the reconsideration, or initially, if it is formally requested.
- UM decisions are communicated in writing to the Provider or Facility and Member. These letters provide details on appeal rights and the address to use when sending additional information.

Requests for appeal of Pre-Service requests will always be handled as a Member appeal. An expedited appeal is available for cases meeting the expedited criteria. Detailed instructions are included in the UM decision letter.

Appeals should be submitted to Wellpoint, along with:

- A copy of the response to the original complaint.
- Provider or facility name, address, phone number, email, and either NPI or TIN
- The member’s name and Wellpoint ID number
- Claim, authorization, or reference number and date of service
- Specific reason(s) for disagreement with decision
- All supporting statements and documentation (medical records, etc.)
- A signed DOR (Designation of Representation) is needed if the provider is appealing on behalf of the member. No DOR is required when the provider is appealing on their own behalf.

# Member Quality of Care/Quality of Service Investigations

The Grievances and Appeals department develops, maintains, and implements policies and procedures for identifying, reporting, and evaluating potential quality of care/service (QOC/QOS) concerns or sentinel events involving Wellpoint Members. This includes cases reviewed as the result of a grievance submitted by a Member and potential quality issues ("PQI") reviewed as the result of a referral received from an Wellpoint clinical associate. All Wellpoint associates who may encounter clinical care/service concerns or sentinel events are informed of these policies.

Quality of care grievances and PQIs are processed by clinical associates. Medical records and a response from the Provider and/or Facility are requested. Requests for information, including medical records, must be returned by Providers on or before the due date on the request letter so that a determination can be made regarding the severity of the Potential QOC/QOS concern. Failure to return or timely return the requested information may result in escalation of the issue and potential corrective action, up to and including review for termination of contract and removal from the network.

If the clinical associate determines, based on the circumstances and applicable review of records, that the matter is a non-issue with no identifiable quality concern or that the evidence suggests a known or recognized complication, the clinical associate may assign a severity level consistent with such a finding. If the circumstances and/or evidence suggest a QOC concern beyond a known or recognized complication, then the clinical associate will prepare and send a summary to the appropriate Medical Director for review.

Specialty-matched reviewers evaluate the matter, and an appropriate Medical Director makes a determination of the severity of the QOC matter. If the QOC matter was initiated by a Member, the Member is advised that a resolution was reached, but the details and outcome of the review are protected by peer review statutes and will not be provided.

The Provider and/or Facility will also receive a letter advising of the QOC/QOS determination and any associated corrective action.

Significant quality of care issues and/or failure to participate or respond to information requests may be elevated for additional review and appropriate action, including, but not limited to, referrals to the Credentialing Committee.

Providers and Facilities are contractually obligated to actively cooperate with QOC/QOS reviews/investigations.

Allegations of quality concerns regarding the care of our members require review of relevant materials, including, but not limited to, records of member treatment and internal investigations performed by Providers and Facilities in connection with the allegations received. This information is protected by Peer Review confidentiality, which will be maintained during Wellpoint's QOC review.

**Corrective Action Plan (CAP)**

When corrective action is required, Providers and/or Facilities will be notified of appropriate follow-up interventions which can include one or more of the following: development of a CAP from the Provider and/or Facility to address the reviewed issues of concern, Continuing Medical Education, chart reviews, on-site audits, tracking and trending, Provider and/or Facility counseling, and/or referral to the appropriate committee for additional action. Providers and Facilities that fail to comply with requests associated with potential QOC/QOS allegations, such as the request for information for

investigations, the completion of corrective action plans by the noticed deadline and/or failure to comply with the terms of a corrective action plan will be referred to the Credentialing Committee for further actions, up to and including, termination of contract and removal from the network.

**Reporting**

G&A leadership reports grievance and PQI rates, categories, and trends to the appropriate Quality Improvement Committee on a bi-annual basis or more often as appropriate. Quality improvement or educational opportunities are reported, and corrective measures are implemented as applicable. Results of corrective actions are reported to the Committee. The Quality Council reviews these trends annually during the process of prioritizing quality improvement activities for the subsequent year.

# Reimbursement Requirements and Policies

This section includes reimbursement requirements and policies on how Wellpoint will reimburse Providers and Facilities for certain services. Wellpoint reserves the right to review and revise policies when necessary.

Wellpoint's public provider website is the source for reimbursement policies. To locate the policies online, go to the **Wellpoint Provider webpage**, and under the **For Providers** menu, select **Claims & reimbursement**.

### Wellpoint Rate

The "Wellpoint Rate" means the lesser of one hundred percent (100%) of Eligible Charges for Covered Services, or the total reimbursement amount that Provider or Facility and Wellpoint have agreed upon as set forth in the Plan Compensation Schedule (PCS). The Wellpoint Rate includes applicable Cost Shares and shall represent payment in full to Provider or Facility for Covered Services.

Non-Priced Codes for Covered Services

Wellpoint reserves the right to establish a rate for codes that are not priced in this PCS or in the Fee Schedule(s), including but not limited to, Not Otherwise Classified Codes ("NOC"), Not Otherwise Specified (NOS), Miscellaneous, Individual Consideration Codes ("IC"), and By Report ("BR") (collectively "Non-Priced Codes"). Wellpoint shall only reimburse Non-Priced Codes for Covered Services in the following situations:

(i) the Non-Priced Code does not have a published dollar amount on the then-current applicable Plan, State, or CMS Fee Schedule,

(ii) the Non-Priced Code has a zero dollar amount listed, or

(iii) the Non-Priced Code requires manual pricing.

In such situations, such Non-Priced Code shall be reimbursed at a rate established by Wellpoint for such Covered Service. Notwithstanding the foregoing, Wellpoint shall not price Non-Priced Codes that are not Covered Services under the Members Health Benefit Plan.

Wellpoint may require the submission of medical records, invoices, or other documentation for Claims payment consideration.

### Balance Billing Members

In accordance with Chapter 32A, Section 20 of the Massachusetts General Laws, Massachusetts providers rendering services to members in the indemnity plan offered by the GIC, which is the Wellpoint State Indemnity Plan, may NOT collect any amount from a member in such plan in excess of the allowed or determined payment by that plan. We ask that you comply with this Massachusetts legislative statute when caring for our members.

### Blood, Blood Products, and Administration

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

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

### Changes During Admission/Continuous Outpatient Encounter

There are elements that could change during an admission/outpatient encounter. The following table shows the scenarios and the date to be used for the entire Claim:

| Change | Effective Date |
|---|---|
| Member's Insurance Coverage | Admission/First day of continuous Outpatient Encounter |
| Facility's Contracted Rate (other than DRG) | Admission/First day of continuous Outpatient Encounter |
| DRG Base Rate | Admission |
| DRG Grouper | Discharge |
| DRG Relative Weight | Discharge |
| CPT & HCPCS coding changes | Discharge/Last day of continuous Outpatient Encounter |

### Coding Requirements

Providers and Facilities will submit Claims in a format consistent with industry standards and acceptable to Wellpoint.

### Comprehensive Health Planning

Facility shall not bill Wellpoint, Plan or a Member for Health Services, expanded facilities, capital operating costs or any other matter of service requiring a certificate of need approval or exemption under existing law, or similar or successor laws that may be adopted from time to time, unless said approval or exemption has been granted in writing.

### Courtesy Room

"Courtesy Room" means an area in the Facility where a professional provider is permitted by Facility to provide Health Services to Members. Wellpoint will not separately reimburse for Courtesy Room charges.

### Different Settings Charges

If Wellpoint determines that Facility submits charges differently for the same service performed in a different setting, Wellpoint may reimburse at the Wellpoint Rate for the lesser of the two charges.

### Eligibility and Payment

A verification of eligibility is not a guarantee of payment.

### Emergency Room Supplies and Services Charges

The Emergency Room level reimbursement includes all monitoring, equipment, supply, and time and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel employed for the examination and treatment of patients.

### Evaluation and Management (E&M) Services

Prior to payment, Wellpoint may review E&M Claims to determine, in accordance with correct coding requirements and/or reimbursement policy as applicable, whether the E&M code level submitted is

higher than the E&M code level supported on the Claim. If the E&M code level submitted is higher than the E&M code level supported on the Claim, Wellpoint reserves the right to:

- Deny the Claim and request resubmission of the Claim with the appropriate E&M level;
- Pend the Claim and request that the Facility or Provider submit documentation supporting the E&M level billed; and/or
- Adjust reimbursement to reflect the lower E&M level supported by the Claim

**Facility Personnel Charges**

Charges for Inpatient Services for Facility personnel are not separately reimbursable, and the reimbursement for such is included in the room and board rate or procedure charge. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions including IV or PICC line insertion at bedside, call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Outpatient Services for Facility personnel are also not separately reimbursable. Reimbursement is included in the reimbursement for the procedure or observation charge.

**General Industry Standard Language**

Per Wellpoint policy and the Agreement, Provider and Facility will follow industry standards related to billing. Per the UB-04 and CMS1500 (or subsequent forms) billing manual, referenced as Coded Service Identifier(s).

**Instrument Trays**

Charges for instrument trays for any procedure are included in the cost of the procedure and are not separately reimbursable. See Operating Room Time and Procedure Charges and Routine Supplies sections for additional information.

**Interim Bill Claims**

Wellpoint shall not adjudicate Claims submitted as interim bills for services reimbursed under the DRG methodology.

**IV Sedation and Local Anesthesia**

Charges for IV Sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, ~~is~~ are not separately reimbursable and are included as part of the Operating Room (OR) time/procedure reimbursement. Charges for medications-drugs used for sedation and local anesthesia are separately reimbursable.

**Lab Charges**

The reimbursement of charges for specimen collection are considered facility personnel charges and the reimbursement is included in the room and board or procedure/observation charges. Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws.

Processing, handling, and referral fees are considered included in the procedure/lab test performed and are not separately reimbursable.

### Labor Care Charges

Wellpoint will reimburse appropriately billed room and board or labor charges. Payment will not be made on both charges billed concurrently. Facilities reimbursed under DRG will not be reimbursed by Wellpoint for Outpatient Services rendered prior to the admission.

### Medical Care Provided to or by Family Members

Services for any type of medical care rendered by a Provider to him/herself or to an immediate family Member (as defined below), who is a Member, are not eligible for coverage and should not be billed to Wellpoint. In addition, a Provider may not be selected as a Primary Care Physician (PCP) by his/her immediate family member.

Unless otherwise set forth in a Member's Health Benefit Plan, an immediate family Member includes: father, mother, children, spouse, domestic partner, legal guardian, grandparent, grandchild, sibling, step-father, step-mother, step-children, step-grandparent, step-grandchild, and/or step-sibling.

### Neuromonitoring (Technical component)

Wellpoint will consider the technical component for neuromonitoring services performed in an operating room setting to be included in the surgical procedure reimbursement.

Therefore, Claims submitted by anyone other than the rendering facility will not be eligible for separate or additional reimbursement. If the rendering facility utilizes a neuromonitoring vendor to perform any services, then it is the rendering facility's responsibility to reimburse the vendor directly. Any Claims submitted to Wellpoint for these additional services will be denied, as they will be considered part of the all-inclusive facility reimbursement.

### Nursing Procedures

Wellpoint will not separately reimburse fees associated with nursing procedures or services provided by Facility nursing staff or unlicensed Facility personnel (technicians) performed during an inpatient (IP) admission or outpatient (OP) visit. Examples include, but are not limited, to intravenous (IV) injections or IV fluid administration/monitoring, intramuscular (IM) injections, subcutaneous (SQ) injections, nasogastric tube (NGT) insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, pulse oximetry, etc.) and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration, OP chemotherapy administration, or OP infusion administration which are submitted without a room charge, observation charges, or procedure charges other than blood, chemotherapy, or infusion administration.)

### Operating Room Time and Procedure Charges

The operating room (OR) charge will be reimbursed on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes. The Operating Room is defined as surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac catheterization (cath) labs, Hybrid Rooms, X-ray, pulmonary, and cardiology procedural rooms. The operating room reimbursement will reflect the cost of:

- The use of the operating room
- The services of qualified professional and technical personnel

- Any supplies, items, equipment, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services. Refer to the *Routine Supplies* section of the manual.

The operating room charge will not reflect the cost of robotic technology and is not eligible for separate reimbursement. Examples of charges that are not eligible for separate or additional reimbursement are listed below:

- Increased operating room unit cost charges for the use of the robotic technology
- Charges billed under CPT or HCPCS codes that are specific to robotic-assisted surgery, including, but not limited to, S2900
- Supplies billed related to the use of robotic technology.
- Reference the Technology Assisted Surgical Procedures reimbursement policy.

**Other Agreements**

If Facility currently maintains a separate Agreement(s) with Wellpoint solely for the provision and payment of home health care services, skilled nursing Facility services, ambulatory surgical Facility services, or other agreements that Wellpoint designates (hereinafter collectively "Other Agreement(s)"), said Other Agreement(s) will remain in effect and control the provision and payment of Covered Services rendered there under.

**Personal Care Items**

Personal care items used for patient convenience are not reimbursable. Examples include but are not limited to deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, eye lubricants, powder, soap, telephone calls, television, tissues, toothbrush, and toothpaste.

**Pharmacy Charges**

Pharmacy charges will be reimbursed to include only the cost of the drugs prescribed by the attending physician. Medications furnished to patients shall not include an additional separate charge for administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel. Wellpoint will reimburse at the Wellpoint Rate for the drug. All other services are included in the Wellpoint Rate. Examples of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy (Rx) cart.

**Portable Charges**

Portable Charges are included in the reimbursement for the procedure, test, or x-ray and are not separately reimbursable.

**Pre-Operative Care or Holding Room Charges**

Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure, and are not separately reimbursed. In addition, nursing care provided in the pre-operative care area will not be reimbursed separately. Reimbursement for the procedure includes all nursing care provided.

### Preparation (Set-Up) Charges

Charges for set-up, equipment, or materials in preparation for procedures or tests are included in the reimbursement for that particular procedure or test.

### Provider and Facility Records

Provider and Facility shall prepare and maintain all appropriate medical, financial, administrative, and other records as may be needed for Members receiving Health Services. All of Provider and Facility's records on Members shall be maintained in accordance with prudent record-keeping procedures and as required by any applicable federal, state, or local laws, rules, or regulations.

### Recovery Room Charges

Reimbursement for recovery room services (time or flat fee) includes all used and or available services, equipment, monitoring, nursing care that is necessary for the patient's welfare and safety during his/her confinement. This will include, but is not limited to, cardiac monitoring, Dinamap®, pulse oximeter, injection fees, nursing, nursing time, nursing supervision, equipment and supplies (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

### Recovery Room Services Related to IV Sedation and/or Local Anesthesia

Wellpoint will not provide reimbursement for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post-procedure room or a phase II recovery (step-down), e.g., arteriograms. The Wellpoint Rate shall not exceed the Facility's approved average semi-private room and board rate less discount, as submitted to Wellpoint.

### Respiratory Services

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

### Routine Supplies

Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately reimbursable in the inpatient and outpatient environments. Reimbursement is included in the reimbursement for the room, procedure, or observation charges.

### Semi-Private Room Rate

Wellpoint must be notified in writing of any changes, and new rates will be loaded thirty (30) days after such notification. No Claims will be reprocessed as a result of changes to semi-private room rates. All eligible charges for Covered Services will be limited to the approved average semi-private room and board rate, less discount, as submitted to Wellpoint.

### Services Related to Non-Covered Services, Supplies, or Treatment

Reimbursement shall not be made for claims submitted for services, supplies, or treatment related to, or for complications directly related to, a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-covered Service.

### Special Procedure Room Charge

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

### Stand-by Charges

Standby equipment and consumable items, such as oxygen, which are on standby, are not reimbursable. Only actual use is covered. Staff on standby is included in the reimbursement for the procedure and is also not separately reimbursable.

### Stat Charges

Stat charges are included in the reimbursement for the procedure, test, and or X-ray. These charges are not separately reimbursable.

### Submission of Claim/Encounter Data

Facilities and Providers will submit Claims and encounter data to Wellpoint on a CMS-1500, UB04, or subsequent form, in a manner consistent with industry standards and policies and procedures as approved by Wellpoint. Wellpoint will make best efforts to pay all complete and accurate Claims for Covered Services submitted by Facilities and Providers in accordance with the applicable state statute, exclusive of Claims that have been suspended due to the need to determine Medical Necessity, to the extent of Wellpoint's payment liability, if any, because of issues such as coordination of benefits, subrogation or verification of coverage.

### Supplies and Equipment

Charges for medical equipment, including but not limited to IV pumps, PCA Pumps, isolation carts, mechanical ventilators, continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BIPAP) machines, and related supplies, are not separately reimbursable. Oxygen charges, including but not limited to oxygen therapy per minute/per hour when billed with room types ICU/CCU/NICU or any Specialty Care area, are not separately reimbursable.

### Tech Support Charges

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

### Telemetry

Telemetry charges in ER/ICU/CCU/NICU or telemetry unit are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable. Separately billed telemetry charges will only be paid if observation ("OBS") charges do not exceed approved average semi-private room and board rate less discount, as submitted to Wellpoint.

### Test or Procedures Prior to Admission(s) or Outpatient Services

The following diagnostic services, defined by specific Coded Service Identifier(s), are considered part of pre-admission/pre-surgical/preoperative testing:

254 – Drugs incident to other diagnostic services

255 – Drugs incident to radiology

30X – Laboratory

31X – Laboratory pathological

32X – Radiology diagnostic

341 – Nuclear medicine, diagnostic

35X – CT scan

40X – Other imaging services

46X – Pulmonary function

48X – Cardiology

53X – Osteopathic services

61X – MRI

62X – Medical/surgical supplies, incident to radiology or other services

73X – EKG/ECG

74X – EEG

92X – Other diagnostic services

Non-diagnostic services are also considered part of pre-admission/pre-surgical/preoperative testing if they are furnished in connection with the principal diagnosis that necessitates the outpatient procedure or the Member's admission as an inpatient.

**Time Calculation**

- **Operating Room (OR)** –Time should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.
- **Recovery Room** – Time should be calculated from the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit (PACU) record.
- **Post Recovery Room** – Time charges should be calculated from the time the patient leaves the recovery room until discharge.
- **Hospital/ Technical Anesthesia Component**- Time should be calculated from the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse's notes. The time the anesthesiologist spends with the patient in pre-op and in the recovery room is not to be included in the hospital anesthesia time calculation.

**Undocumented or Unsupported Charges**

Per Wellpoint policy, Wellpoint will not reimburse charges that are not documented on medical records or supported with documentation.

**Video or Digital Equipment used in Procedures**

Charges for video or digital equipment used for visual enhancement during a procedure are included in the reimbursement for the procedure and are not separately reimbursable. Examples include, but

are not limited to, Ultrasound and Fluoroscopy guidance. Charges for batteries, covers, film, anti-fogger solution, tapes, etc., are also not separately reimbursable.

### Additional Reimbursement Guidelines for Disallowed Charges

For any Claims that are reimbursed at a percent of charge, only Charges for Covered Services are eligible for reimbursement. The disallowed charges (charges not eligible for reimbursement) include, **but are not limited to**, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by the specific agreement. Refer to the contractual fee schedule for payment determination.

The tables below illustrate examples of non-reimbursable items/services codes:

| **Facility Responsibility** | |
|---|---|
| **Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below** | **Description of Excluded Items** |
| 0990 – 0999 | Personal Care Items<br>Courtesy/Hospitality Room<br>Patient Convenience Items (0990)<br>Cafeteria, Guest Tray (0991)<br>Private Linen Service (0992)<br>Telephone, Telegraph (0993)<br>TV, Radio (0994)<br>Non-patient Room Rentals (0995)<br>Beauty Shop, Barber (0998)<br>Other Patient Convenience Items (0999) |
| 0369 | Preoperative Care or Holding Room Charges |
| 0760 – 0769 | Special Procedure Room Charge |
| 0111 – 0119 | Private Room* (subject to Member's Benefit) |
| 0221 | Admission Charge |
| 0480 – 0489 | Stand-by Charges |
| 0220, 0949 | Add on Stat Charges |
| 0270 – 0279, 0360 | Video Equipment Used in Procedures |
| 0270, 0271, 0272 | **Supplies and Equipment**<br>Blood Pressure cuffs/Stethoscopes<br>Thermometers, Temperature Probes, etc.<br>Pacing Cables/Wires/Probes<br>Pressure/Pump Transducers<br>Transducer Kits/Packs<br>SCD Sleeves/Compression Sleeves/Ted Hose<br>Oximeter Sensors/Probes/Covers<br>Electrodes, Electrode Cables/Wires<br>Oral swabs/toothettes<br>Wipes (baby, cleansing, etc.)<br>Bedpans/Urinals<br>Bed Scales/Alarms<br>Specialty Beds<br>Foley/Straight Catheters, Urometers/Leg Bags/Tubing<br>Specimen traps/containers/kits |

| Facility Responsibility | |
|---|---|
| **Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below** | **Description of Excluded Items** |
| | Tourniquets<br>Syringes/Needles/Lancets/Butterflies<br>Isolation carts/supplies<br>Dressing Change Trays/Packs/Kits<br>Dressings/Gauze/Sponges<br>Kerlix/Tegaderm/OpSite/Telfa<br>Skin cleansers/preps<br>Cotton Balls<br>Band-Aids, Tape, Q-Tips<br>Diapers/Chucks/Pads/Briefs<br>Irrigation Solutions<br>ID/Allergy bracelets<br>Foley stat lock<br>Gloves/Gowns/Drapes/Covers/Blankets<br>Ice Packs/Heating Pads/Water Bottles<br>Kits/Packs (Gowns, Towels and Drapes)<br>Basins/basin sets<br>Positioning Aides/Wedges/Pillows<br>Suction Canisters/Tubing/Tips/Catheters/Liners<br>Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.)<br>Preps/prep trays<br>Masks (including CPAP and Nasal Cannulas/Prongs)<br>Bonnets/Hats/Hoods<br>Smoke Evacuator Tubing<br>Restraints/Posey Belts<br>OR Equipment/Supplies (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.)<br>IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, etc.); |
| 0220 – 0222, 0229, 0250 | Tech Support Charges<br>Pharmacy Administrative Fee (including mixing meds)<br>Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility)<br>Patient transport fees |
| 0223 | Utilization Review Service Charges |
| 263 | IV Infusion for therapy, prophylaxis (96365, 96366)<br>IV Infusion additional for therapy:<br>IV Infusion concurrent for therapy (96368);<br>IV Injection (96374, 96379) |
| 0229, 0760 – 0762, 0769, 0270, 410 – 413, 0419 | Other Charges<br>Observations hours may never exceed the charge of a semiprivate room charge<br>Oxygen charges while a patient is on a ventilator<br>Respiratory assessment/vent management charges |

| Facility Responsibility | |
|---|---|
| **Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below** | **Description of Excluded Items** |
| 0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310 | Nursing Procedures and 99001 – Handling and/or conveyance of specimen from patient (charge for specimen handling) |
| 0230 | Incremental Nursing – General |
| 0231 | Nursing Charge – Nursery |
| 0232 | Nursing Charge – Obstetrics (OB) |
| 0233 | Nursing Charge – Intensive Care Unit (ICU) |
| 0234 | Nursing Charge – Cardiac Care Unit (CCU) |
| 0235 | Nursing Charge – Hospice |
| 0239 | Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR) |
| 0250 – 0259, 0636 | Pharmacy<br>Compounding fees<br>Medication prep<br>Nonspecific descriptions<br>Anesthesia Gases – Billed in conjunction with Anesthesia Charges<br>IV Solutions 250 cc or less<br>Miscellaneous Descriptions<br>Non-FDA Approved Medications (subject to UM determination- Medical Policies) |
| 0256 | Experimental Drugs (subject to UM determination- Medical Policies) |
| 0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392 | Venipuncture (CPT Code 36415, 36416 or G0001)<br>Specimen collection<br>Draw fees<br>Phlebotomy<br>Heel stick<br>Blood storage and processing blood administration<br>Thawing/Pooling/Splitting, etc. |
| 0222, 0270, 0272, 0410, 0460 | Portable Charges |
| 0270 – 0279, 0290, 0320, 0410, 0460 | Supplies and Equipment (including rentals)<br>Preparation (Set-up) Charges; Set-up is included in the fee for the procedure and/or the room and board<br>Oxygen (ICU/CCU/Progressive) O.R., ER and Recovery<br>Instrument Trays and/or Surgical Packs<br>Drills/Saws (All power equipment used in O.R.)<br>Drill Bits<br>Blades<br>IV pumps and PCA (Patient Controlled Analgesia) pumps<br>Isolation supplies<br>Daily Floor Supply Charges<br>X-ray Aprons/Shields<br>Blood Pressure Monitor<br>Beds/Mattress |

| Facility Responsibility | |
|---|---|
| **Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below** | **Description of Excluded Items** |
| | Patient Lifts/Slings<br>Restraints<br>Transfer Belt<br>Bair Hugger Machine/Blankets<br>SCD Pumps<br>Heel/Elbow Protector<br>Burrs<br>Cardiac Monitor<br>EKG Electrodes<br>Vent Circuit<br>Suction Supplies for Vent Patient<br>Electrocautery Grounding Pad<br>Bovie Tips/Electrodes<br>Anesthesia Supplies When Billed with Anesthesia Charges<br>Case Carts<br>C-Arm/Fluoroscopic Charge<br>Wound Vacuum Pump and supplies<br>Bovie/Electro Cautery Unit<br>Wall Suction<br>Retractors<br>Single Instruments<br>Oximeter Monitor<br>CPM Machines<br>Lasers<br>DaVinci Machine/Robot |
| 0309 – 0369, 0419, 0619 | After Hours – Call-back |
| 0370 – 0379, 0410, 0460, 0480 – 0489 | Anesthesia (Specifically, conscious/moderate sedation by same physician or procedure nurse)<br>Nursing care<br>Monitoring<br>Pre- or Post-evaluation and education<br>IV sedation and local anesthesia by same physician or procedure nurse<br>Intubation/Extubation<br>CPR |
| 410 | Nursing/Respiratory Functions:<br>Oximetry (94760, 94761, 94762)<br>Vent Management<br>Postural Drainage<br>Suctioning Procedure<br>Nursing/Respiratory care performed while patient is on vent |
| 0480 – 0489 | Percutaneous Transluminal Coronary Angioplasty (PTCA) stand-by charges |
| 0940 – 0945 | Education/Training |

| Facility Responsibility | |
|---|---|
| **Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below** | **Description of Excluded Items** |
| 0270, 0272, 0300 – 0309 | Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, etc.) |

| Member Responsibility | |
|---|---|
| **Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below** | **Description of Excluded Items** |
| 0110 – 0119 | Private Room (subject to the Member's Benefit Agreement) |
| 0990 | Patient Convenience Items |
| 0991 | Cafeteria, Guest Tray |
| 0992 | Private Linen Service |
| 0993 | Telephone, Telegraph |
| 0994 | TV, Radio |
| 0995 | Non-patient Room Rentals |
| 0996 | Late Discharge |
| 0998 | Beauty Shop, Barber |
| 0999 | Other Patient Convenience Items |

# Medical Policies and Clinical Guidelines

## Clinical Practice Guidelines

Wellpoint considers clinical practice guidelines to be an important component of health care. Wellpoint adopts nationally recognized clinical practice guidelines, and encourages physicians to utilize these guidelines to improve the health of Members. Several national organizations such as, National Heart, Lung and Blood Institute, American Diabetes Association and the American Heart Association, produce guidelines for asthma, diabetes, hypertension, and other conditions. The guidelines, which Wellpoint uses for quality and disease management programs, are based on reasonable medical evidence. Wellpoint reviews the guidelines at least every year or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances and recent medical research.

To access the guidelines, go to the **Wellpoint Provider webpage.**

With respect to the issue of coverage, each Member should review their Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The Certificate of Coverage and/or Schedule of Benefits supersede the clinical practice guidelines.

## Preventive Health Guidelines

Wellpoint considers prevention to be an important component of health care. Wellpoint develops preventive health guidelines in accordance with recommendations made by nationally recognized organizations and societies such as the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Advisory Committee on Immunizations Practices (ACIP), the American College of Obstetrics and Gynecology (ACOG) and the United States Preventive Services Task Force (USPSTF). The above organizations make recommendations based on reasonable medical evidence.

Wellpoint reviews the guidelines annually for content accuracy, current primary sources, new technological advances and recent medical research and make appropriate changes based on this review of the recommendations and/or preventive health mandates. Wellpoint encourages physicians to utilize these guidelines to improve the health of Members.

The current guidelines are available online. To access the guidelines, go to the **Wellpoint Provider webpage.**

With respect to the issue of coverage, each Member should review their Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The Certificate of Coverage and/or Schedule of Benefits supersede the preventive health guidelines.

## Medical Policies and Clinical Utilization Management (UM) Guidelines

The Office of Medical Policy & Technology Assessment (“OMPTA”) develops medical policy and clinical UM guidelines (collectively, “Medical Policy”) for the company. The principal component of the process is the review for development of medical necessity and/or investigational and not medically necessary position statements or clinical indications that are objective and based on medical evidence for certain new medical services and/or procedures or for new uses of existing services and/or procedures. The services, consisting of medical, surgical, and behavioral health treatments, may

include, but are not limited to, devices, biologics, specialty pharmaceuticals, gene therapies, and professional health services.

Medical Policies are intended to reflect current scientific data and clinical thinking. While Medical Policy sets forth position statements or clinical indications regarding the medical necessity of individual services and/or procedures, Federal and State law, as well as contract language, including definitions and specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

The Medical Policy & Technology Assessment Committee ("MPTAC") is a multiple disciplinary group including physicians from various medical and behavioral health specialties, clinical practice environments, and geographic areas. Voting membership may include external physicians in clinical practices and participating in networks, external physicians in academic practices and participating in networks, internal medical directors, and Chairs of MPTAC Subcommittees. Non-voting Members may include internal legal counsel and internal medical directors.

Additional details regarding the Medical Policy development process, including information about MPTAC and its Subcommittees, are provided in **ADMIN.00001 Medical Policy Formation.**

**Medical Policy and Clinical Utilization Management (UM) Guidelines Distinction**

*Medical Policy and Clinical UM Guidelines* differ in the type of determination being made. Both set forth position statements or clinical indications regarding the medical necessity of individual services and/or procedures. In general, Medical Policy may be developed to address investigational technologies (including a novel application of an existing technology) and services where there is a significant concern regarding Member safety. Clinical UM guidelines may be developed to address Medical Necessity criteria for technologies or services where sufficient clinical evidence exists to evaluate the clinical appropriateness of the request, goal length of stay (GLOS), place of service, and level of care. In addition, Medical Policies are implemented by all Plans, while clinical UM guidelines are adopted and implemented at the discretion of the local Plan or line of business.

**Accessing Medical Policies and Clinical UM Guidelines**

Medical Policies and Clinical UM Guidelines are available on our websites, which provide transparency for Providers, Facilities, Members, and the public in general. Some vendor guidelines used to make coverage determinations are proprietary and are not publicly available on the health plan's websites, but are available upon request.

The clinical UM guidelines published on Wellpoint's website represent the clinical UM guidelines currently available to all Plans for adoption throughout our organization. Because local practice patterns, claims systems, and benefit designs vary, a local Plan may choose whether to adopt a particular clinical UM guideline. The online clinical UM guideline adoption lists can be used to confirm whether the local Plan has adopted the clinical UM guideline(s) in question. Adoption lists are created and maintained solely by each local Plan.

To view Medical Policies and Clinical UM Guidelines online, go to the **Wellpoint Provider webpage**. Click on **Medical Policies** and then **Medical Policies & Clinical UM Guidelines.** Read and accept the *Acknowledgement*, then click on "**Yes, please continue**." Search for policies and guidelines using a keyword or code, or select "Full List page" to view the entire list of policies and guidelines. Page link is below:

**Wellpoint Medical Policy and Clinical UM Guidelines – Full List**

### Other Criteria

In addition to *Medical Policy and Clinical UM Guidelines* maintained for coverage decisions, the health plan may adopt third-party criteria, which are developed and maintained by other organizations. Where the health plan has developed criteria that address a service also described in one of the third party's sets of criteria, the health plan's medical policy supersedes.

To access third-party criteria, go to the **Wellpoint Provider webpage**. Click on **Medical policies**, select **"Medical Policies & Clinical UM Guidelines."** Scroll to **Other Criteria** and select the desired criteria.

# Utilization Management

## Utilization Management Program

Utilization Review (sometimes referred to as Utilization Management) means our evaluation of clinical information for the purpose of making favorable determinations and adverse determinations to ensure appropriateness of care.

The Utilization Management (UM) program goal is that Members receive the appropriate quantity and quality of healthcare services, delivered at the appropriate time, and in a setting consistent with their medical care needs. Providers and Facilities agree to abide by the following UM program requirements in accordance with the terms of the Agreement and the Member's Health Benefit Plan. Providers and Facilities agree to cooperate with Wellpoint in the development and implementation of action plans arising under these programs. Provider or Facility shall comply with all requests for medical information required to complete UM reviews. Providers and Facilities agree to adhere to the following provisions and provide the information as outlined within this Utilization Management section.

Decisions are based on medical necessity and appropriateness of care and service, and the organization does not specifically reward denials of coverage.

**UM Definitions**

**Adverse Determination:** means a denial, reduction, or failure to make payment (in whole or in part) for a benefit based on a determination that a benefit is experimental, investigational, or not medically necessary or appropriate as defined in the applicable health benefit plan. This may apply to Prospective, Continued Stay, and Retrospective reviews.

**Business Day:** Monday through Friday, excluding designated company holidays.

**Discharge Planning:** includes coordination of medical services and supplies, medical personnel, and family to facilitate the Member's timely discharge to a more appropriate level of care following an inpatient admission.

**Notification:** The telephonic and/or written/electronic communication to the applicable Provider(s), Facility, and the Member documenting the UM determination.

**Pre-Certification: includes Pre-Authorization/Pre-Service/Prospective).** List of services that require Review by UM prior to service delivery. For UM team to perform this Review, the Provider submits the pertinent information as soon as possible to UM prior to service delivery.

**Review Types:**

- **Prospective Review:** Utilization review that is conducted on a health care service (or supply) that requires Pre-certification prior to its delivery to the Member.
- **Continued Stay Review:** Utilization review that is conducted during a Member's ongoing stay in a Facility or course of treatment. Continued Stay Review includes Continuation of Services (Urgent Care & Extensions).
- **Retrospective Review:** Utilization review that is conducted after the health care service (or supply) has been provided to the Member.
- **Urgent Care Review**: Request for medical care or services where application of the time frame for making routine or non-life-threatening care determinations:

- 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
- Could seriously jeopardize the life, health, or safety of the Member or others, due to the Member's psychological state, or
- In the opinion of a practitioner who is a licensed or certified professional providing medical care or behavioral healthcare services with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

**Program Overview**

Utilization review may be required for Prospective, Continued Stay, or Retrospective services. UM may be conducted via multiple communication paths.

The review may consider such factors as the Medical Necessity of services provided, and whether the service involves cosmetic or experimental/investigative procedures.

Provider or Facility shall comply with all requests for medical information required to complete UM review up to and including discharge planning coordination. To facilitate the review process, Provider or Facility shall make best efforts to supply requested information within twenty-four (24) hours of request.

UM will provide electronic or written Notification for determinations to the Member, provider and/or facility, as applicable. Any Notification of an Adverse Determination will include, in clear, understandable language, the factual bases for the Adverse Determination and the criteria and standards on which the Adverse Determination is based.

UM Review Timeframes follow Federal, State, and accreditation requirements as applicable review.

The determination that services are medically necessary is based on the information provided and is not a guarantee that benefits will be paid. Payments are based on the Member's coverage at the time of service. These terms typically include certain exclusions, limitations, and other conditions.

Reimbursement for preauthorized or approved health care services will be denied if:

- The information submitted for preauthorization regarding the service to be delivered to the Member was fraudulent or intentionally misrepresentative.
- Critical information requested by Wellpoint regarding the service to be delivered to the Member was omitted, such that the Plan's determination would have been different had it known the critical information.
- A planned course of treatment for the Member that was preauthorized or approved by the [Plan] was not substantially followed by the health care provider.
- On the date the preauthorized or approved service was delivered, (1) the Member was not covered by the Plan; (2) the Plan maintained an automated eligibility verification system that was available to the contracting provider by telephone or via the Internet; and (3) according to the verification system, the Member was not covered by the Plan.

Inpatient admissions require UM review. UM for inpatient services may include, but is not limited to acute hospitalizations, units described as "sub-acute," "step-down" and "skilled nursing facility;" designated skilled nursing beds/units; residential treatment facilities, comprehensive outpatient rehabilitation facilities; rehabilitation units; inpatient hospice; and sub-acute rehabilitation facilities or transitional living centers. These services are subject to admission review for determination of medical

necessity, including site of service and level of care. In addition, Utilization Management services may be provided by a Carelon entity.

Non-inpatient services may require Pre-Certification Review.

The list of **Pre-Certification Requirements** can be accessed online. Go to the **Wellpoint Provider webpage**, then on the horizontal menu, select **Prior Authorization** under the **Provider Resources** heading. Select the appropriate link depending on the type of Member Plan. The Pre-certification requirements may be confirmed by contacting the appropriate phone number on the back of the Member's ID card.

**Prospective and Continued Stay Review**

A. Elective inpatient admission and outpatient procedures require review and to have a decision rendered **before** the service occurs. Information provided to UM shall include demographic and clinical information, including, but not limited to, primary diagnosis. For information on applicable penalties for non-compliance, see the *Failure to Comply with Utilization Management Program* section.

B. Emergency inpatient admissions require the Provider or Facility to notify UM within forty-eight (48) hours. If the forty-eight (48) hours expires on a day that is not a Business Day, the timeframe will be extended to include the next Business Day. Information provided to UM shall include demographic and clinical information, including, but not limited to, primary diagnosis. For information on applicable penalties for non-compliance, see the *Failure to Comply with Utilization Management Program* section.

**Retrospective Utilization Management**

Penalties may result for failing to preauthorize elective inpatient admissions, outpatient procedures, or providing notification within forty-five (48) hours of an emergency admission even if records are reviewed retrospectively. For information on applicable penalties for non-compliance see *Failure to Comply with Utilization Management Program* section.

**Medical Policies and Clinical UM Guidelines**

Refer to the Medical Policies and Clinical Utilization Management (UM) Guidelines section of this manual for additional information about Medical Policy and Clinical UM Guidelines.

**On-Site/Electronic Medical Record Review (EMR)**

If applicable, the Facility agrees to provide UM with on-site or EMR access, for inpatient admission reviews.

Certain services may be excluded from On-Site or EMR Review.

**Failure to Comply With Utilization Management Program Processes**

Provider and Facility acknowledge that Wellpoint may apply monetary penalties such as a reduction in payment, as a result of Provider's or Facility's failure to provide notice of admission or obtain Pre-Certification Review on specified outpatient procedures, as required under the Agreement or for Provider's or Facility's failure to fully comply with and participate in any cost management programs and/or UM programs. Members may not be balance billed for penalty amounts.

Penalties include but are not limited to the following:

- Pre-Certification review is required for elective inpatient admissions and outpatient procedures that require Pre-Certification/Pre-Authorization as specified by Wellpoint that are not submitted for review and a decision rendered **BEFORE** the service occurs will be subject to a 100%

payment penalty unless extenuating circumstances exist as further described below. Providers and Facilities can only dispute the 100% penalty in order to present evidence of extenuating circumstances.

- Payment for emergency inpatient admissions will be subject to a 100% penalty if the notification is not provided within forty-eight (48) hours of admission. Providers and Facilities can only dispute the 100% penalty in order to present evidence of extenuating circumstances by requesting a Claim Payment Reconsideration as further described in the Claims Payment Disputes section of this manual. If the forty-eight (48) hours expires on a day that is not a Business Day, the time frame will be extended to include the next Business Day.

Extenuating Circumstances Approval List

- Insurance information was not available from the Member at the time of admission or incorrect information was received from the Member, due to illness, mental status, or language differences at the time of services. Including primary payer issues (e.g., Medicare, AKA admissions or VIP Member admitted under a false name, etc.).
- Wellpoint health system problems prevented authorization from being obtained or Wellpoint health provides erroneous information, (e.g., misinformation about authorization requirements or Member eligibility).
- Admission or services received are court ordered.
- The need for another covered service was revealed and performed at the time the original authorized service was performed, the newly revealed covered service would not receive a late call penalty
- The Member presented with emergency/urgent condition or life-threatening illness/injury/trauma (e.g., intubation or loss of consciousness).
- Routine Maternity Admissions/Newborn Admissions – active/Coordination of Benefits Membership
- Routine Maternity Admissions
- Proof of timely notification of admission of emergency admission was received with forty-eight (48) hours or the first business day following admission. If the forty-eight (48) hours expires on a day that is not a business day the timeframe will be extended to include the next business day. Substantiation may be requested.
- Provider or Facility was given misinformation about authorization or patient eligibility by an Wellpoint Health employee or Department of Medical Assistance (DMAS).
- Transition of Care. This includes transfer from one hospital to another or transfer to home.
- The Member was traveling out of the area and the Provider had difficulty finding who to call for the authorization.
- Retro enrollments issues where the Member was terminated and then reinstated, but the application was not loaded timely.
- Member’s plan reinstated post admission and retroactive to a date prior to the admission
- A Provider or Facility system outage extending 48 hours beyond the date of service requiring authorization prevented the authorization from being obtained and Provider has provided adequate evidence of the system outage.

- A Member is admitted to observation and then becomes inpatient.
- Any other Extenuating Circumstances specific to the health plan.

**Utilization Statistics Information**

On occasion, Wellpoint may request utilization data. These may include, but are not limited to:

- Member name
- Member identification number
- Date of service or date specimen collected
- Physician name and/or identification number
- HEDIS Measures or any other pertinent information Wellpoint deems necessary

This information will be provided by Facility or Provider at no charge to Wellpoint.

**Inpatient Electronic Data Exchange**

For additional information go to the *Admission, Discharge and Transfer Messaging Data* section of this manual which can be found under *Legal and Administrative Requirements*.

**Submit Pre-Certification Requests Digitally**

Using Availity.com to submit requests, offers a streamlined and efficient experience for providers requesting inpatient and outpatient medical services for members covered by Wellpoint. Providers can also use the Availity Essentials Authorization application to check authorization status, regardless of how the authorization was submitted. For additional information go to Availity Essentials section of this manual, which can be found under *Wellpoint Digital Applications*.

Transplant Pre-Certification requests should be submitted via telephone, fax or secured e-mail notification.

**Peer to Peer Review Process**

Upon request from a treating practitioner, who is a licensed or certified professional providing medical care or behavioral healthcare services and directly involved in the Member's care/treatment plan, Wellpoint provides a clinical peer-to-peer conversation when an adverse medical necessity determination will be made or has been made regarding health care services for Members. The treating practitioner may offer additional information and/or further discuss his/her cases with a peer clinical reviewer. In compliance with accreditation standards, a practitioner or his/her designee may request the peer-to-peer review. Others such as hospital representatives, employers and vendors are not permitted to do so.

**Quality of Care Incident**

Providers and Facilities will notify Wellpoint in the event there is a quality of care incident that involves a Member.

**Audits/Records Requests**

At any time Wellpoint may request on-site, electronic or hard copy medical records, utilization review documentation and/or itemized bills related to Claims for the purposes of conducting audits and reviews to determine Medical Necessity, diagnosis and other coding and documentation of services rendered.

### Case Management

Case Management assists Members to optimize the use of their benefits and available community resources to gain access to quality health care in all settings.

The Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs. Case Management programs are confidential and voluntary and are made available at no extra cost. These programs are provided by, or on behalf of and at the request of, case management staff. These Case Management programs are separate from any Covered Services. If the Member meets program criteria and agrees to take part, the case manager will help the Member meet identified health care needs. This is reached through contact and teamwork with the Member and/or the Member's chosen authorized representative, treating Physician(s), and other providers. In addition, case management services may be provided by a Carelon entity.

Assistance may be provided in coordinating care with existing community-based programs and services. This may include giving information about external agencies and community-based programs and services.

## Carelon Medical Benefits Management

Carelon Medical Benefits Management (Carelon MBM) provides clinical solutions that drive appropriate, safe, and affordable care. Serving more than 50 million Members across 50 states, D.C. and U.S. territories, Carelon Medical Benefits Management promotes optimal care using evidence-based clinical guidelines and real-time decision support for both providers and their patients. The Carelon Medical Benefits Management platform delivers significant cost-of-care savings across an expanding set of clinical domains, including cancer care quality, cardiology, genetic testing, musculoskeletal care, medical and radiation oncology, radiology, rehabilitation, sleep medicine and surgical.

Visit Carelon Medical Benefits Management's program microsites listed below to find program information, resources, clinical guidelines, interactive tutorials, worksheets & checklists, FAQs, and access to the provider portal.

| Carelon MBM Solution | Microsite |
|---|---|
| Cardiovascular | **providers.carelonmedicalbenefitsmanagement.com/cardiovascular** |
| Genetic Testing | **providers.carelonmedicalbenefitsmanagement.com/genetictesting** |
| Medical Oncology | **providers.carelonmedicalbenefitsmanagement.com/medicaloncology** |
| Musculoskeletal | **providers.carelonmedicalbenefitsmanagement.com/musculoskeletal** |
| Radiation Oncology | **providers.carelonmedicalbenefitsmanagement.com/radoncology** |
| Radiology | **providers.carelonmedicalbenefitsmanagement.com/radiology** |
| Rehabilitation | **providers.carelonmedicalbenefitsmanagement.com/rehabilitation** |
| Sleep Medicine | **providers.carelonmedicalbenefitsmanagement.com/sleep** |
| Surgical | **providers.carelonmedicalbenefitsmanagement.com/surgicalprocedures** |

**Submit Pre-certification/Pre-authorization requests to Carelon Medical Benefits Management**

Ordering and servicing Providers may submit Pre-certification/Pre-authorization requests to Carelon Medical Benefits Management in one of the following ways:

- Access the provider portal at **providerportal.com**. Online access is available 24/7 to process orders in real-time and is the fastest and most convenient way to request authorization.
- Call the Carelon Medical Benefits Management Contact Center toll-free number **800-554-0580**.

**OptiNet Registration**

The OptiNet Registration is an important tool that assists ordering providers in real-time decision support information to enable ordering providers to choose high-quality, low-cost imaging and genetic counseling providers for their patients. Servicing providers need to complete the OptiNet Registration online.

To access the OptiNet Registration:

- Access the provider portal directly at **providerportal.com**
    - Once logged into Carelon Medical Benefits Management, from the **My Homepage** screen, choose **Access OptiNet Registration**.
- Select the Registration Type and choose the Access OptiNet Registration button.
- Complete requested information.

The registration does not need to be completed in one sitting. Data can be saved throughout the registration process. Once the registration has been submitted, a score card will be produced for Radiation Solution Facilities; Genetics Testing Facilities will not have a score card. The score for the Facility will be presented to the ordering Provider when the particular Facility is selected as a place of service which drives Ordering Provider Decision Support.

For technical questions, contact Web Support at **800-252-2021**. For specific OptiNet customer services requests, contact **877-202-6543**. For any other questions, contact Wellpoint Provider Services.

# Quality Improvement Program

Healthcare is local and Wellpoint has a strong local presence required to understand and support Member needs and provide access to covered care. Wellpoint is well positioned to deliver what Members want: innovative, choice-based products, distinctive service, simplified transactions and better access to information for quality care. Local presence and broad expertise create opportunities for collaborative programs that support Providers and Facilities achieving clinical quality and excellence. Participating Providers and Facilities are expected to cooperate with quality activities. Commitment to health improvement and care management provides added value to Members and Providers helping improve both health and healthcare costs. Wellpoint takes a leadership role to improve the health of its communities and is helping to address key healthcare issues.

Guided by its whole health strategy, Wellpoint uses digital-first solutions to support provision of exceptional experiences, affordability, quality and broadened access to consumers and communities. Our digital solutions are the driving force behind shaping our strategy. Digital access to care is one of the enablers that allows us to create value, respond to societal shifts and meet market and consumer needs. We have a continued focus on integrating data, analytics, insights and digital technologies into every aspect of the business.

**Goals and Objectives**

The goals and objectives support Wellpoint's vision and values; are responsive to the changing needs of Members, Providers, Facilities and the healthcare community; and focus Wellpoint on being a valued health partner across the healthcare continuum. Wellpoint implements evidence-based interventions from both external and internal sources to help build and deliver the best value to customers.

- Develop and maintain a well-integrated system to identify, measure, assess and improve clinical and service quality outcomes through standardized and collaborative activities.
- Evaluate performance in order to take action and respond to the needs of internal/external customers, including compliance with policies, procedures, contractual and regulatory and accreditation requirements.
- Build a safer and more equitable health system through the creation of a safety culture that improves the delivery of healthcare, health outcomes and enterprise alignment with national patient safety efforts.
- Identify and promote educational opportunities for Members, medical and behavioral health Providers.
- Advance health equity locally and nationally to improve lives and communities.
- Address the cultural and linguistic needs of eligible Members to promote improved health and healthcare outcomes for diverse Members.
- Help maximize health status, improve health outcomes and reduce healthcare costs of Members through effective Case Management ("CM"), which includes Behavioral Health ("BH") and Disease Management ("DM") programs addressing complex care needs and Population Health Management ("PHM") which includes CM, BH and DM.

**Patient Safety for Members**

Wellpoint's mission is improving lives and communities, and the quality framework supports this with the promotion of continuous improvement in patient safety. The patient safety goals are to build a safer, more equitable health system and decrease the occurrence of patient safety events by creating a safety culture that improves the delivery of healthcare, health outcomes and alignment with national patient safety efforts. This will be accomplished through the promotion of safe clinical practices in aspects of clinical care and service; to engage Members and medical and behavioral health Providers concerning patient safety in aspects of patient interaction; and to identify opportunities for system and process improvements that promote patient safety within individual practices and across the healthcare continuum. Areas for monitoring are selected by analyzing patient safety data for Members inherent to quality of medical and behavioral healthcare delivery and service. Areas of focus include Population Health Management programs that target keeping members healthy, managing members with emerging risk, patient safety or outcomes across setting and managing multiple chronic illnesses.

## Continuity and Coordination of Care

Wellpoint encourages communication between all physicians, including primary care physicians (PCPs), behavioral health practitioners and medical specialists, as well as other health care professionals who are involved in providing care to Wellpoint Members. Please discuss the importance of this communication with each Member and make every reasonable attempt to elicit permission to coordinate care at the time treatment begins. HIPAA allows the exchange of information between Covered Entities for the purposes of Treatment, Payment and Health Care Operations.

The Wellpoint Quality Improvement Program is an ongoing and integrative program, which features a number of evaluative surveys and improvement activities designed to help ensure the continuity and coordination of care across physician and other health care professional sites, enhancing the quality, safety, and appropriateness of medical and behavioral health care services offered by Providers.

## Continuity of Care/Transition of Care Program

This program is for Members when their Provider or Facility terminates from the network and new Members (meeting certain criteria) who have been participating in active treatment with a provider not within Wellpoint's network.

Wellpoint makes reasonable efforts to notify Members affected by the termination of a Provider or Facility according to contractual, regulatory and accreditation requirements and prior to the effective termination date. Wellpoint also helps them select a new Provider or Facility.

Wellpoint will work to facilitate the Continuity of Care/Transition of Care (COC/TOC) when Members, or their covered dependents with qualifying conditions, need assistance in transitioning to in-network Providers or Facilities. The goal of this process is to minimize service interruption and to assist in coordinating a safe transition of care. Completion of Covered Services may be allowed at an in-network benefit and reimbursement level with an out-of-network provider for a period of time, according to contractual, regulatory and accreditation requirements, when necessary to complete a course of treatment and to arrange for a safe transfer to an in-network Provider or Facility.

Completion of Covered Services by a Provider or Facility whose contract has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity will not be facilitated.

In addition to the above, due to the requirements of the Federal Consolidation Appropriations Act (CAA), effective January 1, 2022, there are federal continuity of care obligations resulting from (i) the termination of Providers or Facilities from Wellpoint's network and (ii) the termination of a group health

plan from Wellpoint that results in a loss of benefits provided under such group health plan with respect to Provider or Facility.

Members may contact Customer Care to get information on Continuity of Care/Transition of Care.

## Overview of HEDIS®

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures used to compare the performance of managed care plans and physicians based on value rather than cost. HEDIS is coordinated and administered by NCQA and is one of the most widely used sets of health care performance measures in the United States. Wellpoint's HEDIS Quality Team is responsible for collecting clinical information from Provider offices in accordance with HEDIS specifications. Data is collected in four ways: Administratively, Hybrid, Survey or via Electronic Clinical Data Systems. Currently, HEDIS includes 95* measures across six* domains:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Reported using Electronic Clinical Data Systems

Record requests to Provider offices is a year round process. Wellpoint requests the records be returned within the specified time frame to allow time to abstract the records and request additional information if needed from other Providers. Health plans use HEDIS data to encourage their contracted providers to make improvements in the quality of care and service they provide. Employers and consumers use HEDIS data to help them select the best health plan for their needs.

*Subject to change



## Overview of MHQP's Statewide Patient Experience Survey (PES)

The Massachusetts Health Quality Partners (MHQP) Statewide Patient Experience Survey (PES) survey represents an effort to accurately and reliably capture key information from Wellpoint's Members about their experiences with a specific primary care provider and with that doctor's office in the past year. This includes the Member's access to medical care and the quality of the services provided by Wellpoint's network of Providers. Wellpoint analyzes this feedback to identify issues causing Members dissatisfaction and works to develop effective interventions to address them. Wellpoint takes this survey feedback very seriously.

Results of these surveys are shared with Providers annually, so they have an opportunity to learn how Wellpoint Members feel about the services provided. Wellpoint encourages Providers to assess their own practice to identify opportunities to improve patients' access to care and improve interpersonal skills to make the patient care experience a more positive one.

# Culturally & Linguistically Appropriate Services

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

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

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

Providers and Facilities also bring their own cultural orientations, including the culture of medicine. Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

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

Wellpoint ensures Providers and Facilities have access to resources to help support the delivery of culturally and linguistically appropriate services. Wellpoint encourages Providers and Facilities to access and utilize **MyDiversePatients.com**.

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

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.

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

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

# Centers of Medical Excellence

Wellpoint currently offers access to Centers of Medical Excellence (“CME”) programs in solid organ and blood/marrow transplants, cellular immunotherapy CAR-T and ventricular assist devices (“VAD”), The CME designation is awarded to qualified programs by a panel of national experts currently practicing in the fields of solid organ, bone marrow transplantation, and cardiac surgery representing centers across the country. Each Center must meet Wellpoint’s CME participation requirements and is selected through a rigorous evaluation of clinical data that provides insight into the Facility's structures, processes, and outcomes of care. Current transplant designations include the following transplants: adult and pediatric autologous/allogeneic bone marrow/stem cell, adult and pediatric heart, adult and pediatric lung, adult combination heart/lung, adult and pediatric liver, adult and pediatric kidney, adult simultaneous kidney/pancreas, and adult pancreas.

CME program selection criteria are designed to evaluate overall quality, providing a comprehensive view of how the Facility delivers specialty care. For more information contact Provider Services

**Transplant**

- Nearly 104,000 people in the United States were waiting for a lifesaving organ transplant from one of the nation's more than 250 transplant centers in the United States as of December, 2022. In the United States, more than 42,800 organ transplants in 2022. In 2022, annual records set for total number of kidney, liver, heart and lung transplants.
- The Wellpoint CME Transplant Network facilities demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. Each Facility meets stringent clinical criteria and is reviewed by a panel of physicians with expertise in transplants. Criteria established in collaboration with expert physicians' and medical organizations' recommendations, including the Center for International Blood and Marrow Transplant Research (“CIBMTR”), the Scientific Registry of Transplant Recipients (“SRTR”), and the Foundation for the Accreditation of Cellular Therapy (“FACT”).
- Members have access to over transplant specific programs for adult and pediatric heart, lung, liver, kidney, and bone marrow/stem cell transplant, and adult combined heart/lung, combined liver kidney, pancreas, and combined kidney/pancreas transplant.

**Ventricular Assist Devices**

- Wellpoint’s Centers of Medical Excellence Ventricular Assist Device (VAD) launched in 2017. VADs are implantable pumps that assist the heart by pumping blood in the circulatory system of individuals with end-stage heart failure.
- According to the Centers for Disease Control and Prevention Heart failure reports that about 6.2 million adults in the United States have heart failures a major public health problem associated with significant hospital admission rates, mortality, and costly health care services.
- Based on registry data, >33,000 left ventricular assist devices (LVADs) were implanted from June 2006 to June 2021. An estimated 3000+ VADs will be implanted worldwide this year, but the volume is expected to increase as newer, smaller devices receive regulatory approval, clinical indications slowly expand and the continued increase in centers certified to place these devices.

**Cellular Immunotherapy (Chimeric Antigen Receptor Therapy – "CAR-T")**

- The U.S. Food & Drug Administration (FDA) continues to approve new cellular immunotherapy products called Chimeric Antigen Receptor T-cell (CAR-T), which are genetically modified autologous T cell immunotherapies that provides new treatment options for cancer patients. This treatment involves genetic re-engineering of a patient's white blood cells.
- There are seven (7) Chimeric Antigen Receptor T cell therapies (CAR-T) products, listed below, approved by the FDA. This list continues to grow as new products are approved:
    1. Yescarta® (axicabtagene ciloleucel) for treatment in Adult Patients
    2. Kymriah® (tisangenlecleucel) for treatment in Pediatric and Adult Patients
    3. Tecartus™ (brexucabtagene autoleucel) for treatment in Adult Patients
    4. Abecma® (idecabtagene vicleucel) for treatment in Adult Patients
    5. Breyanzi® (idecabtagene maraleucel) for treatment in Adult Patients
    6. Carvykti® (ciltacabtagene autoleucel) for treatment in Adult Patients
    7. Omisirge (omidubicel) for treatment in Pediatric and Adult Patients
- These procedures can be performed in the Inpatient (IP) or Outpatient (OP) setting and Care and follow-up continues over the first year.
- Wellpoint Medical Policy requires the procedure be performed at a Certified CAR-T center.
- Wellpoint has a Centers of Medical Excellence Network that continues to expand. These programs are reviewed by our Bone Marrow National Transplant Quality Review Committee. Until a Provider or Facility is contracted, each referral will require a Letter of Agreement.

**Gene Therapy**

- The U.S. Food & Drug Administration (FDA) continues to approve new gene therapy products which provide new treatments for various conditions. This treatment involves Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material

# Audit and Review

*This section does not apply to audits or reviews performed by the Special Investigations Unit (SIU). For information on SIU processes, refer to the Fraud, Waste, and Abuse section located in this Manual.*

## Wellpoint Audit and Review Policy

All capitalized terms used in this Policy shall have the meaning as set forth in the Provider or Facility Agreement between Wellpoint and Provider or Facility, unless otherwise defined below for this section.

There may be times when Wellpoint conducts Claim reviews or audits to confirm that charges for covered healthcare services are accurately reported and reimbursed in compliance with the Provider or Facility Agreement and Wellpoint's policies and procedures, as well as general industry standard guidelines and regulations.

In order to conduct such reviews and audits, Wellpoint or its designee may request documentation, most commonly in the form of patient medical records and/or itemized bill. Wellpoint may accept additional documentation from Provider or Facility that typically might not be included in medical records, such as other documents substantiating the treatment, health service, or delivery of supplies.

This policy documents Wellpoint's guidelines for Claims requiring additional documentation and the Provider's or Facility's compliance for the provision of requested documentation.

### Definitions

The following definitions shall apply to this Audit and Review section only:

- Agreement means the written contract between Wellpoint and Provider or Facility that describes the duties and obligations of Wellpoint and the Provider or Facility, and which contains the terms and conditions upon which Wellpoint will reimburse Provider or Facility for Health Services rendered by Provider or Facility to Member(s).
- Audit means post-payment evaluation of Health Services or documents relating to such Health Services rendered by Provider or Facility, and conducted for the purpose of determining appropriate reimbursement under the terms of the Agreement.
- Audit Appeal means a written request with supporting documentation to Wellpoint from a Provider or Facility to reconsider a payment determination.
- Audit Appeal Response means Wellpoint's or its designee's written response to the Appeal after reviewing all Supporting Documentation provided by Provider or Facility.
- Business Associate or designee means a third party designated by Wellpoint to perform an Audit or any related function on behalf of Wellpoint.
- Notice of Overpayment means a document that constitutes notice to the Provider or Facility that Wellpoint or its designee believes an overpayment has been made by Wellpoint. The Notice of Overpayment shall contain administrative data relating to the amount of overpayment. Unless otherwise stated in the Agreement between the Provider or Facility and Wellpoint, Notice of Overpayment shall be sent to Provider or Facility.
- Provider Manual means the proprietary Wellpoint document available to the Provider and Facility, which outlines Reimbursement Requirements and Policies.

- Recoupment means the recovery of an amount paid to Provider or Facility which Wellpoint has determined constitutes an overpayment not supported by an Agreement between the Provider or Facility and Wellpoint. In accordance with applicable laws, regulations, and unless an agreement expressly states otherwise, a Recoupment may be performed against a separate Wellpoint payment unrelated to the service or subject made to the Provider or Facility.
- Review means the Claim and supporting documentation will be evaluated prior to payment.
- Supporting Documentation means the written material contained in a Member's medical records or other Provider or Facility documentation, Claim details, prior authorization clinical information, and supply invoices supporting the Provider's or Facility's Claim.

**Documents Reviewed During an Audit or Review**

The following is a description of the documents that may be reviewed by Wellpoint or its designee, along with a short explanation of the importance of each of the documents in the Audit and Review processes. It is important to note that Providers and Facilities must comply with applicable state and federal record-keeping requirements.

A. Confirm that health services were delivered by the Provider or Facility

   Auditors/Reviewers will verify that the Provider's or Facility's Claim is corroborated by Supporting Documentation reflecting the Health Services delivered and billed by the Provider or Facility. The Provider or Facility must review, approve, and document all such policies and procedures by any applicable accreditation bodies.

B. Confirm charges were accurately reported on the Claim in compliance with Wellpoint's Policies as well as general industry standard guidelines and regulations.

   Auditors/Reviewers may review Supporting Documentation, including the Member's health record documents. The health record includes the clinical data on diagnoses, treatments, and outcomes. A health record generally includes pertinent information related to care and must support services billed by the Provider or Facility.

   Auditors/Reviewers may review the Claim Itemized Billing for a breakdown of the services billed and supply invoices for pricing determinations.

Auditors/Reviewers may reference the Wellpoint Reimbursement Policies available on the **Wellpoint Provider webpage**. Choose the **Claims** horizontal menu, then select **Reimbursement Policies**.

**Policy**

Upon request from Wellpoint or its designee, Providers and Facilities are required to submit additional documentation for Claims identified for pre-payment review or post-payment audit.

Wellpoint or its designee will use the following guidelines for records requests for Claims identified for pre-payment review or post-payment audit. A request may be made via paper or electronic format.

- A Provider's or Facility's physical or electronic address may be confirmed prior to an original letter of request for supporting documentation is sent.
- When a response is not received within thirty (30) days of the date of the initial request, a second request letter will be sent.
- When a response is not received within fifteen (15) days of date of the second request, a final request letter will be sent.

- When a response is not received within fifteen (15) days of the date of the final request (60 days total):
  - Wellpoint or its designee will initiate Claim denial for Claims identified as pre-payment review or post-payment audit, as Provider or Facility failed to submit the required documentation. The Member shall be held harmless for such payment denials.

    or
  - Wellpoint or its designee will initiate recoupments for Claims identified as post-payment audit, as Provider or Facility failed to submit the required documentation. The Member shall be held harmless for such recoupments.

Wellpoint or its designee will not be liable for interest or penalties when payment is denied or recouped when Provider or Facility fails to submit required or requested documentation for Claims identified for pre-payment review or post-payment audit.

**Procedure**

**Review of Documents:** Wellpoint or its designee will request in writing any supporting documentation required for audit or review. The Provider or Facility will supply the requested documentation within the time frame outlined above.

**Desk or Off-site Audits:** Wellpoint or its designee may conduct Audits from its offices and/or offsite locations. Facility or Provider will comply with timeline and specific requested documentation listed in Wellpoint's request for additional documentation.

**Completion of Desk or Off-site Audit**: Upon completion of the Audit where an overpayment is identified, Wellpoint will generate a Notice of Overpayment. The Notice of Overpayment will identify the Claim overpayment and include an explanation remark for the overpayment. If the Provider or Facility agrees with the Notice of Overpayment, then the Provider or Facility has thirty (30) calendar days to reimburse Wellpoint the amount indicated in the form of a refund.

Should the Provider or Facility disagree with the Notice of Overpayment, then the Provider or Facility may appeal the Notice of Overpayment. If the Provider or Facility does not submit an Appeal against the Notice of Overpayment and does not reimburse Wellpoint within the thirty (30) calendar days, then Wellpoint will initiate recoupment as applicable and determined per Provider or Facility Agreement and state guidelines.

**On-site Audits**: Wellpoint or its designee may, but is not required to, conduct Audits on-site at the Provider's or Facility's location. If Wellpoint or its designee conducts an Audit at a Provider's or Facility's location, the Provider or Facility will make available suitable workspace for Wellpoint's or its designee's on-site Audit activities. During the Audit, Wellpoint or its designee will have complete access to the applicable health records, including ancillary department records and/or invoice detail, without producing a signed Member authorization.

When conducting credit balance reviews, Provider or Facility will give Wellpoint or its designee a complete list of credit balances for primary, secondary, and tertiary coverage, when applicable. In addition, Wellpoint or its designee will have access to the Provider's or Facility's patient accounting system to review payment history, notes, Explanation of Benefits, and insurance information to determine the validity of credit balances. If the Provider or Facility refuses to allow Wellpoint or its designee access to the items requested to complete the Audit, Wellpoint or its designee may opt to complete the Audit based on the information available.

All Audits (to include medical chart audits and diagnosis-related group reviews) shall be conducted free of charge, despite any Provider or Facility policy to the contrary.

**Completion of Audit (On-site Audit only):** Upon completion of the Audit, Wellpoint or its designee will generate and give to Provider or Facility a final Audit Report. This Audit Report may be provided on the day the Audit is completed, or it may be generated after further research is performed. If further research is needed, the final Audit Report will be generated at any time after the completion of the Audit, but generally within ninety (90) days. Occasionally, the final audit report will be generated at the conclusion of the exit interview, which is performed on the last day of the Audit.

During the exit interview, Wellpoint or its designee will discuss with Provider or Facility its Audit findings found in the final Audit Report. This Audit Report may list items such as charges unsupported by adequate documentation, under-billed items, late-billed items, and charges requiring additional supporting documentation.

If the Provider or Facility agrees with the Audit findings and has no further information to provide to Wellpoint or its designee, then Provider or Facility may sign the final Audit Report acknowledging agreement with the findings. At that point, Provider or Facility has thirty (30) calendar days to reimburse Wellpoint the amount indicated in the final Audit Report. Should the Provider or Facility disagree with the final Audit Report generated during the exit interview, then Provider or Facility may either supply the requested documentation or Appeal the Audit findings.

**Provider or Facility Audit Appeals:** See Audit Appeal Policy.

**No Appeal (On-site audit only):** If the Provider or Facility does not formally Appeal the findings in the final Audit Report **and** submit supporting documentation within the (thirty) 30 calendar day timeframe, the initial determination will stand and Wellpoint or its designee will process adjustments to recover the amount identified in the final Audit Report.

**Scheduling of Audit (Hospital Bill Audits Only):** After review of the documents submitted, if Wellpoint or its designee determines an Audit or Review is required, Wellpoint or its designee will call the Provider or Facility to request a mutually satisfactory time for Wellpoint or its designee to conduct an Audit; however, the Audit must occur within forty-five (45) calendar days of the request.

**Rescheduling of Audit:** Should Provider or Facility desire to reschedule an Audit, Provider or Facility must submit its request with a suggested new date to Wellpoint or its designee in writing at least seven (7) calendar days in advance of the day of the Audit. Provider's or Facility's new date for the Audit must occur within thirty (30) calendar days of the date of the original Audit. Provider or Facility may be responsible for cancellation fees incurred by Wellpoint or its designee due to Provider's or Facility's rescheduling. While Wellpoint or its designee prefers to work with the Provider or Facility in finding a mutually convenient time, there may be instances when Wellpoint or its designee must respond quickly to requests by regulators or its clients. In those circumstances, Wellpoint or its designee will send a notice to the Provider or Facility to schedule an Audit within the seventy-two (72) hour timeframe.

**Under-billed and Late-billed Claims:** During an on-site audit, Provider or Facility may identify Claims for which Provider or Facility under-billed or failed to bill for review by Wellpoint during the Audit. Under-billed or late-billed Claims not identified by the Provider or Facility before the Audit commences will not be evaluated in the Audit.

## Audit Appeal Policy

### Purpose

To establish a timeline for responding to Provider or Facility Appeals of Audits. This section does not apply to appeals or reconsideration of Claims denied on pre-payment review. If Provider or Facility

does not agree with the Claim determination for Claims denied on a pre-payment review basis, follow the instructions on the Remittance Advice.

**Procedure**

- Unless otherwise expressly set forth in an Agreement, Provider or Facility shall have the right to Appeal the findings in the Notice of Overpayment. An Audit Appeal of the Notice of Overpayment must be in writing and received by Wellpoint or its designee within thirty (30) calendar days of the date of the Notice of Overpayment unless applicable law expressly indicates otherwise. The Audit Appeal should address the findings from the Notice of Overpayment that Provider or Facility disputes, as well as the basis for the Provider's or Facility's belief that such finding(s) are not accurate. All findings disputed by the Provider or Facility in the Audit Appeal must be accompanied by relevant Supporting Documentation. If the Provider or Facility does not timely appeal, retraction will begin at the expiration of the thirty (30) calendar days unless expressly prohibited by contractual obligations or applicable law.
- Upon receipt of a timely Audit Appeal, complete with Supporting Documentation as required under this Policy, Wellpoint or its designee shall issue an Audit Appeal Response to the Provider or Facility. Wellpoint's or its designee's response shall address each matter contained in the Provider's or Facility's Audit Appeal. If appropriate, Wellpoint's or its designee's Audit Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Notice of Overpayment. Wellpoint's or its designee's response shall be sent via email, mail, or portal to the Provider or Facility within thirty (30) calendar days of the date Wellpoint or its designee received the Provider's or Facility's Audit Appeal and Supporting Documentation.
- The Provider or Facility shall have fifteen (15) calendar days from the date of Wellpoint's or its designee's Audit Appeal Response to respond with additional documentation or, if appropriate in the state, a remittance check to Wellpoint or its designee. If no Provider or Facility response or remittance check (if applicable) is received within the fifteen (15) calendar day timeframe, Wellpoint or its designee shall begin recoupment of the amount contained in Wellpoint's or its designee's response, and a confirming recoupment notification will be sent to the Provider or Facility.
- Upon receipt of a timely Provider or Facility appeal response, complete with Supporting Documentation as required under this Policy, Wellpoint or its designee shall formulate a final Audit Appeal Response. Wellpoint's or its designee's final Audit Appeal Response shall address each matter contained in the Provider's or Facility's response. Wellpoint's or its designee's final Audit Appeal Response shall be sent via email, mail, or portal to the Provider or Facility within fifteen (15) calendar days of the date Wellpoint or its designee received the Provider or Facility response and Supporting Documentation.
- If applicable in the state, the Provider or Facility shall have fifteen (15) calendar days from the date of Wellpoint's or its designee's final Audit Appeal Response to send a remittance check to Wellpoint or its designee. If no remittance check is received within the fifteen (15) calendar day timeframe, Wellpoint or its designee shall recoup the amount contained in Wellpoint's or its designee's final Audit Appeal Response.

# Fraud, Waste, and Abuse Detection

Wellpoint is committed to protecting the integrity of Wellpoint's health care programs and the effectiveness of operations by preventing, detecting, and investigating fraud, waste, and abuse (FWA). Combating FWA begins with knowledge and awareness.

- **Fraud**: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person—or any other person—committing it. This includes any act that constitutes fraud under applicable Federal or State law.
- **Waste:** Includes overusing services or other practices that, directly or indirectly, result in excessive costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** behaviors that are inconsistent with sound financial, business, and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet professionally recognized standards for health care. This includes any member actions that result in unnecessary costs.

One of the most important steps to help prevent Member fraud is as simple as reviewing the Member identification card to ensure that the individual seeking services is the same as the Member listed on the card. It is the first line of defense against possible fraud.

Learn more at **fighthealthcarefraud.com**.

## Reporting Fraud, Waste, and Abuse

If someone suspects any Member (a person who receives benefits) or Provider has committed fraud, waste or abuse, they have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators.

Report concerns:

- Visit **Wellpoint Provider webpage**, scroll to the bottom footer and click on "**Report Waste, Fraud and Abuse**" to be directed to the **fighthealthcarefraud.com** education site; at the top of the page click "Report it" and complete the "**Report Waste, Fraud and Abuse**" form
- Participating providers can call Provider Solutions
- Non-participating providers can call customer service

Any incident of suspected fraud, waste, or abuse may be reported to Wellpoint anonymously; however, WellPoint's ability to investigate an anonymously reported matter may be limited if Wellpoint doesn't have enough information. Wellpoint encourages Providers and Facilities to give as much information as possible when report an incident of suspected fraud, waste, or abuse. Wellpoint appreciates referrals for suspected fraud, waste, or abuse, but be advised that Wellpoint does not routinely update individuals who make reports as it may potentially compromise an investigation.

Examples of Member Fraud, Waste, and Abuse

- Forging, altering, or selling prescriptions

- Letting someone else use the Member's ID (Identification) card
- Relocating to out-of-service Plan area and not letting the Plan know
- Using someone else's Member ID card

When reporting concerns involving a Member include:

- The Member's name
- The Member's date of birth, Member ID, or case number if available
- The city where the Member resides
- Specific details describing the suspected fraud, waste, or abuse

Examples of Provider Fraud, Waste, and Abuse (FWA):

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Overutilization
- Soliciting, offering, or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding – when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

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

- Name, address, and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if available
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

To learn more about health care fraud and how to aid in the prevention of it, visit **fighthealthcarefraud.com.**

## Investigation Process

The Special Investigations Unit (SIU) investigates suspected incidents of FWA for all types of services. Wellpoint may take corrective action with a Provider or Facility, which may include, but is not limited to:

- *Written warning and/or education*: Wellpoint sends letters to the Provider or Facility advising the Provider or Facility of the issues and the need for improvement. Letters may include education or may advise of further action.
- *Medical record review*: Wellpoint reviews medical records to investigate allegations or validate the appropriateness of Claims submissions. Failure to submit medical records when requested may result in an overpayment determination and/or placement on prepayment review.
- *Prepayment Review*: Specific to a Provider or Facility under investigation, a certified professional coder in the SIU evaluates Claims prior to payment. Edits in Wellpoint's Claims processing systems identify these Claims for review to prevent automatic Claims payments in specific situations.
- *Recoveries*: Wellpoint recovers overpayments directly from the Provider or Facility. Failure of the Provider or Facility to return the overpayment may result in reduced payment for future Claims, termination from our network, and/or legal action.

If you are working with the SIU, all communication (checks, correspondence) should be sent to:

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

Please note:

- If a Provider or Facility is working with the SIU and sending paper medical records and/or Claims based on an SIU request, that address is supplied in correspondence from the SIU. If you have questions, contact your investigator.
- An opportunity to submit Claims and medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at 800-AVAILITY (282-4548) for more information.
- Our company does not accept postdated checks. Any fees incurred for a check returned due to insufficient funds are the responsibility of the Provider or Facility.

## SIU Prepayment Review

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

Once a Claim, or a Provider or Facility, is identified as an outlier or has otherwise come to Wellpoint's attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination that the Provider's or Facility's actions

may involve FWA, unless exigent circumstances exist, the Provider or Facility is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider or Facility is on prepayment review, the Provider or Facility will be required to submit medical records and any other supporting documentation with each Claim so Wellpoint can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation to Wellpoint in accordance with this requirement will result in a denial of the Claim under review. During the pendency of the prepayment review, if requested, The Provider or Facility will be given the opportunity to discussion of his/her/its prepayment review status.

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

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

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

## Acting on Investigative Findings

In addition to the previously mentioned actions, Wellpoint may refer suspected criminal activity committed by a Member, Provider, or Facility to the appropriate regulatory and/or law enforcement agencies.

# Provider (Pharmacy and Prescriber) Home Program

Access to opioid medications for treating acute and chronic health conditions is at an all-time high. While these medications are helping patients live longer and healthier lives, exceeding prescribing frequency, dosages, and duration can also lead to unintended disorders or accidental overdose. Multiple controlled medications prescribed by multiple healthcare providers places our members at an increased health and safety risk than those who adhere to clinical recommendations.

To address this growing epidemic, Wellpoint partners with pharmacies and prescribers to better administer drug benefits via the Pharmacy and Prescriber Home Program. Through this program we help build a care team that focuses on increased communication and coordination. The information in this section applies to Wellpoint Members with prescription drug coverage.

The primary goal of the Pharmacy and Prescriber Home Program is to significantly reduce the risk of prescription cascading, doctor shopping, and harmful drug-to-drug interactions caused by overutilization of controlled substance medications. If a Member is believed to be at an increased safety risk due to obtaining multiple controlled substances from multiple providers and/or pharmacies, they may meet enrollment criteria.

The program limits a qualifying Member to the use of one specific participating pharmacy or prescriber for Schedule II-V controlled medications for a period of no less than twelve (12) consecutive months. The assigned providers will write and/or fill the Member's controlled substance medications throughout the term of their enrollment in the program. Attempts to receive services from a non-prescriber or pharmacy home provider will result in the claim being denied.

**About the Program**

The Pharmacy and Prescriber Home Program includes:

- Reimbursement of controlled substance claims when written by the designated prescriber and/or filled at the Member's Pharmacy Home. All controlled substance claims are denied if written by any prescriber or filled at any pharmacy other than the Member's assigned Pharmacy or Prescriber Home.
- Temporary overrides for urgent or emergent situations only[1].
- Access to Mail Order and Specialty pharmacies, in addition to the Pharmacy Home.

**Qualifying Criteria**

A Member whose prescription claims' history shows they meet the below inclusion criteria may be enrolled in the Pharmacy and Prescriber Home Program if they have[2]:

- Received five or more controlled substance prescriptions (government-regulated drugs) in a ninety (90)-day period.
- Received controlled substance prescriptions from three or more prescribers in a ninety (90)-day period.
- Visited three or more pharmacies to fill controlled substance prescriptions in a ninety (90)-day period.

**Enrollment**

The member is expected to actively participate in reducing their safety risk by only receiving health care and prescription medications from their assigned lock-in providers. If they fail to follow medical advice, the assigned providers are not required to provide requested referrals or treatment.

Once enrolled, the pharmacy and/or prescriber is selected by the Member or, if no selection is made, is automatically assigned based on a retrospective Drug Utilization Review (DUR) of the Member's prescription claims history.

Following the selection of the new Pharmacy and/or Prescriber Home, all prescribing physicians will receive:

- Notification of the Member's enrollment.
- The assigned pharmacy/prescriber information.
- A 3-month prescription profile containing a list of controlled substance prescribers, medications, dosages, and quantities received by the Member during that timeframe.

**Communications & Appeals Information**

Members will be sent a notification at least sixty (60) days prior warning them of their potential inclusion in the program. After the sixty (60)-day monitoring period, if the Member continues to meet the enrollment criteria, he/she is contacted in writing of the decision to place them into the Pharmacy and Prescriber Home Program. They will then be given thirty (30) additional days to select a Pharmacy or Prescriber Home and/or to file an appeal of the decision. In the event the Member does not select a Pharmacy and/or Prescriber Home within the allotted timeframe, one will be chosen for the Member on the thirty-first (31$^{st}$)day based on recency and frequency of provider use within their claims ninety (90)-day history.

**Pharmacy & Prescriber Changes**

Wellpoint will ensure both Members and their Providers are notified in writing of their assigned Pharmacy and/or Prescriber Home once confirmed. Requests to change the pharmacy or prescriber provider(s) will only be considered for good cause situations. Examples of good cause are:

- The Member has moved.
- The assigned pharmacy and/or prescriber home is no longer in your plan.
- The pharmacy and/or prescriber home is frequently out of the Member's medicine.

For additional questions or comments regarding enrollment or changes, contact the Member Services number located on the back of the Member's ID card.

We are more committed than ever to equipping Providers with the tools and support necessary to help curb these trends and save lives. Thank you for your partnership as we work together to improve the safety and quality of life of our Members.

[1]Changes to the designated pharmacy and/or prescriber will only be approved if the request meets good cause criteria.

[2]Members with a diagnosis of cancer, second degree burns, third degree burns, sickle-cell anemia or those that are in hospice care may be exempt from enrollment in the program. **Note:** Exemptions are determined by both the member's pharmacy and medical claims history.