Wellpoint Maryland Essential

Provider Manual

wellpoint.com

Effective January 1, 2026

Wellpoint℠

This manual is not wholly inclusive of all Wellpoint policies and procedures. For more information on Wellpoint policies and procedures, visit the provider self-service website at **wellpoint.com** or contact your Provider Relations representative.

Table of Contents

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/prior authorizations
- 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 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.

Notwithstanding the above, Wellpoint will provide at least thirty (30) days' notice to Providers, in writing or electronically, of any changes to the description of the coding guidelines used by Wellpoint that are applicable to services that may be billed by Providers.

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.

Health Insurance Marketplace (Exchanges)

The Affordable Care Act (ACA) authorized the creation of Health Insurance Marketplaces (commonly referred to as Exchanges) to help individuals shop for, select, and enroll in high-quality, affordable private health plans.

Wellpoint offers qualified health plans on the Individual Exchange in many states, as well as health plans not purchased on public exchanges. Qualified health plans on the Individual Exchange follow the same policies and protocols within this Provider Manual, unless otherwise stated in the Provider or Facility Agreement.

Updates about Wellpoint's ACA-compliant health plans and the networks supporting these plans are published in Wellpoint's provider newsletter. To access the newsletter, go to our **Wellpoint Provider News site**. The option to sign up for our email communication updates is also on this site.

Important reminder: Providers and Facilities are able to confirm their participation status in different networks by using the Find Care tool. See the *Online Provider Directory and Demographic Data Integrity* subsection of this manual for more details.

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 website as referenced in the provider manual(s).

Artificial Intelligence (AI) – Restrictions on AI Use in Performing a Health Plan Function

Providers who have been delegated to perform a health plan function (e.g., Utilization Management, credentialing, and/or claims payment) shall not use AI in the performance of any delegated health plan function without the advance written consent of the health plan. Providers shall request such approval in accordance with the notice provisions of the Provider Agreement, and the health plan shall provide its written response in accordance with the notice provisions of the Provider Agreement.

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

Coordination of Benefits

If a Member or eligible dependent is covered by more than one (1) Health Benefit Plan, the carriers involved work together to prevent duplicate payments for any services. This cooperative effort is known as Coordination of Benefits (COB), a provision found 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 the 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 Explanation of Benefit (EOB) from the primary insurance carrier with Coordination of Benefits (COB) Claims submitted for secondary payment.

Data Verification Required

The Consolidated Appropriations Act (CAA) of 2021 is a federal act containing legal and regulatory requirements for health plans and Providers and Facilities to improve the accuracy of Provider directory information.

Providers and Facilities are required to review and verify the accuracy of this information in the online Provider directory every ninety (90) days:

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

Providers who fail to verify their information every ninety (90) days may be removed from the online Provider directory.

Providers will be reinstated to the online Provider directory once verification is completed.

To review, verify, and update your online directory information, Wellpoint uses the provider data management (PDM) capability available on **Availity.com** to update Provider or Facility data. Using the Availity PDM capability meets the verification requirement to validate the Provider demographic data set by the CAA.

For details on Availity PDM, refer to the *Online Provider Directory and Demographic Data Integrity* subsection of this manual.

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.

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 an 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 the 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 (1) 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 fact 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, unless prohibited by applicable law, 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

Wellpoint has the ability to remit payments through electronic funds transfers, single-use virtual credit cards through a provider opt-in process, or checks. Wellpoint does not charge any fees for these payment methods; however, it is critical that Providers consult with their own merchant processor and financial institutions to understand payment processing fees before electing payment preferences with Wellpoint. 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, digitally, or via 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.

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 practitioners to or removing practitioners from 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 another medical practice or entity
- Change in accreditation
- Change in affiliation
- Change in licensure or eligibility status
- Change in operations, business, or corporation

Open Practice

Provider shall give Plan sixty (60) days' prior written notice when Provider no longer accepts new patients. Providers should utilize Availity's Provider Demographic Management (PDM) application on **Availity.com** to request changes to existing practice information.

Patient Safety Standards Attestation Required by Hospitals

As a qualified health plan (QHP) issuer, Wellpoint must ensure compliance with federal regulation 45 CFR 156.1110 when contracting with hospitals with more than fifty (50) beds. This regulation mandates QHPs to verify that hospitals meet these specific patient safety standards:

- The hospital must use a patient safety evaluation system as defined in 42 CFR 3.20 by:
    - Collecting and reporting data to patient safety organizations (PSOs)
    - Implementing a mechanism for comprehensive person-centered hospital discharge
    - Improving care coordination and healthcare quality for each patient

- If the hospital is not working with a PSO, the hospital must implement an evidence-based initiative to improve healthcare quality, reduce preventable harm, prevent readmission, and improve care coordination.

To help us ensure compliance, we require participating hospitals to attest to meeting these patient safety standards by completing the Patient Safety Standards form annually. To access the form, go to the **Wellpoint Provider Home page**, and under the **Resources** menu, select **Forms and Guides.** Under the **Affordable Care Act** section, select **Patient Safety Standards Form**.

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.

Encounter data for risk adjustment purposes

Commercial Risk Adjustment and Data Submission: Risk adjustment is the process used by Health and Human Services (HHS) to adjust the payment made to health plans under the Affordable Care Act (ACA) based on the health status of Members who are insured under small group or individual health benefit plans compliant with the ACA (aka “ACA Compliant Plans”). Risk adjustment was implemented to pay health plans more accurately for the predicted health cost expenditures of Members by adjusting payments based on demographics (age and gender) as well as health status. Wellpoint, as a qualifying health plan, is required to submit diagnosis data collected from encounters and Claim data to HHS for purposes of risk adjustment. Because HHS requires that health plans submit all ICD-10 codes for each beneficiary, Wellpoint also collects diagnosis data from the Members’ medical records created and maintained by the Provider or Facility.

Under the HHS risk adjustment model, the health plan is permitted to submit diagnosis data from inpatient hospital, outpatient hospital, and physician/qualified non-physician, e.g., nurse practitioner encounters only.

Maintaining documentation of Members’ visits and of Members’ diagnoses and chronic conditions helps Wellpoint fulfill its requirements under the Affordable Care Act. Those requirements relate to the risk adjustment, reinsurance, and risk corridor, or “3Rs” provision in the ACA. To ensure that Wellpoint is reporting current and accurate Member diagnoses, Providers and Facilities may be asked to complete an Encounter Facilitation Form (also known as a SOAP note) for Members insured under small group or individual health benefit plans suspected of having unreported or out-of-date condition information in their records. Wellpoint’s goal is to have this information confirmed and/or updated no less than annually. As a condition of the Facility or Provider’s Agreement with Wellpoint, the Provider or Facility shall comply with Wellpoint’s requests to submit complete and accurate medical records, Encounter Facilitation Forms, or other similar encounter or risk adjustment data in a timely manner to Wellpoint Plan or designee upon request. Providers and Facilities also agree to cooperate with

Wellpoint's, or its designee's, requests to reach out to patients to request appointments or encounters so additional information can be collected to resolve any gaps in care (example –- blood tests in certain instances) and to provide the updated and complete Member health information to Wellpoint to help it fulfill its requirements under the Affordable Care Act.

In addition to the above ACA-related commercial risk adjustment requirements, Providers and Facilities also may be required to produce certain documentation for Members enrolled in Medicare Advantage or Medicaid.

RADV Audits

As part of the risk adjustment process, HHS will perform a risk adjustment data validation (RADV) audit in order to validate the Members' diagnosis data that was previously submitted by health plans. These audits are typically performed once a year. If the health plan is selected by HHS to participate in a RADV audit, the health plan and the Providers or Facilities that treated the Members included in the audit will be required to submit medical records to validate the diagnosis data previously submitted.

ICD-10-CM Codes

HHS requires that physicians use the ICD-10-CM Codes (ICD-10 Codes) or successor codes and coding practices services under ACA-compliant plans. In all cases, the medical record documentation must support the ICD-10 Codes or successor codes selected and substantiate that proper coding guidelines were followed by the Provider or Facility. For example, in accordance with the guidelines, it is important for Providers and Facilities to code all conditions that co-exist at the time of an encounter and that require or affect patient care, treatment, or management. In addition, coding guidelines require that the Provider or Facility code to the highest level of specificity, which includes fully documenting the patient's diagnosis.

Medical Record Documentation Requirements

Medical records significantly impact risk adjustment because:

- They are a valuable source of diagnosis data;
- They dictate what ICD-10 Code or successor code is assigned; and
- They are used to validate diagnosis data that was previously provided to HHS by the health plans.

Because of this, the Provider and Facility play an extremely important role in ensuring that the best documentation practices are established.

HHS record documentation requirements include:

- Patient's name and date of birth should appear on all pages of the record.
- Patient's condition(s) should be clearly documented in the record.
- The documentation must show that the condition was monitored, evaluated, assessed/addressed, or treated (MEAT), or there is evidence of treatment, assessment, monitoring or medicate, plan, evaluate, referral (TAMPER).
- The documentation describing the condition and MEAT or TAMPER must be legible.
- The documentation must be clear, concise, complete, and specific.

- When using abbreviations, use standard and appropriate abbreviations. Because some abbreviations have different meanings, use the abbreviation that is appropriate for the context in which it is being used.
- Physician's/Qualified Non-Physician's signature, credentials, and date must appear on record and must be legible.

Digital Applications

Provider Website

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

Wellpoint designed the provider public website to make navigation easy and 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 select the available content.

Information available on the **Wellpoint Provider webpage** includes:

- Resources
    - Forms and Guides
    - Policies, Guidelines & Manuals
    - Medical Policies & Clinical Utilization Management Guidelines
    - Availity, EMR, & Digital Solutions
    - Referrals
    - Prior Authorizations
    - Education and Training
    - Provider News
- Claims
    - Claim Submission
    - Reimbursement Policies
    - Electronic Data Interchange (EDI)
    - Availity, EMR, & Digital Solutions
- Patient Care
    - Behavioral Health
    - Dental
- Pharmacy
- Provider News
- Provider Enrollment and Maintenance
    - Join Our Network
    - Provider Maintenance & Demographic Updates

Email 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 **wellpoint.com**
- 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.

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.
- **Search as a Guest**: Search by Selecting a Plan and Network.

Note: The Member's Network Name should be on the lower right corner of the front of the Member's ID card.

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 thirty (30) days **prior** to the change/update. Any requests received with less than thirty (30) days' notice may be assigned a future effective date. Contractual terms may supersede effective date requests.

Important: If updates are not submitted thirty (30) 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

***** To request participation for a new provider or practitioner, even if joining an existing practice, providers or practitioners must first begin the Application process. Go to the **Wellpoint Provider webpage** and select **Provider Enrollment and Maintenance**, then **Join Our Network**.

******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.).

Submit Provider demographic data requests and roster submissions through Roster Upload

Use the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all professional and facility care providers. **The PDM application is the preferred intake tool for Providers to submit demographic change requests, including submitting roster uploads.** If preferred, Providers may continue to utilize the Provider Enrollment application in Availity Essentials to submit requests to add new practitioners under existing groups for available provider types.

Within the PDM application, Providers have the choice and flexibility to request data updates via the standard PDM experience or by submitting a spreadsheet via a roster upload. Roster Upload is our technology solution designed to streamline and automate provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel document. Any Provider, whether an individual practitioner, group, or facility, can use Roster Upload today. If any roster data updates require credentialing, your submission will be routed appropriately for further action.

The resources for this process are listed below and available on our website. Go to the **Wellpoint Provider webpage** and from the horizontal menu under **Provider Resources**, select **Forms and Guides**, and select the **Roster Upload Rules of Engagement** and **Roster Upload Standard Template**.

- **Roster Upload Rules of Engagement**: A reference document available to ensure error-free submissions, driving accurate and more timely updates through roster uploading.
- **Roster Upload Standard Template:** Use this template to submit your information. More detailed instructions on formatting and submission requirements can also be found on the first tab of the Roster Upload Standard Template (*User Reference Guide*).
- Upload your completed roster via the Availity PDM application.

Accessing PDM Application:

Log onto **Availity.com** and select **My Providers > Provider Data Management** to begin the attestation process. If submitting a roster, find the TIN/business name to be verified and update the information. Before selecting the TIN/business name, select the three-bar menu option on the right side of the window, and select **Upload Rosters,** and follow the prompts.

Availity Administrators will automatically be granted access to PDM. Additional staff may be given access to **Provider Data Management** by an administrator. To find your administrator, go to **My Account Dashboard > My Account > Organization(s) > Administrator Information**.

Exclusions:

- Behavioral Health providers contracted with Carelon Behavioral Health, who will continue to follow the process for demographic requests and/or roster submissions, as outlined by Carelon Behavioral Health.
- Any specific state mandates or requirements for provider demographic updates

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 Providers 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 Members' 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 application from the Patient Registration tab.
- **Provider Data Management:** Update information about your practice digitally. Access the Provider Data Management application through the My Providers 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:

- **Authorization Look Up Tool:** Determine if an authorization is needed for a commercial Member for a specific outpatient medical or behavioral health service.
- **Chat with Payer:** When information is not available self-service through Availity.com, Providers and Facilities can chat with an online representative about prior authorizations, appeals, Claims, eligibility, benefits, and more.
- **Clear Claim Connection:** Research procedure code edits and receive edit rationale.
- **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.

- **Fee Schedule:** Retrieves professional office-based contracted price information for patient services.
- **Preference Center:** A resource for Providers to share their correspondence preferences related to specific transactions, for example, prior authorization decision letters.
- **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 Enrollment:** Submit an online request to join Wellpoint's provider network.
- **Provider Online Reportin**g: 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

Claim submissions status and Claims payment disputes

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

- EDI transaction: X12 837 – professional, institutional, and dental Claim submission (version 5010):
    - Wellpoint supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.
    - 837 Claim batch upload through EDI allows 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. It is the expectation of Wellpoint that electronic Claim payment disputes are adopted when and where they are integrated.
- Provider desktop integration via B2B APIs:
    - Wellpoint has also enabled real-time access to Claim status via APIs, which can be directly integrated within participating 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.

Section 6: Provider Enrollment and Network Management

Provider Enrollment

- **Simplified enrollment process:** Providers and Facilities can enroll as new care provider in our network for professional, ancillary, institutional, and facility provider types through Availity Essentials.
- **Real-Time Tracking:** Providers and Facilities can track the status of their requests in the **My Dashboard** section of the Provider Enrollment and Network Management application.

Contract Changes

- **Streamlined Contract Change Requests**: Providers and Facilities can easily submit certain requests for contract changes through Availity Essentials:

- Amendment requests to add a network or line of business
- Change of Ownership notice
- Contract, line of business, or network termination requests
- TIN Change

- **Real-Time Tracking**: Providers and Facilities can track the status of their requests in the **My Dashboard** section of the Provider Enrollment and Network Management application.

Section 7: Demographic updates

Provider Data Management (PDM)

Availity Essentials Provider Data Management (PDM) is the digital intake application for Providers and Facilities to submit demographic change requests. It is also where Providers can upload a roster with demographic changes. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select Upload Rosters, and follow the prompts.

For Providers and Facilities using the roster upload option, additional resources are available:

- **Error Report:**
  - Providers and Facilities can use this Error Report to understand where errors occurred (specifically which sheet, tab, and row), the cause of the issue, and how to fix it.
  - Providers and Facilities are responsible for using the Error Report to identify errors in a roster, correct them, and resubmit the roster rows that contain errors. Rows in a roster that contain an error will not be processed, and the addition, change, or termination will not be updated in our systems.
- **Results Report:** When a roster has the status partially complete or complete, a Results Report will be created for any rosters received. The Results Report is an Excel file that shows the additions and updates made to your provider group's demographic data based on the information contained in a specific roster.
- **Use the *Roster Submission Guide:*** For Providers and Facilities using the roster upload option, additional information about the Error Report and Results Report can be found in our *Roster Submission Guide*. Find it online at **Availity.com** > Payer Spaces > Select Payer Tile > Resources > Roster Submission Guide using Provider Data Management.

Provider Participation

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 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. Additional information regarding Wellpoint's Credentialing Program can be found in the **Program Summary**, which applicable terms are incorporated into this Provider Manual by reference, available on **wellpoint.com**.

To access the Program Summary, go to the **Wellpoint Provider webpage** and select **Provider Enrollment and Maintenance**, then **Join Our Network**, and then scroll down to **Credentialing**.

Standards of Participation for Non-Credentialed Providers and Facilities

Wellpoint contracts with many types of providers that do not require credentialing, as described on the **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 (1) 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 Provider Services.

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

Provider/Facility	Standards of Participation
Durable Medical Equipment	TJC (JCAHO), CHAP, ACHC, (HQAA) Medicare Certification, The Compliance Team
Hearing Aid Supplier	State Licensure
Intermediate Care Facilities	CTEAM
Immunization Clinic	CDC Certification Pharmacy License, Medicare Certification
Orthotics & Prosthetics	TJC, CHAP, The American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABC) or Board of Certification/ Accreditation (BOC) Ocularist: National Examining Board of Ocularists NEBO Preferred) 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.
- Ground or independently contracted ambulance Providers should file the Claims to the Member's plan state.
- Air Ambulance providers contracted through a facility and submitting services on UB-04 CMS 1450 (facility claim forms), should file claims to the Member's Plan state.
- 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.

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 (aka Tracers)

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 be submitted 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 with 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 the appropriate level of care.

National Drug Codes (NDC)

See the 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 the 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 (UB04) 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 (UB04) 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 for 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 the 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 Disputes* 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 was 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 timely filing timeframe specified in the Provider or Facility Agreement. 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 that 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: • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 7	To indicate the Claim is a replacement Claim: • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 7

Type	Professional Claim	Institutional Claim
	To confirm the Claim that is being replaced: • In Segment "REF – Payer Claim Control Number" • Use F8 in REF01 and list the original payer Claim number is REF02	To confirm the Claim that is being replaced: • In Segment "REF – Payer Claim Control Number" • Use F8 in REF01 and list the original payer Claim number is REF02
	To indicate the Claim was billed in error (Void/Cancel): • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 8	To indicate the Claim was billed in error (Void/Cancel): • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 8
	To confirm the Claim being voided/cancelled: • In Segment "REF – Payer Claim Control Number" • Use F8 in REF01 and list the original payer Claim number in REF02	To confirm the Claim being voided/cancelled: • In Segment "REF – Payer Claim Control Number" • Use F8 in REF01 and list the original payer Claim number in 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 claim information and set the billing frequency and payer control number as follows: • Select **Replacement of Prior Claim** or **Void/Cancel of Prior Claim** for the **Billing Frequency** (or **Frequency Type**) field in the **Claim Information** • 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 claim information and set the billing frequency and payer control number as follows: • Select **Replacement of Prior Claim** or **Void/Cancel of Prior Claim** for the **Billing Frequency** (or **Frequency Type**) field in the **Claim Information** • 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: • In Item Number 22: "Resubmission and/or Original Reference Number" • Use Claim Frequency Type 7 under "Resubmission Code"	To indicate the Claim is a replacement Claim: • In Form Locator 04: "Type of Bill" • Use Claim Frequency Type 7
	To confirm the Claim that is being replaced: On 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: In Form Locator 64: "Document Control Number (DCN)" list the original payer Claim number for the resubmitted Claim.
	To indicate the Claim is a void/cancel of a prior Claim: • In Item Number 22: "Resubmission and/or Original Reference Number" • Use Claim Frequency Type 8 under "Resubmission Code"	To indicate the Claim is a void/cancel of a prior Claim: • In Form Locator 04: "Type of Bill" • Use Claim Frequency Type 8

Type	Professional Claim	Institutional Claim
	To confirm the Claim being voided/cancelled: 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 being voided/cancelled: 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 disputes, refer to the *Claim Payment Dispute* and *Clinical Appeals* sections.

National Drug Codes (NDC)

All practitioners and providers are required to supply the eleven (11)-digit NDC when billing for injections and other drug items on the CMS1500 and UB-04 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 codes or CPT code units
- The valid eleven (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 eleven (11) digits. In order to submit a Claim, Providers and Facilities will need to convert the NDC to an eleven (11)-digit number. Sometimes the NDC is printed on a drug item, and a leading zero has been omitted in one (1) 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 segments 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 (5-4-2 format)	Is complete	12345123412
NDC 1234-1234-1 (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 (5-3-2 format)	Needs a leading zero placed at the beginning of the second segment	12345012312
NDC 12345-1234-1 (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 (1) 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 (1) 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 (1) 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

<u>837 Reporting Fields</u>

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: • F2: International unit • GR: Gram • ML: Milliliter • UN: Unit • 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 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.

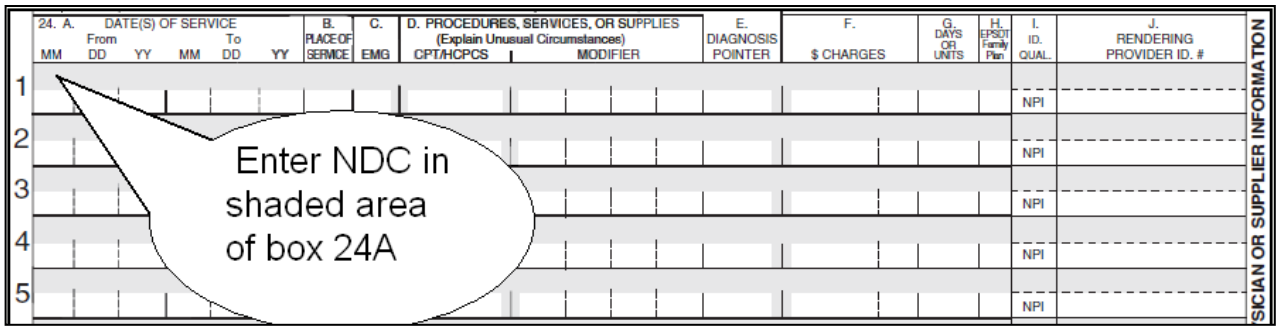
For more information about how to submit an electronic claim, including the NDC Code field using Availity Essentials, log onto **Availity.com**, select the Help & Training tab, and enter Professional or Facility Claim in the search bar.

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 (1) 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 consistently 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; F2 – International Unit GR – Gram ML – Milliliter UN – Units ME – Milligrams and quantity, including a decimal point for correct reporting	GR0.045 ML1.0 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



UB04 Claim Form:

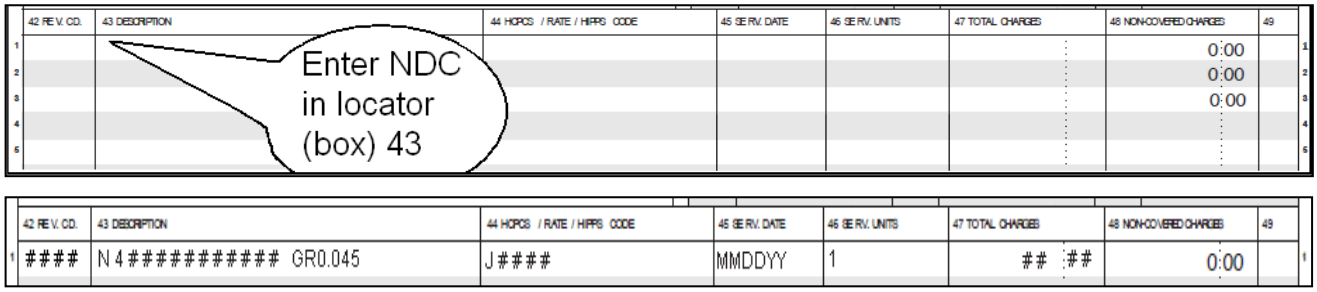
- Even though an NDC is entered, a valid HCPCS or CPT code must also be entered in the Claim form.
- If the NDC billed does not have a specific HCPCS or CPT code assigned, the appropriate miscellaneous code should be assigned per Correct Coding Guidelines.
- DO NOT bill more than one (1) NDC per Claim line.
- The unit of service for the HCPCS or CPT code is very important. Units for injections must be billed consistently with the HCPCS or CPT description of the code.

The following table provides elements of a proper NDC entry on a UB-04 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 the left edge, enter NDC In locator (box) 43 currently labeled as “Description”

How	Example	Where
Enter one (1) of five (5) units of measure qualifiers F2 – International Unit GR – Gram ML – Milliliter UN – Units ME – Milligrams and quantity, including a decimal point for correct reporting	GR0.045 ML1.0 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, is 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 (UB04) will cause the Claim 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 a 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 manually submit 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 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 can view the status of submitted documentation in Availity Essentials Attachment New.

A provider organization's Availity Essentials administrator should complete the following setup 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 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 portions of the medical records may be required, refer to the applicable Wellpoint Medical Policy, Wellpoint Clinical Guideline, Carelon Clinical Criteria, or MCG at **wellpoint.com.** Review the Position Statement section of the Wellpoint Medical Policies, the Clinical Indications section of the applicable Wellpoint Clinical Guidelines, or the Clinical Criteria/Indications

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.

Providers and Facilities can now submit unsolicited medical records using Availity Essentials. A provider 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 is the linkage between 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 > Attachments – New
- From the **Inbox** tab, 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 New inbox for seven calendar days. If the document is not received within this time, documentation can be uploaded using the claim status method 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 the needed documentation to process your Claims. This reduces Claims processing time, and Claims are paid faster.

For more information about Digital RFAI, visit **Availity, EMR, & Digital Solutions** on the **Wellpoint Provider webpage**.

Types of Medical Records Required

Medical records may be needed to determine the medical necessity of a billed code. The following are examples of the types of records needed 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 & Physical, Office Visit/Clinical Notes, Treatment Records & 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.

You can also access EFT enrollment through our **Wellpoint Provider EDI webpage**. Once on the EDI page, scroll to the bottom section EDI Resources and select the Electronic Funds Transfer tab.

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 Service Startup 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 the 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 the 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 (SUI).

Wellpoint Identified Overpayment (aka "solicited")

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

- 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, 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 PO Box 73651 Cleveland, OH 44193-1177	Wellpoint Lockbox 73651 4100 West 150th Street 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 submission 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 the 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 have 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 is 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 the 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 of 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 the 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, visit the **Wellpoint Provider webpage** or 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 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. Typically, Wellpoint makes the request for this information through the Explanation of Payment (EOP). 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 Provider Manual.

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

The Wellpoint Claim Payment Dispute process consists of **two (2) 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 Facilities' 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 ninety (90) working 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, to submit a Claim Payment Reconsideration, except that a provider that believes a Claim has been erroneously denied due to a claims processing error may request a Claim Payment Reconsideration for such Claim within three-hundred sixty-five (365) calendar days from the issue date of the EOP. Claim Payment Reconsiderations made on the basis of erroneous denial due to an alleged claims processing error are not subject to review under the Claim Payment Appeal procedures.

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 three hundred sixty-five (365) 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 Payment Dispute
  PO Box 105568
  Atlanta, GA 30348-5568

- 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 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 Representative/Authorization Form* is needed.

The *Designation of Representative/Authorization Form* can be found online at **wellpoint.com**. Go to the bottom of the webpage, then select **Forms**. Under *Categories*, select **Grievances and Appeals**, then under *State*, select **Maryland**, and select **Designation of Representative/Authorization Form**.

Guidelines and Timeframes for Submitting Clinical Appeals

- Providers and Facilities have one hundred eighty (180) days to file a clinical appeal from the date they receive notice of Wellpoint's initial decision.
- All standard, non-retrospective clinical appeals will be resolved within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) working days from the receipt of the appeal request by Wellpoint unless (1) the clinical appeal involves an emergency appeal; or (2) the involved Member, Member's representative, or Provider filing the

grievance on behalf of such Member agrees in writing to an extension of thirty (30) days or less.

- All standard retrospective clinical appeals will be resolved within a reasonable period of time appropriate to the medical circumstances, but not later than forty-five (45) working days from the receipt of the appeal request by Wellpoint unless (1) the clinical appeal involves an emergency appeal; or (2) the involved Member, Member's representative, or Provider filing the grievance on behalf of such Member agrees in writing to an extension of thirty (30) days or less.
- For clinical appeals, there are two (2) types of review: Emergency and Standard.

  1. *Emergency Appeal:* An appeal will constitute an emergency case upon the determination that a case involves prospective review and the health services are necessary to treat a condition or illness that, without immediate medical attention, would either:

     - seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function;
     - cause the Member to be in danger to self or others; or
     - cause the Member to continue using intoxicating substances in an imminently dangerous manner.

     If the Provider filed the appeal, the Provider will determine whether the basis for an emergency case exists. If the Member, or the Member's authorized representative, filed the appeal, then a physician or other appropriate healthcare professional who is board-certified or eligible in the same specialty as the treatment under review, in consultation with the Provider, will make the determination as to whether an emergency case exists.

     Emergency appeal determinations will be made, and verbal notification provided as soon as possible, but no later than twenty-four (24) hours from the date the appeal is filed with Wellpoint. If it is determined that there is insufficient information to complete the request, then we will provide verbal notification to the Member, the Member's authorized representative, or Provider; and will assist in gathering the necessary information without further delay. Written notice will be provided within one (1) calendar day of the date the decision is verbally communicated to the Member, Member's authorized representative, and the Provider, as applicable, if the appeal was filed on behalf of the Member. Written notice of emergency appeal determinations will include the information listed below with respect to written notice of standard appeal determinations.

  2. *Standard Appeal:* A standard appeal is available if a Provider disagrees with a determination that a service was or is not medically necessary or experimental/investigational, and the appeal does not meet the criteria for an emergency appeal specified above. If Wellpoint does not have sufficient information to complete its standard appeal process within five (5) working days after a standard appeal is filed, Wellpoint will notify the person filing the standard appeal that it cannot proceed unless additional information is provided, and assist the person filing the complaint in gathering the necessary information without further delay.

     For standard clinical appeals, in accordance with Maryland law, notification will be provided to a member, member's representative, and provider of a grievance decision:

- the grievance decision will be documented in writing after Wellpoint has provided oral communication of the decision to the member, the member's representative, or the healthcare provider acting on behalf of the member ;

  and

- send, within five (5) working days after the decision has been made, a written notice to the member, the member's representative, and a healthcare provider acting on behalf of the member that:
  - states in detail in clear, understandable language the specific factual bases for the carrier's decision;
    - references the specific criteria and standards, including interpretive guidelines, on which the decision was based, and may not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary";
    - states the name, business address, and business telephone number of:
      - the medical director or associate medical director, as appropriate, who made the decision if the carrier is a health maintenance organization; or
      - the designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process if the carrier is not a health maintenance organization;
    - includes the following information:
      - that the member, the member's representative, or a healthcare provider on behalf of the member has a right to file a complaint with the Maryland Insurance Commissioner within four (4) months after receipt of a carrier's grievance decision;
      - the Maryland Insurance Commissioner's address, telephone number, and fax number;
      - a statement that the Health Advocacy Unit is available to assist the member or the member's representative in filing a complaint with the Maryland Insurance Commissioner; and
      - the address, telephone number, fax number, and electronic mail address of the Health Advocacy Unit.

- 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. 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.

Send the appeal request to:

Wellpoint
PO Box 105568
Atlanta, GA 30348-5568

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 a 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 Plans (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 biannual 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**, choose the **Claims** horizontal menu, then select **Reimbursement Policies**.

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:

1. The Non-Priced Code does not have a published dollar amount on the then-current applicable Plan, State, or CMS Fee Schedule,
2. The Non-Priced Code has a zero dollar amount listed, or
3. 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.

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

**Subject to the Member's Health Benefit Plan*

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.

Eligibility and Payment

A verification of eligibility is not a guarantee of payment.

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

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).

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.

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 the Provider’s 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.

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.

Submission of Claim/Encounter Data

Facilities and Providers will submit Claims and encounter data to Wellpoint on a CMS-1500, UB-04, 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.

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.

Undocumented or Unsupported Charges

Charges that are not documented on medical records or supported with documentation are not reimbursed.

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 the National Heart, Lung, and Blood Institute, the 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,** then under the **Resources** menu, select **Polices, Guidelines & Manuals.** Scroll to **Clinical Practice Guidelines** and select **"Download the Index**".

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 makes 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,** then under the **Resources** menu, select **Policies, Guidelines & Manuals**. Scroll to **Preventive Health Guidelines** and select "**Review the guidelines**".

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.

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**. Select the **Resources** menu, then select **Medical Policies & Clinical UM Guidelines.** Read and accept the *Acknowledgement*, then select "**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**. Select the **Resources** menu, then select **"Medical Policies & Clinical UM Guidelines."** Accept the Acknowledgement by selecting "Yes, please continue". 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, Facility, and the Member documenting the UM determination.

For nonemergency cases, Maryland requires carriers to notify a Member, member's representative, or provider of an adverse decision:

1. Orally by telephone or with the affirmative consent of the Member, the Member's representative, or the healthcare Provider acting on behalf of the Member, by text, facsimile, e-mail, an online portal, or other expedited means; and
2. Send, within five (5) working days after the adverse decision has been made, a written notice to the Member, the Member's representative, and a healthcare Provider acting on behalf of the Member that:
    - references the specific criteria and standards on which the decision was based; does not solely use generalized terms such as: (1) "experimental procedure not covered"; (2) "cosmetic procedure not covered"; (3) "service included under another procedure"; or (4) "not medically necessary";

- states the name, business address, and business telephone number of: (1) the medical director or associate medical director who made the decision if the insurer is an HMO; or (2) the designated employee or representative responsible for the insurer's internal grievance process if the insurer is not an HMO;
- gives written details of the insurer's internal grievance process and procedures;
- informs the Member, Member's representative, or a healthcare Provider acting on their behalf of their right to file a complaint with the Commissioner within four (4) months after receiving an insurer's decision;
- that a complaint may be filed without first filing a grievance if the Member can demonstrate a compelling reason to do so;
- provides the Commissioner's address, telephone number, and facsimile number;
- provides the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

For emergency cases, the notice must include the information above and be sent within one (1) day of giving oral notice to the parties.

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 healthcare 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 healthcare 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 health 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, the Provider or Facility shall make best efforts to supply the requested information within twenty-four (24) hours of the 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.

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 healthcare 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 Wellpoint'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 healthcare 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 under the **Resources** menu, select **Prior Authorization.** 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-eight (48) hours of an emergency admission, even if records are reviewed retrospectively. For information on applicable penalties for non-compliance, see the *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 one-hundred percent (100%) payment penalty unless extenuating circumstances exist as further described below. Providers and Facilities can only dispute the one-hundred percent (100%) penalty in order to present evidence of extenuating circumstances.
- Payment for emergency inpatient admissions will be subject to a one hundred percent (100%) penalty if the notification is not provided within forty-eight (48) hours of admission. Providers and Facilities can only dispute the one-hundred percent (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 system problems prevented authorization from being obtained, or Wellpoint 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).
- For emergency inpatient admissions, if the failure to notify Wellpoint of the admission within the prescribed period of time after that admission was because the Member's medical condition prevented a determination of (1) the patient's insurance status; and (2) if applicable, the emergency admission notification requirements.
- Routine Maternity Admissions/Newborn Admissions – active/Coordination of Benefits Membership
- Proof of timely notification of admission of emergency admission was received within 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 a Wellpoint Health employee or the Department of Medical Assistance (DMAS).
- Transition of Care. This includes transfer from one (1) hospital to another or transfer to home.
- The Member was traveling out of the area, and the Provider had difficulty finding whom to call for the authorization.
- Retro enrollment 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 forty-eight (48) hours beyond the date of service requiring authorization prevented the authorization from being obtained, and the Provider has provided adequate evidence of the system outage.
- A Member is admitted to observation and then becomes an 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 the Facility or Provider at no charge to Wellpoint.

Inpatient Electronic Data Exchange

For additional information, refer to the Admission, Discharge, and Transfer Messaging Data section of this manual, located 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 *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 healthcare 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 anytime, 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 healthcare in all settings.

The Case Management programs help coordinate services for Members with healthcare 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 healthcare 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 MBM 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 the **Carelon MBM program microsite** to find program information, resources, clinical guidelines, interactive tutorials, worksheets and checklists, FAQs, and access to the provider portal.

Provider Connections

Providers are encouraged to visit Carelon's **Provider Connections website**, a news blog for prior authorization staff and provider portal users. Visit the site frequently to learn the best ways to use the Carelon MBM provider portal and how to reduce unnecessary calls by using all available features. Our goal is to provide tips and tricks to make Providers' days easier and more efficient.

Submit Pre-certification/Pre-authorization requests to Carelon MBM

Ordering and servicing Providers may submit Pre-certification/Pre-authorization requests to Carelon MBM 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 MBM Contact Center toll-free number at **833-529-8820**.

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 the 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 scorecard will be produced for Radiation Solution Facilities; Genetics Testing Facilities will not have a scorecard. 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 service requests, contact **877-202-6543**. For any other questions, contact Wellpoint Provider Services.

Quality Improvement Program

Quality Improvement (QI) Program Overview

The Wellpoint Quality Improvement (QI) Program is outlined in the Quality Improvement Program Description (QIPD), which details the Organization's quality infrastructure and activities that support its QI strategies. This section defines the program governance, scope, goals, objectives, structure, and responsibilities, all of which ensure the quality of medical and mental health/substance use disorder (MH/SUD) available to covered members.

Local Presence and Member Needs

Healthcare is local, and the Organization's strong local presence is crucial for understanding and supporting member needs to provide accessible, covered care.

The Organization is well-positioned to deliver innovative, choice-based products, distinctive service, simplified transactions, and better access to information for quality care.

This local presence, combined with broad expertise, facilitates collaborative programs that reward providers and facilities for achieving clinical quality and excellence. Participating providers and facilities are expected to cooperate with quality activities, which enhance member value and improve health and healthcare costs. The Organization plays a leadership role in addressing key healthcare issues and improving community health.

"Whole Health" Strategy and Digital Solutions

Guided by its "Whole Health" strategy, the Organization employs digital-first solutions to deliver exceptional experiences, affordability, high quality, and broader access to care.

Digital solutions are the cornerstone of the Organization's strategy, enabling value creation and responsiveness to societal shifts, market demands, and consumer needs. The Organization focuses on integrating data, analytics, insights, and digital technologies throughout the business.

Commitment to Continuous Quality Improvement

Continuous QI is essential for supporting member health and the Organization's business objectives. This commitment aligns with the Organization's mission statement: "*Improving lives and communities. Simplifying healthcare. Expecting more."* The pursuit of excellence, driven by this mission, forms the foundation for programs and initiatives that aim to achieve meaningful and measurable quality outcomes for members.

Vision and Core Values

The Organization's vision is to be the most innovative, valuable, and inclusive partner. The Organization is dedicated to enhancing member and provider satisfaction, improving health status and quality of care outcomes,

delivering value-based products and services, enhancing patient safety, improving care coordination, and promoting access to medical services.

The comprehensive and integrated QI program involves departments that support quality initiatives, systematically monitoring and evaluating the safety, appropriateness, and quality of medical and MH/SUD healthcare services by network providers and identifying opportunities for continuous improvement.

Core values such as leadership, community, integrity, agility, and diversity provide a solid foundation for achieving success.

QI Program Goals and Objectives

The goals and objectives of the QI program support the Organization's vision and values and respond to the evolving needs of members, providers, facilities, and the healthcare community.

These goals focus on establishing the Organization as a valued health partner across the healthcare continuum. The Organization implements evidence-based interventions from both external and internal sources to deliver the best value to customers.

Goals and Objectives

- Quality Of Clinical Care

  Goal: Improve Member health through the enhancement of clinical quality outcomes

  - Objective 1: Identify, monitor, and report priority HEDIS measures
  - Objective 2: Promote evidence-based practices

- Safety of Clinical Care

  Goal: Promote patient safety and health equity

  - Objective 1: Promote transparency and collaboration to improve patient safety
  - Objective 2: Identify and analyze health disparities

- Quality of Service

  Goal: Provide high-quality services to Members

  - Objective 1: Maintain operational excellence through compliance with policies and standards
  - Objective 2: Streamline processes to enhance operational efficiency

- Member Experience

  Goal: Optimize the Member experience

  - Objective 1: Gather, analyze, and act on member feedback
  - Objective 2: Encourage the use of technology to ease member access

Member Rights and Responsibilities

The delivery of quality healthcare requires cooperation between Members, their Providers and Facilities, and their healthcare benefit plans. One of the first steps is for Members, Providers, and Facilities to understand Member rights and responsibilities. Therefore, Wellpoint has adopted a Members' Rights and Responsibilities statement, which can be accessed by going to **wellpoint.com.** Members or Providers who do not have access to the website can request copies by contacting Wellpoint or by calling the number on the back of the Member ID card.

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 healthcare 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 that features a number of evaluative surveys and improvement activities designed to help ensure the continuity and coordination of care across physician and other healthcare professional sites, enhancing the quality, safety, and appropriateness of medical and behavioral health 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 Consolidated 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.

Performance Data

Provider/Facility Performance Data means compliance rates, reports, and other information related to the appropriateness, cost, efficiency, and/or quality of care delivered by an individual healthcare practitioner, such as a physician, or a healthcare organization, such as a hospital. Common examples of performance data would include the Healthcare Effectiveness Data and Information Set (HEDIS) quality of care measures maintained by the National Committee for Quality Assurance (NCQA) and the comprehensive set of measures maintained by the National Quality Forum (NQF).

"Provider/Facility Performance Data may be used for multiple Plan programs and initiatives, including but not limited to:

- **Reward Programs** – Pay for performance (P4P), pay for value (PFV), and other results-based reimbursement programs that tie Provider or Facility reimbursement to performance against a defined set of compliance and quality metrics supported with timely and actionable reporting.

Reimbursement models include but are not limited to total cost of care shared savings/risk programs, enhanced fee schedules, and episode bundled payment arrangements.

- **Recognition Programs** – Programs designed to transparently identify high-value Providers and Facilities and make that information available to consumers, employers, peer practitioners, and other healthcare stakeholders.

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 healthcare 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 eighty-eight (88)* measures across six (6)* 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.

To simplify staying current with annual HEDIS documentation changes, we've developed a comprehensive HEDIS Resource Library for your use. This library includes tip sheets with coding guidance and measure-specific information, along with other helpful materials to support accurate documentation and claims coding guidance— promoting proper reimbursement and quality reporting.

To access these materials, log into Availity, select Payer, then the Resource tab, or reach out to your plan representative or consultant for assistance.

*Subject to change

Overview of CAHPS®

CAHPS® (Consumer Assessment of Healthcare Providers and Systems) surveys represent an effort to accurately and reliably capture key information from Wellpoint's Members about their experiences with Wellpoint's Health Plans 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.

Health Plans report survey results to National Committee for Quality Assurance (NCQA), which uses these survey results for the annual accreditation status determinations and to create National

benchmarks for care and service. Health Plans also use CAHPS® survey data for internal quality improvement purposes.

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.

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

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 healthcare to LGBTQIA+ patients.
- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a healthcare encounter.
- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations and learn techniques to improve patient-centered communication to support 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 were set for the 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).
- Offers Members access to a quality designated tr, 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 failure, a major public health problem associated with significant hospital admission rates, mortality, and costly healthcare 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 provide new treatment options for cancer patients. This treatment involves genetic re-engineering of a patient's white blood cells.
- There are nine (9) 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
    8. Amtagvi® (lifileucel) for treatment in Adult Patients
    9. Tecelra® (afamitresgene autoleucel) for treatment in Adult Patients
- These procedures can be performed in the Inpatient (IP) or Outpatient (OP) setting, and Care and follow-up continue over the first year.
- These Members are managed by the transplant Case Managers, and Wellpoint Medical Policy requires the procedure to 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 bills. Wellpoint may accept additional documentation from the Provider or Facility that typically might not be included in medical records, such as other documents substantiating the treatment or 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 the 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 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 being 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 the 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 (sixty (60) days total):
  - Wellpoint or its designee will initiate Claim denial for Claims identified as pre-payment review or post-payment audit, as the 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 the 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 off-site locations. The Facility or Provider will comply with the 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 thirty (30) calendar days, Wellpoint will initiate recoupment as applicable and as determined by the Provider or Facility Agreement and state guidelines.
- **Provider or Facility Audit Appeals:** See Audit Appeal Policy.

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 the 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 the 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 the 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 the Provider or Facility disputes, as well as the basis for the Provider's or Facility's belief that such findings 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 healthcare 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 the **Wellpoint Provider webpage**, scroll to the bottom footer, and click on **Report Waste, Fraud and Abuse** to be directed to the **fighthealthcarefraud.com** website. At the top of the page, select **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 reporting 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 an 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:

- 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 that 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.

Recoupment/Offset/Adjustment for Overpayments

Wellpoint is entitled to recover any overpayments or incorrect payments made to a Provider or Facility (Overpayment Amount) by offsetting these amounts against any payments due to the Provider or Facility under any Health Benefit Plan agreement. When Wellpoint identifies an overpayment, the Provider or Facility is required to refund the amount in the timeframe specified in the notification. If the refund is not provided within this period, Wellpoint may offset future payments to recoup the overpaid amount. Providers and Facilities are obliged to return overpayments for any reason, including errors in billing, regardless of whether they were intentional.

Should a Provider or Facility contest the determination of an overpayment, they have the right to appeal this decision through Wellpoint’s established procedures. However, this appeal does not suspend Wellpoint’s ability to recover the overpayment unless mandated by regulatory requirements. In cases of non-payment, Wellpoint reserves the right to enlist a third-party collection agency.

Pharmacy and Prescriber Home Program

Access to opioid and other controlled medications for both acute and chronic conditions continues to rise nationwide. While these medications play an important role in managing pain and improving quality of life, use that exceeds recommended clinical guidelines—such as higher dosages, increased frequency, or prolonged duration—can create significant safety concerns. These include increased risk of dependency, medication-related disorders, and accidental overdose.

Members who obtain controlled substances from multiple prescribers or multiple pharmacies face additional risks, including conflicting treatment plans, unrecognized drug interactions, and limited continuity of care. These patterns may indicate fragmented care or potential unsafe medication use.

To protect Members and support safer prescribing, Wellpoint established the Pharmacy and Prescriber Home Program. This program strengthens communication, visibility, and care coordination among Providers while ensuring Members receive clinically appropriate and consistent treatment. It reflects Wellpoint's commitment to improving whole-person health by reducing preventable harm and promoting high-quality, integrated care.

Program Overview

The Pharmacy and Prescriber Home Program (also known as a "lock-in" program) partners with prescribers and pharmacies to promote safe, coordinated management of controlled medications. Once enrolled, a member obtains Schedule II–V controlled substances exclusively from an assigned prescriber and/or pharmacy for a minimum of twelve (12) months.

These "home" Providers become key members of the Member's care team, helping ensure:

- Unified clinical oversight
- Reduced risk of duplicate or conflicting prescriptions
- Lower likelihood of prescription cascading, doctor shopping, or unsafe drug-to-drug interactions
- Improved continuity of care and communication among treating clinicians

This program applies to **Wellpoint Members with prescription drug coverage**.

Core Program Rules

The Pharmacy and Prescriber Home Program includes:

- Reimbursement of controlled-substance claims only when:
    - Written by the Member's designated prescriber; and/or
    - Filled at the Member's designated pharmacy home. All other controlled-substance claims will be denied.
- **Temporary overrides** may be granted for urgent or emergent situations.
- **Access to mail order and specialty pharmacies** remains available in addition to the Pharmacy Home, when clinically appropriate.

Attempts to obtain covered controlled substances outside the assigned Home Providers will result in claim denial.

Qualifying Criteria

A member may be enrolled if their recent prescription drug history indicates an elevated safety risk. Enrollment criteria include any of the following within a **ninety (90)-day period**:

- Five (5) or more controlled substance prescriptions
- Controlled substance prescriptions from three (3) or more different prescribers
- Controlled substance prescriptions filled at three (3) or more different pharmacies

Note: Members with a diagnosis of cancer, second-degree burns, third-degree burns, sickle-cell anemia, or those who 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.

These criteria are based on regulatory best practices and are used to identify patterns that may require added care coordination and oversight.

Enrollment Process

Members enrolled in the program are expected to support their own safety by using only their assigned Home pharmacy and/or prescriber for controlled substances. Failure to follow medical advice or program requirements may limit a Provider's ability to offer referrals or continue treatment.

Selection of Home Providers

- Members may select their preferred participating prescriber and/or pharmacy.
- If a member does not choose, Wellpoint will assign providers based on a retrospective Drug Utilization Review (DUR) of prescription claims—typically selecting the providers most frequently used.

Provider Notifications

Once a Home Provider is selected or assigned, all prescribers involved in the member's controlled-substance care will receive:

- A notice of the member's enrollment
- The assigned prescriber/pharmacy information
- A three-month prescription profile listing all controlled substance medications previously obtained, including dosages, quantities, and prescribers

This ensures all clinicians involved have appropriate visibility into the member's treatment history.

Member Communications and Rights

<u>Advance Notice</u>

Members are notified sixty (60) days prior to potential enrollment and are monitored during this period. If risk factors continue, a formal enrollment notice is sent.

<u>Appeal Rights</u>

Members have thirty (30) days after receiving their enrollment notification to:

- Select a Home prescriber/pharmacy, and/or
- File an appeal if they disagree with the enrollment decision

If the Member does not select a Home Provider within thirty (30) days, one will be automatically assigned based on recent Claims history.

Changing a Home Prescriber or Pharmacy

Wellpoint will notify both the Member and Providers of the confirmed Home prescriber and/or pharmacy. Changes may be approved for good-cause situations, such as:

- The Member moves to a new location
- The assigned Provider leaves the network
- The assigned pharmacy regularly lacks necessary medications

Members or Providers may contact Member Services (using the number on the back of the member's ID card) for assistance with change requests or general program questions.

Wellpoint's Commitment to Providers and Members

Wellpoint remains committed to improving the health, safety, and well-being of all members. By strengthening care coordination and providing tools to reduce unsafe prescribing patterns, this program supports:

- Better health outcomes
- Reduced preventable harm
- Enhanced partnership between pharmacies, prescribers, and care teams

We value collaboration with Providers in creating safer, more effective care pathways for Members who need them most.

wellpoint.com

MD-WP-CM-PM-000061-25-S134 | January 2026