Wellpoint

Provider Manual

833-731-2167 (TTY 711) | provider.wellpoint.com/

January 1, 2026

Wellpoint

Carelon Behavioral Health, Inc. is an independent company providing utilization management services on behalf of the health plan.
Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.
CarelonRx, Inc. is a separate company providing utilization review services on behalf of the health plan.

Coverage provided by: In Arizona: Wellpoint Texas, Inc., Wellpoint Ohio, Inc., or Wellpoint Insurance Company. In Iowa: Wellpoint Iowa, Inc. In New Jersey: Wellpoint New Jersey, Inc. or Wellpoint Insurance Company. In South Carolina: Wellpoint South Carolina, Inc. In Tennessee: Wellpoint Tennessee, Inc. or Wellpoint Insurance Coverage. In Texas: Wellpoint Insurance Company or Wellpoint Texas, Inc. In Washington: Wellpoint Washington, Inc., who profoundly acknowledges and respects the inherent sovereignty of the federally recognized Tribes in Washington state. In our efforts to promote high-quality healthcare, we honor the Tribal right of self-governance, holding in deep esteem the government-to-government relationship existing between the state and the Tribes, a bond reiterated by the Centennial Accord and established by RCW 43.376. We heartily commit to enhancing our coordination, collaboration, and recognition of the deeply rooted traditions and values of the Tribal communities. In West Virginia: Wellpoint West Virginia, Inc.

MULTI-WP-CR-PM-087720-25 | January 2026

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1 WELLPOINT OVERVIEW

Wellpoint corporation is a wholly owned by Wellpoint, Inc. As a leader in managed healthcare services for the public sector, the Wellpoint subsidiary health plans help low-income families, children, pregnant women, people with disabilities, and members of Medicare Advantage and Special Needs Plans get the healthcare they need.

Purpose Statement

Together, we are transforming healthcare with trusted and caring solutions.

Vision

To be America's valued health partner.

- Trustworthy
- Accountable
- Innovative
- Caring
- Easy to do business with

Strategy

Our strategy is to:

- Improve access to preventive primary care services by ensuring the selection of a primary care provider (PCP) who will serve as doctor, service manager, and coordinator for all basic medical services.
- Improve the health statuses and outcomes of our members.
- Educate members about their benefits, responsibilities, and the appropriate use of healthcare services.
- Encourage stable, long-term relationships between providers and members.
- Encourage medically appropriate use of specialists and emergency rooms.
- Commit to community-based enterprises and community outreach.
- Facilitate the integration of physical and behavioral healthcare.
- Foster quality improvement processes that actively involve providers in re-engineering healthcare delivery.
- Encourage a customer service orientation with regular measurement of member and provider satisfaction.
- Partner with providers to ensure members receive preventive services for improving our Healthcare Effectiveness Data and Information Set (HEDIS®) data collection and star ratings.

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

Escalating healthcare costs are driven in part by a pattern of fragmented, episodic care and, quite often, unmanaged health problems of members. Wellpoint strives to educate members to encourage the appropriate use of the managed care system and to be involved in all aspects of their healthcare.

2 MEDICARE ADVANTAGE OVERVIEW

Medicare Advantage offered by Wellpoint refers to the Medicare Advantage Special Needs Plans (SNPs) and integrated Medicare Advantage Prescription Drug (MA-PD) plans we offer. All network providers are contracted with Wellpoint through a *Participating Provider Agreement*. As a participating provider in the Medicare network, your contract will have a Medicare rate sheet in addition to any rate sheets for other Wellpoint products in which you participate. We strive to incorporate expertise available nationally into operating local community-based healthcare plans with experienced staff to complement our operations. Wellpoint believes hospitals, physicians, and other providers play a pivotal role in managed care. Wellpoint can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high-quality provider network. We are committed to assisting you in providing quality healthcare, and hope the information in this manual is beneficial to you and your office staff. As a participating provider, you are invited to participate in our quality improvement committees. Most committee meetings are prescheduled at times and locations intended to be convenient for you. Please call Provider Services at the Dedicated Service Unit (DSU) at **866-805-4589** with any suggestions, comments, or questions, or if you are interested in learning more about specific policies. Together, we can arrange for and provide an integrated system of coordinated, efficient, and quality care for our members.

3 MEDICARE MEMBER AND ENROLLMENT INFORMATION

3.1 Enrollment periods

Members have a choice of getting their Medicare healthcare services through original Medicare or through one of the Medicare Advantage plans offered by Wellpoint. The Centers for Medicare & Medicaid Services (CMS) mails a copy of the document *Medicare & You* to Medicare beneficiaries describing Medicare benefits and plan choices every fall.
Medicare beneficiaries can enroll in Medicare Advantage plans during certain time periods called election periods. Five important election periods are:

- Annual Election Period (AEP): The AEP occurs from October 15 to December 7 every year. Medicare beneficiaries can enroll into or disenroll from a Medicare Advantage plan during this time. The effective date of the change is January 1 of the following year.
- Medicare Advantage Disenrollment Period (MADP): During the MADP, Medicare beneficiaries have the opportunity to disenroll from a Medicare Advantage plan and return to original Medicare. If they choose to return to original Medicare, they have the option of enrolling into a stand-alone prescription drug plan, which Wellpoint does not offer. The time frame for this election period is January 1 to February 14 of each year.
- Initial Coverage Election Period (ICEP): When a person first becomes eligible for Medicare Part A and enrolls in Medicare Part B, they have a seven-month period to enroll in a Medicare Advantage plan. This usually happens around the person's 65th birthday.
- Initial Enrollment Period for Part D (IEP): This is the period when an individual is first eligible to enroll in a Part D plan. An individual is eligible to enroll in a Part D plan when they are entitled to Part A or is enrolled in Part B and permanently resides in the service area of the plan. Generally, individuals will have an IEP that is the same period as the Initial Enrollment Period for Medicare Part B, a seven-month period that begins three months before the month the individual meets the eligibility requirements for Part B and ends three months after the month of eligibility.
- Special Election Period:
  - CMS has identified several circumstances under which a person may change Medicare options outside of the annual or initial enrollment periods. For example, there is an SEP for individuals who have Medicare Part A and Part B and receive any type of assistance from the Medicaid program. This includes both "full benefit" dual eligible individuals as well as individuals often referred to as "partial duals" who receive cost sharing assistance under Medicaid (for example, QMB-only, SLMB-only, etc.) and individuals who qualify for low income subsidy, but who do not receive Medicaid benefits.
  - This SEP begins the month the individual becomes dually eligible and exists as long as they receive Medicaid benefits; however, there are limits in how often it can be used. This SEP allows an individual to enroll in, or disenroll from, an MA plan once per calendar quarter during the first nine months of the year. This SEP can be used once during each of the following time periods:
    - January – March,
    - April – June, and
    - July – September.
  - It may not be used in the 4th quarter of the year (October – December).

After CMS confirms the enrollee's eligibility, we send the member a letter to confirm their enrollment. A new member will also receive:

- An ID card.

- A provider directory.
- A formulary (which lists the prescription drugs we cover).
- An Evidence of Coverage (EOC) document
- Summary of Benefits

Additionally, CMS can perform a retro-enrollment or retro-disenrollment in limited circumstances. Wellpoint follows CMS directives on member enrollment and disenrollment dates; they are not determined by the plan. If retroactivity occurs, this may have an impact on claims payments.

Members who choose to enroll in a plan from Wellpoint will receive a member ID card containing the member's name, member number, and basic information about the member's benefits. Members enrolled in a Medicare Advantage offered by Wellpoint plan receive an *EOC* document from Wellpoint describing the Medicare benefits and services they receive. Medicare Advantage offered by Wellpoint plan, members should present their member ID cards when receiving services (sample ID cards below).

State	Web link
Arizona	**provider.wellpoint.com/arizona-provider/benefits/benefits-and-pharmacy**
Iowa	**https://www.provider.wellpoint.com/iowa-provider/member-eligibility-and-pharmacy**
New Jersey	**https://www.provider.wellpoint.com/new-jersey-provider/resources/manuals-and-guides**
South Carolina	**https://www.wellpoint.com/sc/provider/state-federal/resources/policies-guidelines-manuals**
Tennessee	**https://www.provider.wellpoint.com/tennessee-provider/resources/policies-guidelines-and-manuals**
Texas	**https://www.wellpoint.com/tx/provider/state-federal/resources/policies-guidelines-manuals**
Washington	**https://www.provider.wellpoint.com/washington-provider/resources/manuals-and-guides**
West Virginia	**https://www.wellpoint.com/wv/provider/state-federal/resources/policies-guidelines-manuals**

3.2 The Provider Self-Service Website

Wellpoint provides access to a website **https://www.wellpoint.com/provider,** that contains the full complement of online provider resources. The website features an online provider inquiry tool to reduce unnecessary telephone calls by enabling easy access at your convenience to the following resources:

- Online support services, such as:
  - New user registration and activation, login help, and username and password reset
  - Forms to update provider demographics and information such as tax ID or group affiliation changes
  - Provider panel reports
  - Online daily PCP quality reports:
    - Hospital/inpatient admission, transfer, and discharge reports
    - HEDIS measures
- Interactive look-up tools and reference materials, such as:

- Provider/referral directories
- Prior Authorization lookup tool
- Claims status/submission tool
- Reimbursement policies
- Provider manuals and quick reference cards (provider manuals are available two ways, via the provider website or through your local Network Relations Consultant)

Wellpoint also offers a dedicated Provider Services team called the DSU to assist with prior authorization and notification, health plan network information, member eligibility, claims information, and inquiries. The team can also take any recommendations you may have for improving our processes and managed care program. Below you will find additional information we hope will assist you in your day-to-day interaction with Wellpoint.

3.3 Availity Essentials

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

If your provider organization is new to Availity and you want to register your organization and you will be designated as the primary administrator, you'll begin by creating your Availity user account. You'll start by selecting **Register** on the Availity home page at **Availity.com** and follow the registration wizard to create your account. Select this link for full details on the registration process: **Availity.com/documents/learning/Availity_Portal_Registration.pdf**
For training, visit the **Digital Provider Learning Hub** to take live and on-demand courses with your Availity User/Password. Or you can visit **Availity.com** and select **Get Trained** under **Help & Training** in the top black bar. From here, you can sign up for informative webinars and even receive credit from the American Academy of Professional Coders for many sessions.
For any questions or additional registration assistance, contact Availity Client Services at **800-282-4548**, Monday to Friday from 5 a.m. to 5 p.m. Pacific time.

3.4 Quick Reference Information

Quick Reference Information	
Dedicated Service Unit (DSU)	Contact the DSU at **866-805-4589** for member eligibility, Nurse HelpLine, and pharmacy services.
AT&T Relay Service	For English, call **800-855-2880**; for Spanish, call **800-855-2884**.
Notification/ Prior Authorization	• May be telephoned, submitted online, or faxed to Wellpoint: • Telephone: **866-805-4589** Home health, durable medical equipment, therapies, and discharge planning: **888-235-8468** Concurrent review clinical documentation: **888-700-2197** • Behavioral health inpatient: **844-430-1702** • Behavioral health outpatient: **844-430-1703** • Initial admission notifications and all other services: **800-964-3627** • Web: **provider.wellpoint.com/** • Data required for complete notification/prior authorization: • Member ID number

<table>
<tr><th colspan="2">Quick Reference Information</th></tr>
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– Legible name of referring provider
– Legible name of individual referred to provider
– Number of visits/services
– Dates of service
– Diagnosis
– Current Procedural Terminology (CPT®) code

Pre-Service Prior Authorization: Providers are required to provide notification in advance of services to allow Wellpoint to meet CMS processing timeframes:

– Medical:

o Standard — 07 Calendar Days
o Expedited — 72 Hours

Pharmacy (including Part B medical injectables):

– Standard — 72 Hours
– Expedited — 24 Hours

ER admissions:
Within one business day for all ER admissions. Clinical staff is available during normal business hours from 8 a.m.-5 p.m. local time.
Clinical information is required for prior authorization (the Prior Authorization Request Form is also available online.)

</td></tr>
<tr><td>Claims Submission: Paper (for all Medicare markets: Arizona, Iowa, New Jersey, New Mexico, South Carolina, Tennessee, Texas, Washington, and West Virginia)</td><td>Submit paper claims to:
Wellpoint
P.O. Box 61010
Virginia Beach, VA 23466-1010

If you are a delegated provider with an organization that is not listed here, please contact your delegation organization to report change in address and/or practice status.</td></tr>
<tr><td>Claims Submission: Electronic</td><td>Electronic claims payer ID:
<table>
<tr><th>Clearinghouse</th><th>Payer number</th><th>Phone number</th></tr>
<tr><td>Availity</td><td>26375</td><td>877-334-8446</td></tr>
</table>
Contact Availity
Please contact Availity Client Services with any questions at 800-Availity (282-4548)
Timely filing is governed by the terms of the provider agreement. Timely filing for each market is the same as the Wellpoint timely filing requirement for its Medicaid product in each state and within the number of days listed in the table below from the date of service. Please see your contract for timely filing requirements.

Wellpoint provides an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and prior authorization status at provider.wellpoint.com.</td></tr>
</table>

Quick Reference Information	
	If you are unable to access the internet, you may receive claims, eligibility, and prior authorization status over the telephone at any time by calling our automated Provider Services number at the DSU toll free at **866-805-4589**.
National Provider Identifier (NPI)	The *Health Insurance Portability and Accountability Act* (*HIPAA*) *of 1996* requires the adoption of a standard unique provider identifier for healthcare providers. All Wellpoint participating providers must have an NPI number. The NPI is a 10-digit intelligence-free numeric identifier. Intelligence-free means the numbers do not carry information about healthcare providers, such as the state in which they practice or their specialty. Providers can apply for an NPI by completing an application: • Online at **https://nppes.cms.hhs.gov** (Estimated time to complete the NPI application is 20 minutes) • By downloading a paper copy at **https://nppes.cms.hhs.gov** • By calling **800-465-3203** and requesting an application Please send your NPI to: Provider Data Management Wellpoint P. O. Box 62509 Virginia Beach, VA 23466-2509 Email: NPImail@wellpoint.com
Medicare Advantage Participating Provider Appeals	Medicare appeals are determined by the liable party, not by the initiator. Please refer to the denial letter or *Explanation of Payment* (*EOP*) issued to determine the correct appeals process. Medicare Participating Provider Standard Appeals: A formal request for review of a previous Wellpoint decision where medical necessity was not established where provider liability was assigned (see original decision letter) for services already rendered. Medicare Complaints, Appeals & Grievances (MCAG) Attention: Medical Necessity Provider Appeals Mailstop: OH0205-A537 4361 Irwin Simpson Road Mason, Ohio 45040
Medicare Advantage Participating Provider Administrative Plea and Disputes	Medicare Provider Administrative Pleas: A formal request for review of a previous Wellpoint decision where a determination was made that the participating provider failed to follow administrative rules and provider liability was assigned (see original decision letter) where services have already been rendered. and Medicare Provider Payment Disputes A formal request from a provider contesting the paid amount on a claim which does not include a medical necessity or administrative denial, and claims payment determinations have already been rendered. Provider Payment Disputes P.O. Box 61599 Virginia Beach, VA 23466-1599 Readmission Disputes

Quick Reference Information	
Medicare Member Appeals	Medicare appeals are determined by the liable party, not by the initiator. Please refer to the denial letter or *EOP* issued to determine the correct appeals process to follow. All Medicare member liability appeals should be sent to: Wellpoint Medicare Complaints, Appeals, & Grievances (MCAG) Attention: Member Appeals Unit Mailstop: OH0205-A537 4361 Irwin Simpson Road Mason, Ohio 45040 Physicians can request expedited or standard pre-service appeals on behalf of members; however, if the request is not from the treating physician, an *Appointment of Representative* form (*AOR*) may be required. The *Appointment of Representative Form* can be found online and downloaded at cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207. In the event that applying the standard appeal timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, an expedited or fast appeal can be initiated by contacting us in one of the following ways: Medicare Complaints, Appeals, and Grievances Department Wellpoint – Expedited Appeals 4361 Irwin Simpson Road Mason, Ohio 05040-9598 Mail Stop: OH0205-A537 Fax: **888-458-1406** (Part C) 888-458-1407 (Part D) Phone: Call the number on the back of the member's ID card. Please indicate if you are requesting an expedited appeal.
Provider Service Representatives	For more information, contact Provider Services at the DSU at **866-805-4589** or your local Network Relations Consultant.

3.5 Ongoing Provider Communications and Feedback

To ensure providers are up to date with information required to work effectively with Wellpoint and our members, we provide frequent communications to providers in the form of broadcast faxes, provider manual updates, newsletters and information posted to the website.

4 PARTICIPATING PROVIDER INFORMATION

4.1 The Medicare Advantage Provider Network

Medicare members obtain covered services by choosing a PCP who is part of the network to assist and coordinate their care. Members are encouraged to coordinate with their PCP before seeking care from a specialist, except in the case of specified services (such as women's routine and preventive care and behavioral healthcare).
Note: Some services provided by a specialist may require prior authorization or a referral. All referrals to a provider that are not within the Wellpoint network require prior authorization. Please refer to **Provider Obligations — Prior Authorization.**

When referring a member to a specialist, it's critical to select a participating provider within our Medicare network to maximize the member's benefit and minimize their out-of-pocket expenses. If you need help finding a participating provider, please call Provider Services at the DSU at **866-805-4589**. If you believe you must refer to a provider outside of our network, you must notify Wellpoint in advance of that request in order for an organization determination to be made. Failure to initiate this request may result in claims denials and member liability. This includes such services as laboratories; however, it does not include urgent or emergent services. Please refer to **Provider Obligations — Prior Authorization**.

4.2 The PCP Role

Members are asked to select a PCP when enrolling in a Medicare Advantage offered by Wellpoint plan and may request a change to their selected PCP at any time. Member-requested PCP changes will become effective the first day of the following month, except in extenuating circumstances. Wellpoint contracts with certain physicians that members may choose as their PCPs and may be individual practitioners associated with a contracted medical group or an independent practice association. The PCP is responsible for referring or obtaining prior authorization for covered services for members. Medicare-participating PCPs are generally physicians of internal medicine, family practitioners, general practitioners, pediatricians, obstetricians/gynecologists, or geriatricians. Federally qualified health centers (FQHCs) and rural health clinics (RHCs) may be included as PCPs.

The PCP is a network physician who has responsibility for the complete care of their members, whether providing it themself or by referral to the appropriate provider of care within the network. Any referral to a provider outside of the network will require prior authorization from Wellpoint. Please refer to **Provider Obligations — Prior Authorization**.

The PCP is the primary coordinator for member's care; therefore, directing and managing all care planning needs. This also includes implementing, coordinating, and sharing the care plan with the member — allowing members to participate in their healthcare decisions and provide input into their proposed treatment plans.

The Health Plan supports the care planning process during care transitions and sharing pertinent available health information developed and updated during Complex Case Management, Condition Care, and Social Services case. This PCP-directed methodology enables the PCP and their support team to closely manage and monitor the member's care and health status.

When coordinating member care, the PCP should refer the member to a participating provider within the Wellpoint network. To assist the specialty care provider, the PCP should provide the specialist with the following clinical information:

- Member name

- Referring PCP
- Reason for the consultation
- History of the present illness
- Diagnostic procedures and results
- Pertinent past medical history
- Current medications and treatments
- Problem list and diagnosis
- Specific request of the specialist

Any referral to a nonparticipating provider will require prior authorization from Wellpoint or the services may not be covered. Contact Provider Services at the DSU at **866-805-4589** for questions or more information.

4.3 The Specialist Role

A specialist is any licensed provider (as defined by Medicare) providing specialty medical services to members. A PCP may refer a member to a specialist when medically necessary. Specialists must obtain authorization from Wellpoint before performing certain procedures or when referring members to noncontracted providers. Please refer to the *Summary of Benefits* or *EOC* documents for those procedures requiring prior authorization. You can review prior authorization requirements online at **provider.wellpoint.com/**or call Provider Services at the DSU at **866-805-4589**.
After performing the initial consultation with a member, a specialist should:

- Communicate the member's condition and recommendations for treatment or follow-up care with the PCP.
- Send the PCP the consultation report, including medical findings, test results, assessment, treatment plan, and any other pertinent information.

If the specialist needs to refer a member to another provider, the referral should be to another Wellpoint provider. Any referral to a nonparticipating provider will require prior authorization from Wellpoint. Please refer to **Provider Obligations — Prior Authorization**.

4.4 Specialist as a PCP

In some cases, a specialist, physician assistant, nurse practitioner, or certified nurse midwife under physician supervision may be a PCP. This must be authorized by the health plan's Case Management department. Requirements and exceptions vary by market. If you have any questions, contact the DSU. To download a copy of the *Specialist as a PCP Form*, go to **provider.wellpoint.com/** and select *Forms* under *Provider Resources & Documents*.

4.5 Participating Provider Responsibilities

- Manage the medical and healthcare needs of members, including monitoring and following up on care provided by other providers, providing coordination necessary for services provided by specialists and ancillary providers (both in and out-of-network), and maintaining a medical record meeting Wellpoint standards
- Provide coverage 24 hours a day, 7 days a week; regular hours of operation should be clearly defined and communicated to members
- Provide all services ethically, legally, and in a culturally competent manner, and meet the unique needs of members with special healthcare needs
- Participate in systems established by Wellpoint to facilitate the sharing of records, subject to applicable confidentiality and *HIPAA* requirements

- Make provisions to communicate in the language or fashion primarily used by their assigned members
- Provide hearing interpreter services on request to members who are deaf or hard of hearing
- Participate in and cooperate with Wellpoint in any reasonable internal and external quality assurance, utilization review, continuing education, and other similar programs established by Wellpoint
- Comply with Medicare laws, regulations, and CMS instructions, agree to audits and inspections by CMS and/or its designees, cooperate, assist, and provide information as requested, and maintain records for a minimum of 10 years
- Participate in and cooperate with the Wellpoint appeal and grievance procedures
- **Agree to not balance bill** members for monies that are not their responsibility or that should be paid for by another carrier (in the case of a dually-eligible member covered both by Medicare and Medicaid with full coverage of Medicare cost sharing under a Medicare Savings Program or a dually eligible member enrolled in the Qualified Medicare Beneficiary (QMB) program, federal law requires providers may bill only the member's health plan or the state Medicaid agency for copays or other cost-sharing amounts. **Providers may not bill such members for cost sharing.**)
- Continue care in progress during and after termination of a member's contract for up to 60 days, or such longer period of time required by state laws and regulations, until a continuity of service plan is in place to transition the member to another network provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations (**for New Jersey providers,** continuity of care requirements are in accordance with *Attachment B – Medicare to Wellpoint New Jersey, Inc. Participating Provider Agreement*)
- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Develop and have an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens
- Establish an appropriate mechanism to fulfill obligations under the *Americans with Disabilities Act of 1990* (*ADA*)
- Support, cooperate, and comply with Wellpoint Quality Improvement program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner
- Inform Wellpoint if a member objects to the provisions of any counseling, treatments, or referral services for religious reasons
- Treat all members with respect and dignity, provide appropriate privacy, and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release
- Provide members complete information concerning their diagnosis, evaluation, treatment, and prognosis, and give them the opportunity to participate in decisions involving their healthcare, except when contraindicated for medical reasons
- Advise members about their health status, medical care, or treatment options, regardless of whether benefits for such care are provided under the program, and advise them on treatments that may be self-administered
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings
- Have a policy and procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection

- Agree to maintain communication with the appropriate agencies, such as local police, social services agencies, and poison control centers, to provide high-quality patient care
- Agree any notation in a member's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research will be clearly contrasted with entries regarding the provision of nonresearch-related care
- Participate in the interdisciplinary care team meetings when necessary
- Complete annual model of care training

If a member self-refers or a provider is referring to another provider, that provider is responsible for checking the Wellpoint provider directory to ensure the specialist is in the network. Referrals to Wellpoint -contracted specialists do not require prior authorization; all referrals to providers outside Wellpoint require prior authorization unless urgent or emergent services are needed. Some procedures performed by specialist physicians may require prior authorization. Please refer to the *Summary of Benefits* document for procedures that require prior authorization or call Provider Services at the DSU at **866-805-4589**. If you cannot locate a provider in the Wellpoint network, you should contact Provider Services at the DSU at **866-805-4589**. You must obtain authorization from Wellpoint before referring members to noncontracted providers. Additionally, certain services/procedures require prior authorization from Wellpoint.

Provide **advanced** notification to members of services that are not covered by the plan or Medicare in accordance with Medicare requirements, and must explicitly state that such increased benefits are applicable to Medicare only and do not indicate increased Medicaid benefits to avoid potential member confusion. Additionally, each marketing item must include the following disclaimer:

Notice: The state plan is not responsible for payment for these benefits, except for appropriate cost-sharing amounts. The State Plan is not responsible for guaranteeing the availability or quality of these benefits. Please refer to **Provider Obligations — Prior Authorization**.
Note: Wellpoint does **not** cover the use of any experimental procedures or experimental medications, except under certain circumstances.

4.6 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.

4.7 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."

4.8 Submitting provider demographic data requests and roster submissions through Roster Automation

Use the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all professional and facility care providers.* **The PDM application is now the intake tool for care providers to submit demographic change requests, including submitting roster uploads.** If preferred, providers may continue to utilize the Provider 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 Automation is our new technology solution designed to streamline and automate provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel document. Any provider, whether an individual provider/practitioner, group, or facility, can use Roster Automation today:**

The resources for this process are listed below and available on our website. Visit **provider.wellpoint.com/**, then under *For Providers*, select **Forms and Guides**. The **Roster Automation Rules of Engagement** and **Roster Automation Standard Template** appear under the Digital Tools category:

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

Accessing PDM Application

Log onto **Availity.com** and select **My Providers > Provider Data Management** to begin the attestation process. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select **Upload Rosters** (see screenshot below), and follow the prompts.

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

- Behavioral Health providers contracted with Carelon Behavioral Health, Inc. 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

****** If any roster data updates require credentialing, your submission will be routed appropriately for further action.

4.9 Digital Transactions and Electronic Data Exchange

Admission, Discharge, and Transfer messaging data
Facilities are asked to provide Wellpoint with, at minimum, Health Level Seven International (HL7) Admission, Discharge and Transfer (ADT) messaging data for all members on a near real-time basis, including all standard HL7 message events pertaining to ADT as published by HL7. Facility will transfer the message data segments according to the standard HL7 format, or as requested by Wellpoint. On a "near real-time basis" means no later than twenty-four (24) hours from admission, discharge, or transfer for any member.

4.10 Enrollment and Eligibility Verification

All healthcare providers are responsible for verifying enrollment and eligibility before services are rendered, except in the case of an emergency. In general, eligibility should be verified at the time of service and at least once monthly for ongoing services. In an emergency, eligibility should be determined as soon as possible after the member's condition is stabilized. When a patient presents as a member, providers must verify eligibility, enrollment, and coverage by performing the following steps:

- Request the member's Wellpoint ID card; if there are questions regarding the information, call Provider Services at the DSU at **866-805-4589** to verify eligibility, deductibles, coinsurance amounts, copays, and other benefit information, or use the online provider inquiry tool at **provider.wellpoint.com/**
- Copy both sides of the member's Wellpoint ID card and place the copies in the member's medical record
- Determine if the member is covered by another health plan to record information for coordination of benefits purposes
- If you are a PCP, check your Wellpoint Member Panel Listing via **provider.wellpoint.com/**to ensure you are the member's doctor.
- If the patient does not have an ID card, use the online provider inquiry tool at **provider.wellpoint.com/**or call Provider Services at the DSU at **866-805-4589**.

Verify member eligibility
To verify member eligibility, log on to Availity Essentials at **Availity.com**. From the Availity Essentials homepage, select **Patient Registration** > **Eligibility & Benefits**.

4.11 Member Missed Appointments

Members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. Wellpoint requires providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling. The contact must be by telephone and should be designed to educate the member about the importance of keeping appointments and to encourage the member to reschedule the appointment.

Members who frequently cancel or fail to show up for appointments without rescheduling may need additional education in appropriate methods of accessing care. In these cases, please call Provider Services at the DSU at **866-805-4589** to address the situation. Wellpoint staff will contact the member and provide more extensive education and/or case management as appropriate. It is Wellpoint's goal for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP.

4.12 Noncompliant Wellpoint Members

Wellpoint recognizes providers may need help in managing nonadherent members. If you have an issue with a member regarding behavior, treatment cooperation, completion of treatment and/or making or appearing for appointments, call Provider Services at the DSU at **866-805-4589**.

A Member or Provider Services representative will contact the member by telephone, or a member advocate will visit the member to provide education and counseling to address the situation, and will report the outcome of any counseling efforts to you.

4.13 Provider and facility digital guidelines

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

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

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 include:

- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response
- Prior authorization submissions, including updates, clinical attachments, authorization status, and clinical appeals
- Claim submission, including attachments, claim status
- Remittances and payments
- Provider Enrollment 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, Inc.
- Services through Carelon Behavioral Health, Inc.

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

(paper, mail, fax, call, chat, etc.). All channels are consistent with industry standards. All EDI transactions use version 5010.
Note: As a mandatory requirement, all trading partners must currently transmit directly to the Availity EDI gateway and have an active Availity Trading Partner Agreement in place. This includes providers using their practice management software & clearinghouse billing vendors.

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

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

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

- EDI transaction: X12 270/271 – eligibility inquiry and response
    - Wellpoint supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- Availity Essentials
    - The Eligibility and Benefits Inquiry verification application allows 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 a provider to upload a batch/file of Claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – Claim status inquiry and response:
    - Wellpoint supports the industry standard X12 276/277 transaction set for Claim status inquiry and response as mandated by HIPAA.
- Availity Essentials – The Claims & Payments application
    - 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 a provider to access online Claim status. Access the Claim payment dispute tool from Claim Status. Claims Status also enables online claim payment disputes in most markets and for most claims. It is the expectation of Wellpoint that electronic Claim payment disputes are adopted when and where 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 Claim 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, are needed to process a Claim.

Section 5: Electronic remittance advice and electronic claims payment

Electronic remittance advice
Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your claims. Wellpoint supports the industry standard X12 835 transaction as mandated per HIPAA.
Providers and Facilities can register, enroll, and manage 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 your claims, contact Availity Client Services at **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 virtual credit card (VCC). VCC allow Providers and Facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply.
  Note that Wellpoint may receive revenue for issuing a VCC. *VCC is not applicable to Providers in Tennessee.

  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 cards 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. *VCC is not applicable to Providers in Tennessee.

- **Zelis Payment Network (ZPN) electronic payment and remittance combination**
  The Zelis Payment Network (ZPN) is an option for Providers and Facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to **Zelis.com**. Zelis may charge fees for their services. Note that Wellpoint may receive revenue for issuing ZPN.
  ERA through Availity is not available for Providers and Facilities using ZPN.

  To disenroll from ZPN payment, there are two (2) options:
  - Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at enrollsafe.payeehub.org.
    OR
  - To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at **877-828-8770**.

Not being enrolled for EFT, VCC, or ZPN will result in paper checks being mailed. *VCC is not applicable to Providers in Tennessee.

Section 6: Provider Enrollment and Network Management

Provider Enrollment

Simplified enrollment process: Providers and Facilities can enroll as a 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:

- Amendments 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.

My Roster:

Providers and Facilities can download roster data through Availity Essentials. This allows the review of data within our system and updates using the formatted file to provide changes.

- To request a roster, go to Availity.com > Payer Spaces > Select Payer Tile > Provider Enrollment and Network Management > Request Current Roster.
- Providers and Facilities will be prompted to select the organization name and TIN they would like included in the roster. Multiple TINs can be included in one request.
- A Roster File Submission confirmation message displays. When the roster is ready to download, it will be available by clicking **Download Requested Roster**. Rosters are usually available within 4 hours. Rosters cannot be requested more than once a day.

Providers and Facilities can edit the downloaded roster and upload the updated version via Availity's Provider Data Management *Upload Roster File* screen to easily make changes to their data. Because the download is correctly formatted, it should enable automatic processing.

**See Section 7: Demographic Updates section for more information about Provider Data Management.*

Provider and Facilities access for Provider Enrollment and Network Management features:

- To access these features, go to Availity.com > Payer Spaces > Select Payer Tile > Provider Enrollment and Network Management application.
- For organizations already using Availity Essentials, the organization's Availity Essentials administrator should go to **My Account Dashboard** from the Availity Essentials home page to register new users and update or unlock accounts for existing users. Staff who need access to the Provider Enrollment and Network Management application need to be granted the role of Provider Enrollment.

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 Provider 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 on and after June 15, 2024. The Results Report is an Excel file that shows the adds 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 Provider 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.

4.14 Second Medical or Surgical Opinion

Members may request a second opinion if they:

- Dispute the reasonableness of a decision.
- Dispute the necessity of a procedure decision.
- Do not respond to medical treatment after a reasonable amount of time.

To receive a second opinion, members must:

- Obtain a second opinion from a provider within the Wellpoint network.
- Be responsible for the applicable copay.

Our DSU staff can assist members and providers with identifying a participating provider for obtaining a second opinion.

4.15 Access and Availability

Participating Wellpoint providers must:

- Provide coverage for members 24 hours a day, 7 days a week.
- Ensure another on-call Wellpoint provider is available to administer care when the PCP is not available.
- Not substitute hospital emergency rooms or urgent care centers for covering providers.
- See members within 30 minutes of a scheduled appointment or inform them of the reason for delay (for example, emergency cases) and offer an alternative appointment.
- Provide an after-hours telephone service to ensure a response to emergency phone calls within 30 minutes and a response to urgent phone calls within one hour; individuals who believe they have an emergency medical condition should be directed to immediately seek emergency services from the nearest emergency facility.

Access and Availability Standards

Type of appointment (medical or behavioral)	**Availability standard**
Patient visit with new PCP	Within 30 calendar days
Routine follow-up or preventive care	As soon as possible, but within 30 calendar days
Routine/symptomatic	Within 7 days
Nonurgent care	Within 7 days
Urgently needed services	Within 24 hours
Emergency	Immediately

Wellpoint monitors adherence to appointment availability standards through office visits, long-term care visits, and tracking of complaints and grievances related to access and/or discrimination. Deviations from the policy are reviewed by the medical director for educational and/or counseling opportunities and tracked for provider recredentialing.
All providers and hospitals are expected to treat Medicare Advantage offered by Wellpoint plan members with the same dignity and consideration as afforded to their non-Medicare patients.

4.16 Covering Physicians

During a provider's absence or unavailability, the provider must arrange for coverage for their members. The provider will either: 1) make arrangements with one or more Wellpoint network providers to provide care for their members, or 2) make arrangements with another similarly licensed and qualified provider who has appropriate medical staff privileges at the same network hospital or medical group, as applicable, to provide care to the members in question. In addition, the covering provider will agree to the terms and conditions of the network provider agreement, including any applicable limitations on compensation, billing, and participation. Providers will be solely responsible for a non-network provider's adherence to such provisions. Providers will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a Medicare member on the provider's behalf.

4.17 Reporting Changes in Address and/or Practice Status

Any changes in a provider's address and/or practice status can be updated online by logging in to **provider.wellpoint.com/**or reported to your local Wellpoint office.

Market	Health Care Networks address
Arizona	Wellpoint PO Box 61010 Virginia Beach, VA 23466-1010 Carelon providers: Carelon Health Attn: Network Operations/Demographic Updates 12900 Park Plaza Drive, Suite 150 Cerritos, CA 90703 **providerrelationssupport@carelon.com** If you are a delegated provider with an organization that is not listed here, please contact your delegation organization to report change in address and/or practice status.
Iowa	4800 Westown Pkwy Suite 200 West Des Moines, IA 50266
New Jersey	Wellpoint 101 Wood Ave. South, Eighth Floor Iselin, NJ 08830
New Mexico	Wellpoint Two Park Square 6565 Americas Parkway NE, Suite 200 Albuquerque, NM 87110
Tennessee	Wellpoint 22 Century Blvd., Suite 310 Nashville, TN 37214
Dallas/Fort Worth	Wellpoint 2505 N. Highway 360, Suite 300 Grand Prairie, TX 75050
El Paso	Wellpoint 5959 Corporate Drive Houston, TX 77036
Houston	Wellpoint 5959 Corporate Drive Houston, TX 77036
Lubbock	Wellpoint

Market	Health Care Networks address
	2505 N. Highway 360, Suite 300 Grand Prairie, TX 75050
San Antonio	Wellpoint 2505 N. Highway 360, Suite 300 Grand Prairie, TX 75050
South Carolina	Wellpoint PO Box 61010 Virginia Beach, VA 23466-1010 Carelon providers: Carelon Health Attn: Network Operations/Demographic Updates 12900 Park Plaza Drive, Suite 150 Cerritos, CA 90703 **providerrelations@caremore.com** If you are a delegated provider with an organization that is not listed here, please contact your delegation organization to report change in address and/or practice status.
Washington	Wellpoint 705 5th Avenue South, Suite 300 Seattle, WA 98104
West Virginia	200 Association Drive Suite 200 Charleston, West Virginia 25311

4.18 Wellpoint Plan-specific Termination Criteria

The occurrence of any of the following is grounds for termination of the Wellpoint provider's participation:

- Loss of reputation among peers due to unethical clinical practice or attitude
- The practice of fraud, waste and/or abuse
- Adverse publicity involving the provider due to acts of omission or commission
- Substance use
- Loss of professional office
- Inadequate record keeping
- Unsafe environment in the provider's office relative to inadequate access or other related issues that might cause a member injury
- An office that is improperly kept, unclean, or does not present a proper appearance
- Failure to meet OSHA guidelines
- Failure to meet *ADA* guidelines
- Failure to meet Clinical Laboratory Improvement Amendments (CLIA) guidelines
- Customer satisfaction ratings that drop below pre-established standards as determined by the Medical Advisory Committee (MAC) (this would include complaints relative to appearance, behavior, medical care, etc.)
- Repetitive complaints about office staff demeanor, presentation, and appearance
- Inclusion on the Debarred Providers Listing of the Office of the Inspector General of the Department of Health and Human Services (see Sanctioned Providers)
- Unfavorable inpatient- or outpatient-related indicators:
- Severity-adjusted morbidity and mortality rates above established norms
- Severity-adjusted length-of-stay above established norms
- Unfavorable outpatient utilization results

- Consistent inappropriate referrals to specialists
- Improper maintenance of high-risk patients, such as those members with diabetes and hypertension
- Underutilization relative to minimum standards of care established per medical management guidelines and/or accepted clinical practice in the community
- Unfavorable malpractice-related issues
- Frequent litigious activity above and beyond what would be expected for a provider in that particular specialty

Wellpoint providers have 30 calendar days to appeal a termination. The Wellpoint process is designed to comply with all state and federal regulations regarding the termination appeal process.

4.19 Incentives and Payment Arrangements

Financial arrangements concerning payment to providers for services to Medicare members are set forth in each provider's agreement with Wellpoint. Wellpoint may also use financial incentives to reward providers for achieving certain quality indicator levels.
Wellpoint does not use or employ financial incentives that would directly or indirectly induce providers to limit or reduce medically necessary services furnished to individual enrollees. In cases where Wellpoint approves provider subcontracting arrangements, those subcontractors cannot employ any financial incentives inconsistent with this policy or with Medicare Advantage regulations.

4.20 Laws Regarding Federal Funds

Payments providers receive for furnishing services to members are derived in whole or part from federal funds. Therefore, providers and any approved subcontractors must comply with certain laws applicable to individuals and entities receiving federal funds, including but not limited to:

Title VI of the Civil Rights Act of 1964, as implemented by 45 CFR Part 80; the Age Discrimination Act of 1975, as implemented by 45 CFR Part 91; the Americans with Disabilities Act; The Rehabilitation Act of 1973, as implemented by 45 CFR Part 84, lobbying restrictions as implemented by 45 CFR Part 93 and 31 USC 1352, Title IX of the Education Ammendments of 1972, as amended (20 U.S>C sections 1681, 1685-1686, and 1783), and any other regulations appliable to receipents of federal funds.

4.21 Prohibition Against Discrimination

Neither Wellpoint nor its contracted providers may deny, limit, or condition the coverage or furnishing of services to members on the basis of any factor related to health status, including but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of healthcare
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability

4.22 Provider Panel — Closing a Panel

When closing a provider panel to new Wellpoint members or other new patients, providers must:

- Give Wellpoint prior written notice to Provider Relations in their health plan or submission using the provider website, the provider panel is closing to new members as of a specific closing date, and accept new members until that closing date. (Written notice only required in Tennessee)
- Keep the provider panel open to members who were patients of that practice before the panel closed or before they were enrolled with Wellpoint.
- Close the provider panel uniformly to all new Medicare patients, including all private payers and commercial or governmental insurers the practice participates with.
- Give Wellpoint prior written notice when reopening the provider panel, including a specific reopening date.

4.23 Provider Panel — Transferring and Terminating Members

Wellpoint will determine reasonable cause for transferring a member based on written request and documentation submitted by the provider. Providers may not transfer a member to another provider due to the costs associated with the member's covered services.
A provider may request termination of a member due to fraud, disruption of medical services or the member's repeated failure to make the required reimbursements for services. In such cases, the provider should contact the DSU at **866-805-4589**.

In the event a practitioner makes the decision to terminate their relationship with a delegated risk entity and decides to join a different delegated risk entity, Wellpoint will allow the practitioner to keep all of their paneled Wellpoint membership and move membership to the different risk entity if the following conditions are met:

- Delegated risk entity must be participating for all products that the practitioner's member panel is comprised of.
- Practitioner must have an attestation stating that the practitioner is leaving their current delegated risk entity and joining a different entity. This attestation must contain effective date of termination from former entity. Wellpoint will transfer membership within 2-weeks of request.
- The new risk entity must include on the roster that is sent to Wellpoint to add the practitioner, a column notating that an attestation was received from the practitioner. Said attestation will be available for Wellpoint to review upon request.

The delegated risk entity that the practitioner is terminating from will make no effort to contact membership assigned to the practitioner nor will the delegated risk entity take action against Wellpoint as Wellpoint is to remain unbiased and neutral throughout all practitioner movement.

Delegated Risk Entities who have language in their contract preventing practitioners who leave the entity from transferring membership from one entity to another. Documentation of signed contract will need to be presented to health plan shall the IPA want to dispute. The information will need to be provided to Wellpoint within 30 days of request.

4.24 Reporting Obligations — Cooperation in Meeting CMS Requirements

Wellpoint is required to provide information to CMS necessary to administer and evaluate the Medicare Advantage program and to establish and facilitate a process for current and prospective members to exercise their choice in obtaining Medicare services.

Wellpoint provides the following information:

- Plan quality and performance indicators such as disenrollment rates (for beneficiaries enrolled in the plan the previous two years)
- Information on member satisfaction
- Information on health outcomes

Providers must cooperate with Wellpoint in its data reporting obligations by providing Wellpoint with any information required to meet these obligations in a timely fashion.

4.25 Reporting Obligations — Certification of Diagnosis Data

Each diagnosis captured in a patient's medical record is the responsibility of the treating provider. Providers should maintain accurate and complete medical records supporting diagnosis data. Medicare Advantage Organizations (MAOs) must submit to CMS all data necessary to characterize the context and purpose of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner. In addition, providers have contractually agreed to submit diagnosis code data that is accurate, complete, and truthful (based on their best knowledge, information, and belief). MAOs must attest annually, based on knowledge, information, and belief, that the risk adjustment data it submits to CMS is accurate, complete, and truthful.

4.26 Cultural Competency

Cultural competency is the integration of congruent behaviors, attitudes, structures, policies, and procedures that come together in a system or agency or among professionals. Cultural competency assists providers and members to:

- Acknowledge the importance of culture and language.
- Assess cross-cultural relations.
- Embrace cultural strengths with people and communities.
- Strive to expand cultural knowledge.
- Understand cultural and linguistic differences.

The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to their provider and to adhere to recommended treatment. Some of the reasons that justify a provider's need for cultural competency include, but are not limited to:

- The perception that illness and disease, and their causes vary by culture
- The diversity of belief systems related to health, healing, and wellness are very diverse
- The fact that culture influences help-seeking behaviors and attitudes toward healthcare providers
- The fact that individual preferences affect traditional and nontraditional approaches to healthcare
- The fact that patients must overcome their personal biases within healthcare systems
- The fact that healthcare providers from culturally and linguistically diverse groups are under-represented in the current service delivery system

Cultural barriers between the provider and member can impact the patient-provider relationship in many ways, including but not limited to:

- The member's level of comfort with the practitioner and the member's fear of what might be found upon examination

- The differences in understanding on the part of diverse consumers in the United States healthcare system
- A fear of rejection of personal health beliefs
- The member's expectation of the healthcare provider and of the treatment

To be culturally competent, Wellpoint expects providers serving members within their geographic locations to demonstrate the following:

- Cultural Awareness:
  - The ability to recognize the cultural factors (norms, values, communication patterns, and world views) that shape personal and professional behavior
  - The ability to modify one's own behavioral style to respond to the needs of others, while at the same time maintaining one's objectivity and identity
- Cultural Knowledge:
  - Culture plays a crucial role in the formation of health or illness beliefs
  - Culture is generally behind a person's rejection or acceptance of medical advice and treatment
  - Different cultures have different attitudes about seeking help
  - Feelings about disclosure are culturally unique
  - There are differences in the acceptability and effectiveness of treatment modalities in various cultural and ethnic groups
  - Verbal and nonverbal language, speech patterns, and communication styles vary by culture and ethnic groups
  - Resources such as formally trained interpreters should be offered to and used by members with various cultural and ethnic differences

- Cultural Skills:
  - The ability to understand the basic similarities and differences between and among the cultures of the persons served
  - The ability to recognize the values and strengths of different cultures
  - The ability to interpret diverse cultural and nonverbal behavior
  - The ability to develop perceptions and understanding of others' needs, values, and preferred means of having those needs met
  - The ability to identify and integrate the critical cultural elements of a situation to make culturally consistent inferences and to demonstrate consistency in actions
  - The ability to recognize the importance of time and the use of group processes to develop and enhance cross-cultural knowledge and understanding
  - The ability to withhold judgment, action, or speech in the absence of information about a person's culture
  - The ability to listen with respect
  - The ability to formulate culturally competent treatment plans
  - The ability to use culturally appropriate community resources
  - The ability to know when and how to use interpreters and to understand the limitations of using interpreters
  - The ability to treat each person uniquely
  - The ability to recognize racial and ethnic differences and know when to respond to culturally based cues
  - The ability to seek out information
  - The ability to use agency resources
  - The capacity to respond flexibly to a range of possible solutions

- The acceptance of ethnic differences among people and the understanding of how these differences affect the treatment process
- The willingness to work with clients of various ethnic minority groups

4.27 Marketing

Providers may not develop or use any materials that market Wellpoint or the Medicare Advantage offered by Wellpoint plans without Wellpoint prior written approval. Under Medicare Advantage program rules, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials meet the CMS marketing guidelines and are first submitted to CMS for review and approval. Additionally, providers can have plan marketing materials in their office as long as marketing materials for all plans the providers participate in are represented. Providers are allowed to have posters or notifications that show they participate in the Medicare Advantage offered by Wellpoint plans as long as the provider displays posters or notifications from all Medicare plans in which they participate.

4.28 Americans With Disabilities Act Requirements

The Wellpoint policies and procedures are designed to promote compliance with the *ADA*. Providers are required to take actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes the following:

- Access to an examination room that accommodates a wheelchair
- Access to a lavatory that accommodates a wheelchair
- Elevator or accessible ramp into facilities
- Handicap parking clearly marked unless there is street-side parking
- Street-level access

5 FIRST LINE OF DEFENSE AGAINST FRAUD AND ABUSE

5.1 General Obligation to Prevent, Detect, and Deter Fraud, Waste, and Abuse

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

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

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

5.2 Reporting Fraud, Waste, And Abuse

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

Report concerns:

- Visit Wellpoint.com, scroll to the bottom footer, and select "Report Waste, Fraud and Abuse" to be directed to the www.fighthealthcarefraud.com education site; at the top of the page, select "Report it" and complete the "Report Fraud, Waste and Abuse" form
- 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 out-of-service Plan area and not letting the Plan know

- Using someone else's Member ID card

When reporting concerns involving a Member include:

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

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

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

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

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

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

5.3 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.

Failure to submit medical records when requested may result in an overpayment determination and/or placement on prepayment review.

If you are working with the SIU, all communication (checks, correspondence) should be sent to:
Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: Investigator Name, #case number

- 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 is the responsibility of the Provider or Facility.

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

Offsets. Wellpoint shall be entitled to offset claims and recoup an amount equal to any overpayments ("Overpayment Amount") or improper payments made by the health plan to Provider or Facility against any payments due and payable by Wellpoint to Provider or Facility with respect to any Health Benefit Plan under any contract with our company, regardless of the cause. Provider or Facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive, or wasteful. Upon determination by Wellpoint that an Overpayment Amount is due from Provider or Facility, Provider or Facility must refund the Overpayment Amount within the timeframe specified in the letter notifying the Provider or Facility of the Overpayment Amount. If the Overpayment Amount is not received within the timeframe specified in the notice letter, Wellpoint shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by Wellpoint to Provider or Facility under any Health Benefit Plan in accordance with Regulatory Requirements. Should Provider or Facility disagree with any determination, Provider or Facility shall have the right to appeal such determination under Wellpoint procedures set forth in this Provider Manual, on condition that such appeal shall not suspend Wellpoint's right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. Wellpoint reserves the right to employ a third-party collection agency in the event of non-payment.

5.5 *Health Insurance Portability and Accountability Act*

The Health Insurance Portability and Accountability Act (HIPAA, also known as the *Kennedy-Kassebaum Bill*) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of healthcare fraud, and simplifies the administration of health insurance.
Wellpoint strives to ensure both Wellpoint and contracted participating providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to *HIPAA*. Providers must have the following procedures in effect since April 14, 2003, to demonstrate compliance with the *HIPAA* privacy regulations.

Wellpoint recognizes its responsibility under the *HIPAA* privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting Wellpoint. However, please note the privacy regulations allow the transfer or sharing of member information, which may be requested by Wellpoint to conduct business and make decisions about care, such as a member's medical record, to make an authorization determination, or resolve a payment appeal. Such requests are considered part of the *HIPAA* definition of treatment, payment, or healthcare operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to Wellpoint, verify the receiving fax number is correct, notify the appropriate staff at Wellpoint, and verify the fax was appropriately received.

Email (unless encrypted) should not be used to transfer files containing member information to Wellpoint (for example, Excel spreadsheets with claim information). Such information should be mailed or faxed.

Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, P.O. Box, or department at Wellpoint.

The Wellpoint voicemail system is secure and password-protected. When leaving messages for Wellpoint associates, providers should only leave the minimum amount of member information required to accomplish the intended purpose.

When contacting Wellpoint, providers should be prepared to verify their name, address, and tax identification number or national provider identifier number.

6 MEDICAL RECORDS

6.1 Requirements Overview

Wellpoint providers must maintain permanent medical records that are:

- Current, detailed and organized; permit effective, confidential patient care; and allow quality reviews
- In conformity with good professional medical practice and appropriate health management
- Located at the primary care site for every Wellpoint member
- Kept in accordance with Wellpoint and state standards as described in this manual
- Retained for 10 years from the final date of the contract or from the date of completion of any audit
- Accessible upon request to Wellpoint and/or downstream entities, any state agency, and the federal government

Wellpoint will:

- Systematically review medical records to ensure compliance with standards. The health plan's MAC oversees and directs Wellpoint in formalizing, adopting, and monitoring guidelines
- Institute actions for improvement when standards are not met
- Maintain a record-keeping system that is designed to collect all pertinent medical management information for each member
- Make information readily available to appropriate health professionals and appropriate state agencies
- Use nationally recognized standards of care and work with providers to develop clinical policies and guidelines of care for members

6.2 Member Medical Records Standards

We require medical records to be current, detailed, and organized for effective, confidential patient care and quarterly review. Your medical records must conform to good professional medical practice and be permanently maintained at the primary care site.

Members are entitled to one copy of their medical record each year, provided at no cost. Members or their representatives should have access to these records.

Our medical records standards include:

- Patient identification information — patient name or ID number must be shown on each page or electronic file
- Personal/biographical data — age, sex, address, employer, home and work telephone numbers, and marital status
- Date and corroboration — dated and identified by the author
- Legibility — if someone other than the author judges it illegible, a second reviewer must evaluate it
- Allergies — must note prominently:
  - Medication allergies
  - Adverse reactions
  - No known allergies (NKA)
- Past medical history — for patients seen three or more times. Include serious accidents, operations, illnesses, and prenatal care of mother and birth for children

- Immunizations — a complete immunization record for pediatric members aged 20 and younger with vaccines and dates of administration
- Diagnostic information
- Significant illnesses and chronic and recurrent medical conditions are indicated in the problem list on all member medical records
- Report contributory and/or chronic conditions if they are monitored, evaluated, addressed, or treated at the visit and impact the care.
- All diagnoses reported on the claim should be fully documented in the medical record, and each diagnosis noted in the medical record should be reported in the claim corresponding to that encounter.
- Medical information, including medication and instruction to patient
- Identification of current problems:
  - Serious illnesses
  - Medical and behavioral conditions
  - Health maintenance concerns
- Instructions including evidence the patient was provided basic teaching and instruction for physical or behavioral health condition
- Smoking/alcohol/substance use — notation required for patients aged 12 and older and seen three or more times
- Consultations, referrals, and specialist reports — consultation, lab, and X-ray reports must have the ordering physician's initials or other documentation signifying review; any consultation or abnormal lab and imaging study results must have an explicit notation
- Emergencies — all emergency care and hospital discharge summaries for all admissions must be noted
- Hospital discharge summaries — must be included for all admissions while enrolled and prior admissions when appropriate
- Advance Directive — must document whether the patient has executed an Advance Directive, such as a Living Will or Durable Power of Attorney

6.3 Documentation Standards for an Episode of Care

When we request clinical documentation from you to support claims payments for services, you must ensure the information provided to us:

- Identifies the member
- Is legible
- Reflects all aspects of care

To be considered complete, documentation for episodes of care will include, at a minimum, the following elements:

- Patient identifying information
- Consent forms
- Health history, including applicable drug allergies
- Types and dates of physical examinations
- Diagnoses and treatment plans for individual episodes of care
- Physician orders
- Face-to-face evaluations
- Progress notes
- Referrals
- Consultation reports
- Laboratory reports

- Imaging reports (including X-ray)
- Surgical reports
- Admission and discharge dates and instructions
- Preventive services provided or offered appropriate to the member's age and health status
- Evidence of coordination of care between primary and specialty physicians

Refer to the standard data elements to be included for specific episodes of care as established by The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A single episode of care refers to continuous care or a series of intervals of brief separations from care to a member by a provider or facility for the same specific medical problem or condition.
Documentation for all episodes of care must meet the following criteria:

- Is legible to someone other than the writer
- Contains information that identifies the member on each page in the medical record
- Contains entries in the medical record that are dated and include author identification (for example, handwritten signatures, unique electronic identifiers, or initials)

Other documentation not directly related to the member
Records should contain information relevant to support clinical practice and used to support documentation regarding episodes of care, including:

- Policies, procedures, and protocols
- Critical incident/occupational health and safety reports
- Statistical and research data
- Clinical assessments
- Published reports/data

Wellpoint may request that you submit additional documentation, including medical records or other documentation not directly related to the member, to support claims you submit. If documentation is not provided following the request or notification, or if documentation does not support the services billed for the episode of care, we may:

- Deny the claim.
- Recover and/or recoup monies previously paid on the claim.

Section 1833(e) of the *Social Security Act* states that Medicare payment can be made only when the documentation supports the service/item. Wellpoint is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

6.4 Patient Visit Data Records Standards

You must provide:

- A history and physical exam with both subjective and objective data for presenting complaints.
- Behavioral health treatment, including at-risk factors:
  - Danger to self/others
  - Ability to care for self
  - Affect
  - Perpetual disorders
  - Cognitive functioning

  - Significant social health
- Admission or initial assessment must include:
  - Current support systems.
  - Lack of support systems.
- Behavioral health treatment — documented assessment at each visit for client status and symptoms, indicating:
  - Decreased
  - Increased
  - Unchanged
  - A plan of treatment, including:
    - Activities.
    - Therapies.
    - Goals to be carried out.
    - Diagnostic tests.
    - Evidence of family involvement in therapy sessions and/or treatment.
    - Medications and change in medications
- Follow-up care encounter forms or notes indicating follow-up care, call, or visit in weeks, months, or PRN.
- Referrals and results of all other aspects of patient care and ancillary services.

We systematically review medical records to ensure compliance and institute actions for improvement when our standards are not met.

We maintain a professional recordkeeping system for services to our members. We make all medical management information available to health professionals and state agencies, and retain these records for 10 years from the date of service.

6.5 Medical Record Review

Federal regulations require Medicare MCOs and their agents review medical records in an effort to avoid over or under payment and verify medical record documentation support for diagnostic conditions. Additionally, the vice president or local health plan leadership for quality management and the Quality Management Committee conduct medical record audits periodically and use the results in the provider recredentialing process.
Wellpoint may contract with a third-party vendor to acquire medical records or conduct onsite reviews. Under *45 CFR § 164.502* (*HIPAA* implementation), providers are permitted to disclose requested data for the purpose of healthcare operations after they have obtained the **general consent** of the member. A general consent form should be an integral part of your medical record file.

6.6 CMS Medicare Risk Adjustment Data Validation Audits

As part of the risk adjustment process, CMS performs two different types of validation audits: Contract-Specific RADV and Part C Improper Payment Measure (IPM) Audits. Both audits are used to validate the MA members' diagnosis data that was previously submitted by Medicare Advantage Organizations. These audits are typically performed once a year. If the Medicare Advantage Organization is selected by CMS to participate in a Contract-Specific RADV and/or Part C IPM Audit, the Medicare Advantage Organization and the providers that treated the MA members included in the audit will be required to submit medical records for the diagnosis codes included in the audit sample. The medical records will be used by CMS to

assess if the diagnosis data is supported by the medical record, an important CMS requirement. More information related to risk adjustment can be found at **cms.gov**.

6.7 Other Risk Adjustment Documentation Reviews and Audits

Providers may be required to submit medical records to Wellpoint for purposes of provider documentation and coding reviews and/or audits. Wellpoint may also engage with providers regarding education and/or remediation to support submission of diagnosis code data that is truthful, accurate, and complete based on best knowledge, information, and belief. Based on the outcome of such documentation and coding reviews and/or audits, providers will be asked and are expected to participate in education and/or remediation.

6.8 Medicare Risk Adjustment Provider Education

Wellpoint maintains a library of provider education and training regarding, for example, condition-specific information Medicare Risk Adjustment (MRA) basics, MRA-related obligations, and medical record documentation and diagnosis coding guidance. Providers are encouraged to explore the **Wellpoint Provider site** and access available trainings. Providers should make their best effort to participate in live (in-person or virtual) and/or on-demand training and education opportunities when offered.

6.9 ICD-10-CM Codes

CMS requires that ICD-10-CM Codes (ICD-10 Codes) be used to report conditions. In all cases, the provider should fully document all conditions, including those that coexist, at the time of the encounter to the highest level of specificity. These should be coded using current coding guidelines to the highest level of specificity supported by the medical documentation.

6.10 Clinical Practice Guidelines

Using nationally recognized standards of care, Wellpoint works with providers to develop clinical policies and guidelines for the care of its membership. The Medical Advisory Committee (MAC) oversees and directs Wellpoint in formulating, adopting, and monitoring guidelines.
Wellpoint selects at least four evidence-based *Clinical Practice Guidelines* (*CPGs*) relevant to the Medicare member population. The guidelines are reviewed and revised by the Wellpoint Quality Improvement Council at least every two years or whenever the guidelines change. The Wellpoint *CPGs* are located online at **provider.wellpoint.com/**. To access the *CPGs*, log in to the secure site with your username and password and select the **Clinical Practice Guidelines** link from the *Clinical Policy and Guidelines* section on the top navigation menu. A copy of the guidelines can be printed from the website.

6.11 Advance directives

Advance directives are written instructions that:

- Give direction to healthcare providers as to the provision of healthcare.
- Provide for treatment choices when a person is incapacitated.
- Are recognized under state law when signed by a competent person.

There are three types of *Advance Directives:*

- A *Durable Power of Attorney* for healthcare (durable power) allows the member to name a patient advocate to act on behalf of the member

- A *Living Will* allows the member to state their wishes in writing, but does not name a patient advocate
- A declaration for mental health treatment gives instructions about a member's future mental health treatment if the member becomes unable to make those decisions. The instructions state whether the member agrees or refuses to have the treatments described in the declaration, with or without conditions and limitations

Wellpoint advance directive policies include:

- Respecting the rights of the member to control decisions relating to their own medical care, including the decision to have provided, withheld, or withdrawn the medical or surgical means or procedures calculated to prolong their life; this right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession
- Adhering to the *Patient Self-Determination Act* and maintaining written policies and procedures regarding advance directives; providers must adhere to this act and to all state and federal standards as specified in SSA 1902(a)(57), 1903(m)(1)(A), 42 CFR §422.128, and 42 CFR 489 subpart I
- Advising members of their right to self-determination regarding advance directives
- Encouraging members to request an advance directive form and education from their PCP at their first appointment
- Assisting members with questions about an advance directive; no Wellpoint employee may serve as witness to an advance directive or as a member's authorized agent or representative
- While members have the right to formulate an advance directive, a Wellpoint associate, a facility, or a provider may conscientiously object to an advance directive within certain limited circumstances if allowed by state law
- Having Member Services, Health Promotion, Provider Relations and/or Health Care Management Services staff review and update advance directive notices and education materials for members on a regular basis
- Member materials will contain information, as applicable, regarding provisions for conscience objection. Materials explain the differences between institution-wide objections based on conscience and those that may be raised by individual physicians

Wellpoint or the practitioner must issue a clear and precise written statement of this limitation to CMS and request a conscience protection waiver. The conscientious objection will be stated clearly and describes the following:

- Describes the range of medical conditions or procedures affected by the conscience objection
- Identifies the state legal authority permitting such objection
- Noting the presence of advance directives in the medical records when conducting medical chart audits

Providers must:

- Comply with the *Patient Self-Determination Act* requirements.
- Make sure the first point of contact in the PCP's office asks the member if they have executed an advance directive.
- Document in the member's medical record their response to an offer to execute any advance directive in a prominent place, including a do-not-resuscitate directive or the provider and member's discussion and action regarding the execution or nonexecution of an advance directive.

- Ask members who have executed an advance directive to bring a copy of the advance directive(s) to the PCP/provider at the first point of contact.
- Make an advance directive part of the member's medical record and put in a prominent place.
- The physician discusses potential medical emergencies with the member and/or family/significant other and with the referring physician, if applicable.
- If an advance directive has not been executed, the first point of contact at the PCP/provider's office will ask the member if they would like advance directive information. If the member desires further information, member advance directive education will be provided
- Not discriminate or retaliate against a member based on whether they have executed an advance directive.

The requirements for advance directives, to include psychiatric advance directives, vary from state to state. Specific forms that meet compliance with each state can be found on the state's official website. Psychiatric advance directive information may be found at **nrc-pad.org**.

7 CREDENTIALING

WELLPOINT'S DISCRETION

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

Credentialing Scope

Credentialing requirements apply to the following:

1. Practitioners who are licensed, certified, or registered by the state to practice independently (without direction or supervision);
2. Practitioners who have an independent relationship with Wellpoint

   An independent relationship exists when Wellpoint directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as primary care practitioners; and
3. Practitioners who provide care to Members under Wellpoint's medical benefits.

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

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

Wellpoint credentials the following licensed/state certified independent health care practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors

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

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

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

Wellpoint credentials the following Health Delivery Organizations (HDOs):

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

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

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)

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

CREDENTIALS COMMITTEE

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

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

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

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

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Wellpoint's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of their right to correct erroneous information or provide additional details regarding the issue, and will include the process for submission of this additional information. Depending on the nature of the issue, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's or HDO's credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Upon request, the practitioner or HDO will be provided with the status of their credentialing or re-credentialing application.

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

NONDISCRIMINATION POLICY

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

INITIAL CREDENTIALING

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

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

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

A. Practitioners

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

B. HDOs

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

RE-CREDENTIALING

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

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

HEALTH DELIVERY ORGANIZATIONS

New HDO applicants will submit a standardized application to Wellpoint for review. If the candidate meets Wellpoint screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail below, in the "Wellpoint Credentialing Program Standards" section, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Wellpoint may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

ONGOING SANCTION MONITORING

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

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

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

APPEALS PROCESS

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

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

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation, or revocation, if a practitioner or HDO has been sanctioned, debarred, or excluded from the

Medicare, Medicaid or FEHB programs, has a criminal conviction, or Wellpoint's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment, or exclusion from the Medicare, Medicaid, or FEHB are not eligible for informal review/reconsideration or formal appeal.

REPORTING REQUIREMENTS

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

WELLPOINT CREDENTIALING PROGRAM STANDARDS

Eligibility Criteria

A. Health care practitioners:

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

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

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

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

    a. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training, and certification requirement:
        i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they

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

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

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

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

5. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (DNV NIAHO), Center for Improvement in Healthcare Quality (CIHQ), an Accreditation Commission for Health Care (ACHC) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may, at its discretion, deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

6. For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

7. For Registered Dieticians (RD), the applicant must have completed a bachelor's degree at a US regionally accredited university or college and coursework accredited or approved by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics. Completion of an ACEND accredited supervised practice program at a healthcare facility, community agency, or a food services corporation, or combined with undergraduate or graduate studies. Typically, a practice program will run six (6) to twelve (12) months in length. Must have passed a national examination administered by the Commission on Dietetic Registration (CDR).

<u>Criteria for Selecting Practitioners</u>

New Applicants (Credentialing):

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
4. No evidence of potential material omission(s) on application.
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members.
6. No current license action.
7. No history of licensing board action in any state.

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

    Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Wellpoint's Members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration, the credentialing process may proceed if all the following criteria are met:
    a. It can be verified that the applicant's application is pending; and
    b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
    c. The applicant agrees to notify Wellpoint upon receipt of the required DEA registration; and
    d. Wellpoint will verify the appropriate DEA/CDS registration via standard sources; and
    e. The applicant agrees that failure to provide the appropriate DEA registration within a 90-day timeframe will result in termination from the network.

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

11. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for Practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating Practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.
12. No history of or current use of illegal drugs or history of or current substance use disorder.
13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
14. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the

Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.

15. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that, together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
16. A minimum of the past 10 years of malpractice claims history is reviewed.
17. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Wellpoint's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs, and board certification criteria for DPMs, and oral and maxillofacial surgeons;
18. No involuntary terminations from an HMO or PPO.
19. No "yes" answers to attestation/disclosure questions on the application form, with the exception of the following:
    a. Investment or business interest in ancillary services, equipment, or supplies;
    b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. Voluntary surrender of state license related to relocation or nonuse of said license;
    d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post-residency training window.
    g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    h. History of a licensing board, hospital, or other professional entity investigation that was closed without any action or sanction.

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

Participation Criteria and Exceptions for Non-Physician Credentialing.

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

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

2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC), or other master level license type based on state licensing regulations:
    a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family, and child counseling, or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
    b. Master or doctoral degrees in divinity, masters in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
    c. Practitioners with PhD training as a clinical psychologist can be reviewed.

d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
e. Licensure to practice independently or in states without licensure or certification:
    i. Marriage & Family Therapists with a master's degree or higher:
        a. Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).
    ii. Mental Health Counselors with a master's degree or higher:
        a. Provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) (proof of NBCC certification required) or meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).

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

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

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

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

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

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

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

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

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

      This certification must be active. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.
   f. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee, or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
   g. The CNM applicant will undergo the standard credentialing process outlined in Wellpoint's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies, including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the Network.

10. Process, Requirements, and Verifications – Physician's Assistants (PA):
   a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners, with the exception of differing information regarding education/training and board certification.
   b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency, provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.

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

11. Process, Requirements, and Verifications – Acupuncturists (non MD/DO):
a. The provider applicant will submit the appropriate application and supporting documents as required of any other Practitioners, with the exception of differing information regarding education/training and board certification.
b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as an Acupuncturist, and all Acupuncturists applicants must have a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM).
c. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
d. The license status must be that of an Acupuncturist as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted, and not subject to probation, terms, or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
e. The provider applicant will undergo the standard credentialing process outlined in Wellpoint's Credentialing Policies. Acupuncturists are subject to all the requirements described in these Credentialing Policies, including (but not limited to): Committee review of Level II files failing to meet predetermined criteria, recredentialing every three (3) years, and continuous sanction and performance monitoring upon participation in the network.

Currently Participating Applicants (Re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;

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

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

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

B. HDO Eligibility Criteria

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

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

2. Additional Participation Criteria for HDO by Provider Type:

HDO TYPE AND WELLPOINT APPROVED ACCREDITING AGENT(S)

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, TCT, DNV NIAHO, ACHC, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, ACHC, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, DNV NIAHO, TJC, TCT
Home Infusion Therapy (HIT)	ACHC, CHAP, TCT, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC
Durable Medical Equipment Suppliers	TJC, CHAP, TCT, ACHC, BOC, HQAA

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	DNV NIAHO, ACHC, TJC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, ACHC

Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Use Disorder	ACHC, CARF, COA, DNV NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, ACHC, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Use Disorder	CARF, DNV NIAHO, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Use Disorder	CARF, COA, DNV NIAHO, ACHC, TJC

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

8 PERFORMANCE AND TERMINATION

8.1 Performance Standards and Compliance

All providers must meet specific performance standards and compliance obligations. When evaluating a provider's performance and compliance, Wellpoint reviews a number of clinical and administrative practice dimensions, including:

- Quality of care — measured by clinical data related to the appropriateness of care and outcomes
- Efficiency of care — measured by clinical and financial data related to healthcare costs
- Member satisfaction — measured by the members' reports regarding accessibility, quality of healthcare, member/provider relations, and the comfort of the office setting
- Administrative requirements — measured by the provider's methods and systems for keeping records and transmitting information
- Participation in clinical standards — measured by the provider's involvement with panels used to monitor quality of care standards

Providers must:

- Comply with all applicable laws and licensing requirements.
- Furnish covered services in a manner consistent with professionally recognized standards of medical and surgical practice generally accepted in the professional community at the time of treatment
- Comply with Wellpoint standards, including:
- Guidelines established by the Centers for Disease Control and Prevention (or any successor entity).
- Federal, state, and local laws regarding professional conduct.
- Comply with Wellpoint policies and procedures regarding the following:
  - Participating on committees and clinical task forces to improve the quality and cost of care
  - Prenotification and/or prior authorization requirements and time frames
  - Provider credentialing requirements
  - Referral policies
  - Case Management Program referrals
  - Appropriately releasing inpatient and outpatient utilization and outcomes information
  - Providing accessibility of member medical record information to fulfill Wellpoint business and clinical needs
  - Cooperating with efforts to assure appropriate levels of care
  - Maintaining a collegial and professional relationship with Wellpoint personnel and fellow providers
  - Providing equal access and treatment to all Medicare members

The following types of noncompliance issues are key areas of concern:

- Unnecessary out-of-network referrals and utilization (which require prior authorization)
- Failure to provide advance notice of admissions or prior authorization of discharges from inpatient facilities, comprehensive outpatient rehabilitation facilities, or home health care services
- Member complaints and grievances filed against the provider
- Underutilization, overutilization, or inappropriate referrals

- Inappropriate billing practices, such as balance billing of Medicare members for monies that are not their responsibility
- Nonsupportive actions and/or attitude

Provider noncompliance is tracked on a calendar year basis. Corrective actions are taken as appropriate.

8.2 Physician — Patient Communications

Providers acting within the lawful scope of practice are encouraged to advise Wellpoint members of the following:

- Health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options
- Risks, benefits, and consequences of treatment or nontreatment
- Opportunity for the individual to refuse treatment and to express preferences about future treatment decisions

Physician and patient communications are a necessary component of standard medical practice. Although coverage under this program is determined by Wellpoint, the provider remains responsible for all treatment decisions related to the Medicare Advantage offered by Wellpoint plan member.

8.3 Provider Participation Decisions: Appeal Process

For providers participating in our network, upon a denial, suspension, termination, or nonrenewal of a physician's participation in the provider network, Wellpoint acts as follows:

- The affected physician is given a written notice of the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by Wellpoint
- The physician is allowed to appeal the action to a hearing panel
- The physician is provided written notice of the right to a hearing and the process and timing for requesting a hearing
- Wellpoint ensures the majority of the hearing panel members are peers of the affected physician
- Wellpoint notifies the NPDB, the appropriate state licensing agency, and any other applicable licensing or disciplinary body to the extent required by law, if a suspension or termination is the result of quality of care deficiencies
- Subcontracted physician groups must ensure these procedures apply equally to physicians within those subcontracted groups.

Wellpoint decisions subject to an appeal include decisions regarding reduction, suspension or termination of a provider's participation resulting from quality deficiencies. Wellpoint notifies the NPDB, the appropriate state licensing agency and any other applicable licensing or disciplinary body to the extent required by law. Written communication to the provider details the deficiencies and informs them of the right to appeal.

8.4 Notification to Members of Provider Termination

Wellpoint will notify members according to CMS guidelines, generally 45 calendar days before the termination date for PCPs and behavioral health providers and 30 calendar days before termination date for other providers. Wellpoint may provide member notification in less than 30 days' notice as a result of a provider's death or exclusion from the federal health programs.

When a termination involves a PCP, all members who are patients of that PCP are notified of the termination.

9 QUALITY MANAGEMENT

Wellpoint maintains a comprehensive Quality Management (QM) program to objectively and systematically monitor and evaluate care and service provided to members. The scope and content of the program reflects the demographic, epidemiologic, medical, and behavioral health needs of the population served. Key components of the program include, but are not limited to:

- Quality of member care and service
- Accessibility and availability of services
- Member safety and prevention
- Continuity and coordination of care
- Appropriateness of service utilization
- Cultural competency
- Member outcomes
- Member and provider satisfaction
- Regulatory and accreditation standards

Members and providers have opportunities to participate in quality management and make recommendations for areas of improvement through complaints, grievances, appeals, satisfaction or other surveys, committee participation where applicable, quality initiatives/projects, and calls to the health plans. QM program goals and outcomes are available to providers and members upon request.
Quality activities are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program.
The Wellpoint QM program tracks and trends quality of care issues and service concerns identified for all care settings. QM staff review member complaints/grievances, reported adverse events, and other information to evaluate the quality of service and care provided to our members. Practitioners and providers must allow Wellpoint to use performance data in cooperation with our quality improvement program and activities.

9.1 CMS Star Ratings

The Centers for Medicare & Medicaid Services (CMS) evaluates all Medicare Advantage (MA) and Prescription Drug (MA-PD) plans using a star rating system. The CMS Five-Star Quality Rating System provides helpful information to consumers, families, and caregivers for comparing MA-PD plans based on a one-to-five rating:

* * * * * equals excellent
* * * * equals very good
* * * equals good
* * equals fair
* equals poor

Many of the measures included in the CMS rating system are measures of preventive care and routine disease management. Some of these are listed below and are subject to change:

- Staying healthy — screening, tests, and vaccines:
- Breast cancer screening
- Colorectal cancer screening
- Annual flu vaccine
- Improving and maintaining physical and mental health
- Monitoring physical activity

- Managing chronic conditions:
  - SNP Care Management
  - Care for the older adult: medication review, functional status assessment, and pain screening
  - Managing osteoporosis in women who had a fracture
  - Obtaining diabetes care for eye exams, kidney disease monitoring, and blood sugar and cholesterol control
  - Controlling blood pressure
  - Improving bladder control
  - Reducing the risk of falling
  - Plan all-cause readmissions
  - Medication adherence and management (oral diabetics, hypertension, and cholesterol medications)

With the growing focus on quality healthcare and plan member satisfaction, CMS assesses MA plan performance. The CMS assessment results in a star rating assigned to each plan. One of the assessment tools used is the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. Medicare beneficiaries who receive healthcare services through a MA-PD plan receive CAHPS surveys through the mail in late February.

The survey asks the Medicare beneficiary to assess their health and the care received from their primary care providers and specialists over the past six months. The survey includes questions regarding providers' communication skills and the member's perception about their access to needed healthcare services. Several questions directly correlate to a plan's CMS star rating. The survey questions ask the member to report their opinion about access to care and the health plan's customer service. It also asks the member to rate the communication received from their providers.

A second assessment tool used by CMS is the Health Outcomes Survey (HOS) to evaluate all managed care organizations with a MA contract. CMS randomly samples Medicare beneficiaries from each participating MA plan. Two years after the initial HOS survey, the same Medicare beneficiaries are surveyed again. The results are part of the effectiveness of care component of the HEDIS rates for the MA plan.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). The rating system empowers consumers, families, and caregivers with information to compare MA-PD plans. The measures of the rating system include preventive care and routine disease management. This information gives consumers, families, and caregivers results to make an educated decision about their healthcare needs. The ratings are posted online and may be accessed at **medicare.gov**. Please note there are separate ratings for Part C (medical) and Part D (prescription drug) services.

Wellpoint encourages participating providers to help improve member satisfaction by:

- Ensuring members receive appointments within acceptable time frames as outlined in the Access and Availability Standards Table in this manual.
- Educating members and talking to them during each visit about their preventive healthcare needs and disease management goals.
- Ensuring providers answer any questions members have regarding newly prescribed medications.
- Ensuring members know to bring all medications and medical histories to their specialists and knows the purpose of a specialist referral.

- Allowing time during the appointment to validate members' understanding of their health conditions and the services required for maintaining a healthy lifestyle.
- Referring members to the Member Services department at the DSU and speaking to a case manager.

9.2 Committee Structure

Wellpoint maintains a comprehensive quality management committee structure as noted below, with program oversight by the board of directors.

9.3 Quality Improvement Council

The purpose of the Corporate Quality Improvement Council is to provide leadership and oversight of the corporate and health plan quality management programs, improve safety, quality of care and services, improve customer service, and improve operating efficiencies. Responsibilities include:

- Review and approval of the program descriptions
- Work plans and annual evaluations for quality management, utilization management, health promotion, credentialing, case management, pharmacy, and disease management
- Review and approval reporting of complaints, appeals, and *Service Level Agreements* (*SLAs*)
- Review of regular standardized reports (at least semi-annually) delineating progress towards goals of the program, actions taken, improvements made, focused study results, and follow-up actions on identified opportunities
- Evaluation of resource adequacy to ensure effective implementation of the programs and ongoing effectiveness
- Recommending policy decisions
- Instituting needed actions and ensure completion
- Ensuring practitioner participation

9.4 Quality Management Committee

The purpose of the health plan Quality Management Committee (QMC) is to maintain quality as a cornerstone of Wellpoint culture and to be an instrument of change through demonstrable improvement in care and service.
The QMC's responsibilities are to:

- Establish strategic direction and monitor and support implementation of the Quality Management Program.
- Establish processes and structure that ensure National Committee for Quality Assurance (NCQA) compliance.
- Review planning, implementation, measurement, and outcomes of clinical/service quality improvement initiatives/projects.
- Coordinate communication of quality management activities throughout the health plans.
- Review HEDIS data and action plans for improvement.
- Review and approve the annual Quality Management Program description.
- Review and approve the annual work plans for each service delivery area.
- Provide oversight and review of delegated services.
- Provide oversight and review of subordinate committees.

- Receive and review reports of utilization review decisions and take action when appropriate.
- Analyze member and provider satisfaction survey responses.
- Monitor the plan's operational indicators through the plan's senior staff.

9.5 Medical Advisory Committee

The health plan Medical Advisory Committee (MAC) has multiple purposes. The MAC assesses levels and quality of care provided to members and recommends, evaluates, and monitors standards of care. The MAC identifies opportunities to improve services and clinical performance by establishing, reviewing, and updating *Clinical Practice Guidelines* based on review of demographic and epidemiologic information to target high-volume, high-risk, and problem-prone conditions. The MAC oversees the peer review process that provides a systematic approach for the monitoring of quality and the appropriateness of care. The MAC advises the health plan administration in any aspect of the health plan policy or operation affecting network providers or members. The MAC approves and provides oversight of the peer review process, the QM Program, and the Utilization Review Program. It oversees and makes recommendations regarding health promotion activities.
The MAC's responsibilities are to:

- Utilize an ongoing peer review system to monitor practice patterns to identify appropriateness of care and to improve risk prevention activities.
- Approve clinical protocols/guidelines that help ensure the delivery of quality care and appropriate resource utilization.
- Review clinical study design and results.
- Develop action plans/recommendations regarding clinical quality improvement studies.
- Oversee member access to care.
- Review and provide feedback regarding new technologies.
- Approve recommendations from subordinate committees.

9.6 Credentialing Committee

The health plan Credentialing Committee (CC) has been delegated authority of the credentialing program by the health plan Quality Management Committee and the National Credentials Committee. It is responsible for the oversight of the credentialing program, decisions regarding the credentialing and recredentialing of the practitioners and providers contracted with the health plan, and oversight of organizations for which credentialing has been delegated
The CC's responsibilities are to:

- Consider/act in response to provider sanctions.
- Approve credentialing/recredentialing policies and procedures.
- Review practitioner and provider credentialing and recredentialing applicants for participation in Wellpoint provider networks.
- Provide pre-delegation, ongoing oversight, and annual review of delegated entities.
- Approve/deny participation at initial credentialing based on credentials meeting or not meeting standards for participation.
- Approve/term continuing participation at recredentialing based on credentials meeting/not meeting standards for participation.

10 HEALTH CARE MANAGEMENT SERVICES

Wellpoint continuously seeks to improve the quality of care provided to its members. We encourage and expect our providers to participate in health promotion and disease prevention programs. Providers are encouraged to collaborate with Wellpoint in efforts to promote Healthy Lifestyles through member education and information sharing.
Providers must fully comply with:

- Healthcare management services, policies, and procedures.
- Quality improvement and other performance improvement programs.
- All regulatory requirements.

The healthcare delivery system is a gatekeeper model that supports the role and relationship of the PCP. The model includes direct contracts with PCPs, hospitals, specialty physicians, and other providers as required to deliver Medicare benefits, additional benefits, and Wellpoint programs for members with complex medical needs. All contracted providers are available to Medicare members by PCP or self-referral for the services identified below. There are no sub networks that limit the choice of specialist referrals based on selection of PCP.
The gatekeeper model requires all members to select a PCP upon joining the plan. Members who do not choose a PCP are assigned one. Wellpoint works with the member, the physician, and the member's representative, as appropriate, to ensure the PCP is suitable to meet the member's special needs. Members must have access to their PCP or a covering physician 24 hours a day, 7 days a week.

10.1 Self-Referral Guidelines

Medicare members may self-refer for the following services:

- Screening mammograms
- Behavioral health
- Influenza and pneumococcal vaccinations
- All preventive services (for example, routine physical examinations, prostate screening, and preventive women's health services, such as Pap tests)

Except for emergent or out-of-area urgent care and dialysis services, in general, Medicare members must obtain services within the Wellpoint network or obtain a prior authorization for covered services outside the network. As a contracted provider with the plan, you are responsible for either referring within the network or obtaining prior authorization from the plan.

10.2 Referral Guidelines

PCPs may only refer members to Wellpoint contracted network specialists to ensure the specialist receives appropriate clinical background data and is aware of the member's ongoing primary care relationship. If a member does not have out-of-network benefits, such as an HMO member, and has expressed a desire to receive care from a different specialist, or you believe the required specialty is not available within the contracted network, contact Provider Services at **866-805-4589**. Provider must obtain prior authorization from Wellpoint before referring members to nonplan providers. Referring a Medicare member out-of-network will result in the claim being denied with member liability unless urgent, emergent, out-of-area renal dialysis, or if prior authorization was obtained from the plan.
Providing Noncovered Services Advanced Notification
For services that require prior authorization or are non-covered by the plan (in other words, statutory exclusion), it becomes extremely important that Wellpoint authorization procedures are followed. If a member elects to receive such care, the member cannot be held financially responsible unless notified in advance of the non-covered services. In such cases when the

network physician fails to follow Wellpoint authorization protocols, Wellpoint may decline to pay the claim, in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.
CMS-issued guidance concerning Advance Notices of Noncoverage. The ABN is an FFS document and cannot be used for Medicare Advantage denials or notifications. Per the **Medicare Claims Processing Manual** from **CMS** (page 4), the ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). CMS advised Medicare Advantage plans that contracted providers are required to provide a coverage determination for services that are not covered by the member's Medicare Advantage plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. If there is any doubt about whether a service is not covered, please seek a coverage determination from the plan.

10.3 Prior Authorization

Certain services/procedures require prior authorization from Wellpoint for participating and nonparticipating PCPs and specialists. Please refer to the list below, or the Precertification Lookup tool online, or call Provider Services at **866-805-4589** for more information. You can also access information concerning prior authorization requirements on our website at **provider.wellpoint.com/.**
CMS defines an expedited/urgent request as 'a request in which waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.' Contracted providers should submit requests in accordance with CMS guidelines to allow for organization determinations within the standard turnaround time, unless the member urgently needs care based on the CMS definition of an expedited/urgent request.
The following are examples of services requiring prior authorization before providing the following non-emergent or urgent care services:

- Behavioral health partial hospitalization
- Skilled Nursing Facility (SNF)
- Home healthcare
- Diagnostic tests, including but not limited to MRI, MRA, PET scans, etc.
- Hospital or ambulatory care center-based outpatient surgeries for certain procedures
- Elective inpatient admissions
- Transplant evaluation and services
- Referrals and services from noncontracted providers
- Durable Medical Equipment (DME)*
- Outpatient IV infusion or injectable medications
- Prosthetics
- Certain reconstructive procedures
- Occupational, speech, and physical therapy services
- Referrals outside of the Wellpoint network
- Requests for non-covered services under the Medicare program

For services that require prior authorization or are non-covered by the plan (in other words, statutory exclusion), it becomes extremely important that all authorization procedures are followed. If a member elects to receive such care, the member cannot be held financially responsible unless notified in advance of the non-covered services. In such cases when the network physician fails to follow authorization protocols, Wellpoint may decline to pay the

claim, in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases. A written coverage determination will help ensure that a claim for non-covered care from a contracted provider is paid accurately. According to CMS, if the appropriate written notice of denial of coverage is not given to the Medicare Advantage member regarding a non-covered service, the claim may be denied, and the member cannot be held financially responsible. Therefore, your failure to obtain an appropriate coverage determination could result in a denial of payment for the non-covered service.
Contact us prior to services being rendered to comply with this requirement, ensure appropriate claims payment, and allow you to bill the Medicare member in the event of noncoverage. As a contracted provider with us, you are prevented from billing the Medicare member for any service that is deemed non-covered if you have not ensured this advanced notification has been issued.

10.4 Medically Necessary Services and Medical Criteria

Multiple clinical and coverage determination guidelines are used to review the appropriateness of a service that has been rendered or requested to determine the care is reasonable and necessary for the diagnosis or treatment of illness or injury, provided in the most appropriate level of care, and is not furnished for the convenience of the member or provider. The clinical guidelines used may include any of the following based on the type of request: CMS, National and Local Coverage and Benefit Guidelines, current editions of InterQual® Level of Care, MCG Guidelines (formerly Milliman Care Guidelines®), Wellpoint *Medical Policies* and *Clinical Utilization Management Guidelines* to review the medical necessity and appropriateness of physical health services, unless superseded by state requirements or regulatory guidance. Wellpoint *Behavioral Health Medical Necessity Criteria* are used for all behavioral health services, unless superseded by state or federal requirements or regulatory guidance. The *Medical Policies* and *Clinical Utilization Management* Guidelines are developed by the Wellpoint Medical Policy and Technology Assessment Committee (MPTAC). Criteria for review of behavioral health issues are reviewed by the National Behavioral Health Clinical Advisory Committee, a subcommittee of MPTAC. In addition to policies developed and or approved through MPTAC, the health plan's medical reviewers use criteria developed by Carelon Medical Benefits Management, Inc. for review of selected requests in some markets.

Wellpoint may collaborate with vendors to conduct medical necessity reviews for physical therapy, occupational therapy, and spine and back pain management and/or other services for our Medicare Advantage members.

These criteria and guidelines are objective and provide a rules-based system for screening proposed medical and behavioral healthcare based on patient-specific, best medical care processes and consistently match medical services to patient needs, based upon clinical appropriateness.

The criteria's comprehensive range of level-of-care alternatives is sensitive to the differing needs of adults, adolescents, and children. When using the criteria to match a level of care to the member's current condition, all reviewers consider the severity of illness and comorbidities, as well as episode-specific variables. Their goal is to view members in a holistic manner to ensure they receive necessary support services within a safe environment optimal for recovery.

Criteria and guidelines are reviewed and approved annually by members of the Medical Policy and Technology Assessment Committee and updated when appropriate. Input from the medical community is solicited and used in developing and updating policies. Policies and

procedures for application of medically necessary criteria are reviewed and approved annually by the Medical Operations Committee.

Getting the best care in the most appropriate setting is key to achieving the best outcomes for our Wellpoint members. These members rely on their healthcare professionals and their health plan to help coordinate this important aspect of their care. To do this, timely communication is essential.

Ensuring that you provide the correct and complete clinical information at the correct time when requesting a medically necessary review, when clinical information is needed.
If the information provided does not support medical necessity, the service cannot be approved under Medicare law. Please provide the necessary information to justify the services you are requesting at the time of the request to allow for an appropriate decision to be made. Any service determined to require a clinical review will be processed in accordance with:

- Section 1861(a)(1)(A) of the *Social Security Act*, which states that Medicare payment can only be made for services/items that are medically necessary and reasonable.
- Section 1833(e) of the *Social Security Act*, which states that Medicare payment can be made only when the documentation supports the service/item.

UM criteria are made available to practitioners upon request UM criteria are made available upon request or by going to **https://www.wellpoint.com/provider** and selecting the appropriate state, then selecting Medical Policies and UM Guidelines under the *Resources* tab.. If a medical necessity decision results in an adverse determination, practitioners are welcome to discuss the denial decision with a Medical Director. For additional information, to speak to a Medical Director, obtain UM criteria, or for any inquiries, contact may be made via the Customer Services Department by calling the number on the members' identification card.

11 HOSPITAL AND ELECTIVE ADMISSION MANAGEMENT

Wellpoint requires prior authorization of all inpatient elective admissions. The referring PCP or specialist physician is responsible for prior authorization. The referring physician identifies the need to schedule a hospital admission and must submit the request to the Wellpoint Health Care Management Services department.

Requests for prior authorization with all supporting documentation should be submitted immediately upon identifying the inpatient request or at least 72 hours prior to the scheduled admission. This will allow Wellpoint to verify benefits and process the prior authorization request. For services that require prior authorization, Wellpoint makes case-by-case determinations that consider an individual's healthcare needs and medical history, in conjunction with nationally recognized standards of care.

11.1 Availity Authorization Application

Availity is the preferred method for the submission of preauthorization requests, offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for members. Additionally, providers can use this tool to make inquiries on previously submitted requests regardless of how they were sent (phone, fax, or other online tool):

- Initiate preauthorization requests online, eliminating the need to call or fax. Availity allows detailed text, photo images, and attachments to be submitted along with your request.
- Make inquiries on previously submitted requests via phone, fax, or other online tool.
- Instant accessibility from almost anywhere, including after business hours.
- Use the dashboard to provide a complete view of all UM requests with real-time status updates, including email notifications if requested using a valid email address.
- Real-time results for some common procedures with immediate decisions.
- Access under *Authorizations and Referrals* via the Availity Essentials.

For an optimal experience with Availity, use a browser that supports 128-bit encryption. This includes Internet Explorer, Chrome, Firefox, or Safari.

Availity Authorization Application is not currently available for the following:

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

Our website will be updated as additional functionality and lines of business are added throughout the year. The hospital can confirm a prior authorization is on file using Availity or by calling Provider Services at the DSU at **866-805-4589** (see the Wellpoint website and the **Provider Inquiry Line section** of this manual for instructions on use of the Provider Inquiry Line). If coverage of an admission has not been approved, the facility should call Provider Services at the DSU at **866-805-4589**. Wellpoint will contact the referring physician directly to resolve the issue.

Wellpoint is available 24 hours a day, 7 days a week to accept prior authorization requests. When a request is received from the physician via telephone or fax for medical services, the care specialist will verify eligibility and benefits. This information will be forwarded to the prior authorization nurse.
The prior authorization nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic

procedures. When appropriate, the prior authorization nurse will assist the physician in identifying alternatives for healthcare delivery as supported by the medical director.
When the clinical information received is in accordance with the definition of medical necessity and in conjunction with nationally recognized standards of care, a Wellpoint reference number will be issued to the referring physician. All utilization guidelines must be supported by an individualized determination of medically necessary based on the member's needs and medical history.

If the prior authorization documentation is incomplete or inadequate, the prior authorization nurse will notify the referring provider to submit the additional necessary documentation.
If the Medical Director denies coverage of the request, the appropriate denial letter, including the appropriate appeal rights, will be mailed to the member and provider.
Member liability for inpatient admissions will be assigned only:

- When the denial is issued prior to the services being rendered.
- When the important message from Medicare is delivered in accordance with CMS guidelines.
- When inpatient services were rendered by a nonparticipating facility, were not precertified, and are not considered services covered under the plan.

Participating providers will be held liable for all other inpatient denials issued. Any subsequent appeals should follow the correct process as outlined in the denial letter.

11.2 Emergent Admission Notification Requirements

Wellpoint requires immediate notification by network hospitals of emergent admissions.
Network hospitals must notify Wellpoint of emergent admissions within one business day.
Health Care Management Services staff will verify eligibility and determine benefit coverage.
Coverage of emergent admissions is authorized based on review by continued stay review process by Wellpoint. When the clinical information received meets nationally recognized standards of care, a Wellpoint approval number will be issued to the hospital.
If the notification documentation provided is incomplete or inadequate, Wellpoint will not approve coverage of the request but will notify the hospital to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter will be mailed to the member and provider, including the appropriate appeal rights.

11.3 Nonemergent Outpatient and Ancillary Services — Prior Authorization and Notification Requirements

Wellpoint requires prior authorization for coverage of selected nonemergent outpatient and ancillary services. Requests for prior authorization with all supporting documentation should be submitted immediately upon identifying the need for the request.
To ensure timeliness of the decision, the following must be provided:

- Member name and ID number
- Name, telephone number, and fax number of physician performing the elective service
- Name of the facility and telephone number where the service is to be performed
- Date of service
- Member diagnosis
- Name of elective procedure to be performed with CPT code
- Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans, and medications)

11.4 Pre-service prior authorizations

Providers are required to provide notification in advance of services to allow Wellpoint to meet CMS processing timeframes:

- Medical:
  - Standard — 07 calendar days
  - Expedited — 72 hours
- Pharmacy (Including Part B Medical Injectables):
  - Standard — 72 Hours
  - Expedited — 24 Hours
- ER admissions:
  - Wellpoint requires notification within one business day for all ER admissions. CMS defines an expedited/urgent request as a request in which waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy. Contracted providers should submit requests in accordance with CMS guidelines to allow for organization determinations within the standard turnaround time, unless the member urgently needs care based on the CMS definition of an expedited/urgent request.

11.5 Inpatient Admission Reviews

Urgent and emergent admissions require notification within one business day of the admission by the provider. The Wellpoint utilization review clinician determines the member's medical status through communication with the hospital's Utilization Review department. Appropriateness of the stay is documented, and concurrent review is initiated. Cases may be referred to the Medical Director, who renders a decision regarding the coverage of hospitalization. Diagnoses meeting specific criteria are referred to the Medical Director for possible coordination by the care management program.

11.6 Affirmative Statement About Incentives

Wellpoint, as a corporation and as individuals involved in UM decisions, is governed by the following statements: UM decision-making is based only on the appropriateness of care and service and existence of coverage.

Wellpoint does not specifically reward practitioners or other individuals for issuing denials of coverage or care. Decisions about hiring, promoting, or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denials of benefits. Financial incentives for Wellpoint UM decision-makers do not encourage decisions that result in underutilization or create barriers to care or service.

11.7 Discharge Planning

Discharge planning is designed to assist the provider in the coordination of a member's discharge when acute care (hospitalization) is no longer necessary. The Wellpoint concurrent review nurse or case manager (working with the Wellpoint medical director) will assist providers and hospitals with the discharge planning process in accordance with requirements of the Medicare Advantage program. At the time of admission and during the hospitalization, the Wellpoint case manager will discuss discharge planning with the provider, member and/or member advocate.

When the provider identifies medically necessary and appropriate services for the member, Wellpoint will assist the provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care. Providers must notify Wellpoint of a

member's discharge and discharge disposition within one business day of the actual discharge date.

11.8 Hospital-Acquired Conditions

A Hospital-Acquired Condition (HAC) is a medical condition or complication that a patient develops
during a hospital stay, which was not present at admission. Examples of HAC include, but are not limited
to:

- A pattern of substandard care that is likely to result in future dangers to members.
- Failure to comply with accepted ethical and professional standards of behavior.
- An action that represents a clear and serious breach of accepted professional standards of care, such that the continued care of members by the provider could endanger their safety or health.
- Potential quality of care issues related to underutilization or overutilization.

Our Quality Management staff will review the identified or potential quality of care issue, request medical records, supporting documentation, and other information as appropriate, relevant to the case. The medical director will make a determination.

We review and analyze the quality of care issues quarterly for the health plan and identify opportunities for improving care and making recommendations for quality improvement actions. On an annual basis, we report quality of care issues to our corporate Quality Improvement Committee. The Credentialing department uses quality of care reports to evaluate practitioners during the recredentialing process. As appropriate and required, we will report incidents to federal, state, and contractual entities as required. Please contact your local Quality Management department when you identify potential incidents.

11.9 Confidentiality Statement

Members have the right to privacy and confidentiality regarding their healthcare records and information in accordance with the Medicare Advantage program and provisions of *HIPAA* concerning members' rights with respect to their protected health information and obligations of covered entities.

Utilization management, case management, disease management, discharge planning, quality management, and claims payment activities are designed to ensure patient-specific information, particularly protected health information obtained during review, is kept confidential in accordance with applicable laws, including *HIPAA*. Information is used for the purposes defined above and shared only with entities who have the authority to receive such information and only with those individuals who need access to such information in order to conduct utilization management and related processes.

Providers must comply with all state and federal laws concerning privacy, confidentiality, accuracy, and timely maintenance of health and other member information. Providers must have policies and procedures regarding use and disclosure of health information and comply with applicable laws.

11.10 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 whom a provider or facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax, or email. 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 redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, providers and facilities must contact Provider Services to report the receipt of misrouted PHI.

11.11 Emergency Services

Wellpoint provides a 24-hour-a-day, 7-day-a-week Nurse HelpLine service with clinical staff to provide triage advice and referral and, if necessary, to make arrangements for treatment of the member. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies.

Wellpoint does **not** discourage members from using the 911 emergency system nor deny access to emergency services. Emergency services are provided to members without requiring prior authorization. Any hospital or provider calling for prior authorization for emergency services will be granted one immediately upon request. Emergency services coverage includes services needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

An emergency medical condition is defined as a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: 1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; and/or 3) serious dysfunction of any bodily organ or part. \

Emergency response is coordinated with community services, including the police, fire, and Emergency Medical Services (EMS) departments, juvenile probation, the judicial system, child protective services, chemical dependency, emergency services, and local mental health authorities, if applicable.

When a member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine. The physician or other appropriate personnel will indicate in the member's chart the results of the emergency medical screening examination. Wellpoint will compensate the provider for the screening, evaluations, and examinations that are reasonable and calculated to assist the healthcare provider to determine whether or not the patient's condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (in other words, whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the member at the treating facility prevails and is binding on Wellpoint. If the emergency department is unable to stabilize and release the member, Wellpoint will assist in coordination of the inpatient admission regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care.

If the member is admitted, the Wellpoint concurrent review nurse will implement the concurrent review process to ensure coordination of care.

11.12 Post-stabilization Care Services

Post-stabilization care services are covered services related to an emergency condition provided after a patient is stabilized to maintain the stabilized condition or improve or resolve the patient's condition. Prior authorization is not required for emergency services in or out of the network. All emergency services are reimbursed at least at the Medicare network rate. Wellpoint will adjudicate emergency and SNF post-stabilization care services that are medically necessary until the emergency condition is stabilized and maintained.

11.13 Nonemergency Services

For routine, symptomatic, beneficiary-initiated outpatient appointments for primary preventive medical care, the request-to-appointment time must be no greater than 30 days, unless the member requests a later time. For routine, symptomatic, beneficiary-initiated outpatient appointments for nonurgent primary medical care, the request-to-appointment time must be no greater than four to six weeks, unless the member requests a later time. Primary medical, including dental care, and outpatient appointments for urgent conditions, must be available within 48 hours. For specialty outpatient referral and/or consultation appointments, the request-to-appointment time must be consistent with the clinical urgency but no greater than 21 days, unless the member requests a later time. For outpatient scheduled appointments, the time the member is seen must not be more than 45 minutes after the scheduled time, unless the member is late. For routine outpatient diagnostic laboratory, diagnostic imaging, and other testing appointments, the request-to-appointment time must be consistent with the clinical urgency but no greater than 14 days, unless the member requests a later time. For urgent outpatient diagnostic laboratory, diagnostic imaging, and other testing, appointment availability will be consistent with the clinical urgency, but no greater than 48 hours. The timing of scheduled follow-up outpatient visits with practitioners must be consistent with the clinical need.

11.14 Urgent Care

Wellpoint requests its members to contact their PCP in situations when urgent, unscheduled care is necessary. Prior authorization with Wellpoint is not required for a member to access an urgent care center.

12 MEMBER MANAGEMENT SUPPORT

12.1 Welcome Call

As part of our member management strategy, Wellpoint offers a welcome call to new members. During the welcome call, new members who have been identified through their health risk assessment as possibly needing additional services are educated regarding the health plan and available services. Additionally, Member Services representatives offer to assist members with any current needs, such as scheduling an initial checkup.

12.2 Appointment Scheduling

Wellpoint, through its participating providers, ensures members have access to primary care services for routine, urgent, and emergency services and to specialty care services for chronic and complex care. Providers will respond to a member's needs and requests in a timely manner. The PCP should make every effort to schedule members for appointments using the PCP Access and Availability guidelines.

12.3 Nurse HelpLine

The Wellpoint Nurse HelpLine is a service designed to support the provider by offering information and education about medical conditions, healthcare, and prevention to members after normal physician practice hours. The Nurse HelpLine provides triage services and helps direct members to appropriate levels of care. The Wellpoint Nurse HelpLine telephone number is **866-805-4589** and is listed on the member's ID card. This ensures members have an additional avenue of access to healthcare information when needed. Features of the Nurse HelpLine include:

- Availability 24 hours a day, 7 days a week for crisis and triage services
- Information based upon nationally recognized and accepted guidelines
- Free translation services for 150 different languages and for members with difficulty hearing
- Education for members about appropriate alternatives for handling nonemergent medical conditions
- Member assessment reports faxed to providers' offices within 24 hours of the call

12.4 Interpreter Services

Wellpoint provides our members with free interpreter services. Services are available 24 hours a day, 7 days a week, and include over 150 languages, as well as services for members who are deaf or hard of hearing. To arrange interpreter services for a member in your care, call Provider Services at the DSU at **866-805-4589**.

12.5 Health Promotion

Wellpoint strives to improve healthy behaviors, reduce illness, and improve the quality of life for our members through comprehensive programs. Educational materials are developed or purchased and disseminated to our members, and health education classes are coordinated with community organizations and network providers contracted with Wellpoint.
Wellpoint manages projects that offer our members education and information regarding their health. Ongoing projects include:

- Creation and distribution of the Wellpoint health education tool used to inform members of health promotion issues and topics.
- Health Tips on Hold (educational telephone messages while the member is on hold).
- Health education programs offered to members.

- Development of health education curricula and procurement of other health education tools (for example, breast self-exam cards).
- Relationship development with community-based organizations to enhance opportunities for members.

12.6 Member Rewards for Health Program*

Wellpoint encourages our members to participate in their healthcare for living healthier lives. Our program rewards members for receiving preventive healthcare services and gives them the option of receiving up to a total of $50 in gift cards per calendar year. When the member visits your office for one or more of the preventive services listed below, they will ask you to sign the Rewards for Health reply card. The member will mail the reply card and receive a gift card. The goal of the program is to increase early detection, decrease the cost of treatment, and improve members' quality of life.
The preventive health services eligible for the Member Rewards for Health Program include:

- Adult immunizations (for example, flu, hepatitis B, and pneumonia vaccinations)
- Annual wellness visit
- Cardiovascular disease screening
- Colorectal cancer screening
- Diabetes screening
- Glaucoma screening (every two years)
- Bone mass measurement
- Smoking cessation
- Mammography
- Prostate cancer screening

12.7 Case Management

The Case Management Solutions Program is a member-centric, integrated continuum of care model that strives to address the totality of each member's physical, behavioral, cognitive, functional, and social needs.
The scope of the Case Management Solutions Program includes, but is not limited to:

- Member identification using a prospective approach that is designed to focus case management resources for members expected to be at the highest risk for poor health outcomes
- Initial and ongoing assessment
- Problem-based, comprehensive care planning to include measurable goals and interventions tailored to the complexity level of the member as determined by initial and ongoing assessments
- Coordination of care with PCPs and specialty providers
- Member education
- Member empowerment using motivational interviewing techniques
- Facilitation of effective member and provider communications
- Program monitoring and evaluation using quantitative and qualitative analysis of data
- Satisfaction and quality of life measurement

Using a prospective systematic approach, members with a risk of poor health outcomes are identified and targeted for case management services. This continuous case finding system evaluates members of a given population based on disease factors and claims history with the goal of improving quality of life through proper utilization of necessary services and a reduction in the use of unnecessary services.

Case management member candidate lists are updated monthly and prioritized to identify members with the highest expected needs for service. Case management resources are focused on meeting listed members' needs by using a mix of standardized and individualized approaches.

A core feature of the Case Management Solutions Program is the emphasis on an integrated approach to meeting the needs of members. The program considers the whole person, including the full range of each member's physical, behavioral, cognitive, functional, and social needs. The role of the case manager is to engage members of identified risk populations and to follow them across healthcare settings, to collaborate with other healthcare team members to determine goals, and to provide access to resources and monitor utilization of resources. The case manager works with the member to identify specific needs and interfaces with the member's providers with the goal of facilitating access to quality, necessary, cost-effective care.

Using information gathered through the assessment process, including a review of the relevant evidence-based clinical guidelines, the case manager develops a goal-based care plan that includes identified interventions for each diagnosis, short- and long-term goals, interventions designed to assist the member in achieving these goals, and identification of barriers to meeting goals or complying with the care plan.

Assessment information, including feedback from members, family/caregivers, and in some cases providers, provides the basis for identification of problems. Areas identified during the assessment that may warrant intervention include, but are not limited to:

- Conditions that compromise member safety
- History of high service utilization
- Use of inappropriate services
- Current treatment plan has been ineffective
- Permanent or temporary loss of function
- High-cost illnesses or injuries
- Comorbid conditions
- Medical/psychological/functional complications
- Health education deficits
- Poor or inconsistent treatment/medication adherence
- Inadequate social support
- Lack of financial resources to meet health or other basic needs
- Identification of barriers or potential barriers to meeting goals or complying with the care plan

Preparation of the care plan includes an evaluation of the member's optimal care path, as well as the member's wishes, values, and degree of motivation to take responsibility for meeting each of the care plan goals. Wherever possible, the case manager encourages the member to suggest their own goals and interventions, as this may increase their investment in their successful completion.

Our case managers work closely with the member and providers to develop and implement the plan of care. As a provider, you may receive a call from the case manager, or a copy of the member's care plan may be sent to you.

If you have identified a patient as a possible candidate for case management and wish to have them evaluated to see if they qualify, you can call the referral for evaluation to 866-805-4589 or the number on the member's identification card and ask for someone in the Case

Management department. The case management department is available Monday through Friday from 8 a.m. to 5 p.m. EST.

12.8 Model of Care (Special Needs Plan)

Model of Care

We have a model of care program in place for members of our Special Needs Plans (SNPs). Our model of care program is comprised of, but not limited to, the following:

1. Evaluating our population and creating measurable goals designed to address the needs identified to improve care in the following areas:
    a. Improving access and affordability of the healthcare needs of the population and addressing issues of Social Determinants of Health (SDoH) of our members were applicable.
    b. Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the health risk assessment (HRA), Individualized Care Plan (ICP), and Interdisciplinary Care Team.
    c. Enhanced care transitions across all healthcare settings and providers
    d. Ensuring appropriate utilization of services for preventive health and chronic conditions.
    e. Goals specific to the population may be defined as part of our model of care.
2. Our staff structure and care management roles are designed to manage the special needs population. Each SNP member is assigned an interdisciplinary care team (ICT) comprised of the case manager/coordinator, the primary care physician and the member/caregiver. The ICT may adjust to add other participants as needed, including any of the following: nurses, physicians, social workers, pharmacists, our member, behavioral health specialists, or as determined by the member.
3. We work to complete an HRA on each new member within 90 days of eligibility and annually before the anniversary of the last HRA. As some individuals may be difficult to reach by phone, our team may contact your office for updated contact information.
4. Based on the results of the health risk assessment and any identified needs, an Individualized Care Plan (ICP) is developed by the case manager working directly with the member and the interdisciplinary care team. The ICP includes interventions designed to educate, inform, and advocate for our members. Use of community resources is facilitated for the member, and for our dual special needs members, benefits are coordinated between Medicare and Medicaid, which may include state agencies supporting the member. The member's care plan should be used to supplement and support your medical plan of care.
5. The interdisciplinary care team (ICT) assigned to each member is responsible for reviewing the care plans, collaborating with providers, and providing recommendations for management of care. Primary care physicians with special needs plan (SNP) members are responsible to review these documents available in the provider portal, or as provided, and give feedback as needed. You and/or your patient may be asked to participate in the care planning and management of the plan of care, and are recommended to review information prior to, or during, member visits and following transitions.
6. We have a contracted provider network having special expertise to manage the special needs population and monitor the use of *Clinical Practice Guidelines* by the contracted providers. Roles of providers include advocating, informing, and educating members, performing assessments, diagnosing, and treating. If you believe our local network does not meet all of your members' specialized needs and would like to recommend possible additions to our network, please contact provider relations at the number on the members' identification card or discuss with the case manager.
7. We are committed to effective, efficient communication with you. We have developed a communication system to support effective information between you, your members, and our care team. Information from our internal systems is available to you through the provider website and may assist you in managing your patient's care. You can access

claim information, the care plan, medication history, the HRA results, and see other providers involved in providing care to the member. Our case managers may reach out to you to discuss needs identified during our case management process and provide important information to assist in coordinating care. You may also receive a copy of the care plan or a phone call from the case manager asking you to review, make comments, or recommendations about the care plan or the needs identified during the care planning process. As an enhancement, our PCPs have the ability to register and receive a daily list of the members who have completed the HRA and/or have an updated care plan available for you to review. You may reach your members' care team by calling the number provided to you on any correspondence or the number on the members' identification card.

8. We support transitions in care for your patients. Special needs plan members typically have many providers and may transition into and out of healthcare institutions. Our Care Management team may contact you and your patient related to certain types of transitions. If you are aware of an upcoming care transition for your patient and would like our team to assist in the coordination, please notify us at the number provided on the member's identification card. Care transition protocols and your role in this process are communicated in this manual.
9. Performance and health outcome measurements are collected, analyzed, and reported to measure health outcomes and quality measures, and also to evaluate the effectiveness of the model of care.
10. SNP model of care training is required annually and available to providers, employees, and contractors. The training may be provided to you in your provider manual, through newsletters, provider orientation, or on our provider website.

12.9 Annual Program Evaluation

Each year, an evaluation of the model of care occurs to identify any modifications that are needed and assess progress toward meeting the program goals. Throughout the year, we periodically review our program to assist us in early identification of any potential issues that may require actions. The results of our defined goals are included as part of the program evaluation. When necessary, we develop action plans for goals that may not be trending toward our benchmarks.

One of our desired outcomes as part of the model of care is to assist you in managing and coordinating care in order to improve the health status and outcomes of your patients. If you have any input regarding our model of care, we welcome your feedback.

12.10 Care Transition Protocols and Management

Assisting with the management of transitions is an important part of our case management and model of care. Members are at risk of fragmented and unsafe care during transitions between care settings and levels of care. To help members and caregivers navigate transitions successfully, assistance is provided through many touch points and through educational materials. Transitions in care refer to the movement between healthcare providers and settings and includes changes in a member's level of care. Examples of transitions include transitions to and from: acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility, home, home health care, and outpatient or ambulatory care centers. A team approach is necessary to assist the member with a successful transition. Managing transitions includes protocols such as assisting with logistical arrangements, providing education to the member and caregiver, coordination between healthcare professionals, and a provider network with appropriate specialists who can address the complex needs of the special needs population. Transitional care includes both the receiving and sending aspects of the transfer. Transitional care management assists in providing continuity of care by creating an environment where the member and the provider are

cooperatively involved in ongoing healthcare management with the goal of providing access to high-quality, cost-effective medical care.

12.11 Personnel Responsible for Coordinating Care Transition

Providers are essential members of the ICT and should assist members by coordinating care and communicating with members of the ICT. Members are connected to the appropriate provider to care for their individual needs including any complex medical conditions. The PCP is responsible for coordinating and arranging referrals to the appropriate care provider. When services are not a covered benefit, coordination with community resources occurs to meet the needs of the population. For our dual population, you are required to coordinate between Medicare and Medicaid. Coordination with Medicaid services includes coordination of benefits and also working with Medicaid case managers/service coordinators and providers of long-term services and supports (LTSS) to close care gaps. In some of our markets, this coordination may also extend to state agencies providing or coordinating Medicaid benefits and services.

Protocols outlining the expectations for managing transitions may be communicated to the provider network through newsletters, published in the provider manual, or on the provider website. Below are some additional protocols for managing transitions not previously addressed in the provider responsibilities:

- Participate in the interdisciplinary care team meetings and/or communication processes as appropriate
- Notify the member in advance of a planned transition
- Provide documentation to the provider or facility about the member to assist in providing continuity of care
- Communicate and follow up with the member and other ICT participants as needed about the transition process
- Communicate health status and plan of care to the member
- Provide a treatment plan/discharge instructions to the member prior to being discharged from one level of care to another
- Provide the relevant patient history to the receiving provider prior to a known transition
- Forward any pertinent diagnostic results to the treating provider
- Communicate the treatment plan and any test results to the referring provider post transition

We assist our members and providers in the management of transitions in multiple ways within our care management programs. The actions below represent some of the ways our care team works with our providers and members to coordinate care and assist in the management of transitions:

- Communicates with the provider to discuss the member's care needs as identified during case management or model of care activities.
- Assist the member in making appointments
- Coordination between Medicaid and Medicare benefits
- Perform medication reconciliation
- Arranging transportation
- Refer to external or internal programs
- Coordinate care with behavioral health
- Assist with arranging durable medical equipment (DME) and home health services
- Coordinate and facilitate transitions to the appropriate level of care

- Provide the member with disease-specific education and self-management techniques
- Contact high-risk members post-discharge to reduce unnecessary readmissions
- During interactions with the member, communicate that support is available from member services to serve as a central point of contact and assist during any transition

12.12 Member Satisfaction

Wellpoint periodically surveys members to measure overall customer satisfaction, including satisfaction with the care received from providers. Wellpoint reviews survey information and shares the results with network providers.

Members are also surveyed by CMS twice a year through the *CAHPS* and *HOS Surveys*. The results of both CMS surveys are part of the Medicare Advantage plans' HEDIS and star ratings. Wellpoint encourages its participating providers to encourage members to actively participate in their healthcare, to receive preventive services timely and to improve their quality of life by following the provider's treatment plan. See the **CMS Star Ratings section** of this manual.

13 CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

13.1 Claims — Billing and Reimbursement

Clean claims for Medicare members are generally adjudicated within 30 calendar days from the date Wellpoint receives the claim. For nonclean claims, the provider receives written notification identifying the claim number, the reason the claim could not be processed, the date the claim was received by Wellpoint and the information required from the provider in order to adjudicate the claim. Wellpoint produces and mails an *Explanation of Payment* (*EOP*) on a weekly basis. The *EOP* delineates for the provider the status of each claim that has been paid or denied.

Medicare members must **not** be balance billed for services rendered as outlined in the participating provider agreement and the Attachment A rate sheet. Medicare members are also not held liable for non-covered services where the provider failed to provide advanced notice of noncoverage via the organization's determination process. Reimbursement by Wellpoint constitutes payment in full except for applicable copays, deductibles, and coinsurance. These amounts will be indicated on the *EOP* and direction provided based on whether Wellpoint is responsible for processing both the primary and secondary claims or not. In instances where Wellpoint is only responsible for processing primary claims, the provider should bill the state Medicaid agency, as would be the standard practice in the Medicare fee-for-service program for Specialty + Rx plan members. See the **Billing Members section** of this manual for additional details about cost sharing.

Provider must use *HIPAA*-compliant billing codes when billing. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitting claims for covered services. An amendment to the *Participating Provider Agreement* will not be required to replace such billing codes. Wellpoint follows Strategic National Implementation Process (SNIP) level 1 through 6 editing for all claims received in accordance with *HIPAA*. Wellpoint will not reimburse any claims submitted using noncompliant billing or SNIP codes.

Providers resubmitting claims for corrections must clearly mark the claim **Corrected Claim**. Failure to mark the claim appropriately may result in denial of the claim as a duplicate. Corrected claims must be received within the applicable timely filing requirements of the originally submitted claim, due to the original claim not being considered a clean claim.

13.2 Claim Status

Providers should access the Wellpoint online claim status inquiry tool at **provider.wellpoint.com/** or call Provider Services at the DSU at **866-805-4589** to check claim status.

Providers can confirm the status and payment detail of their claims by logging in to **Availity Essentials** with their username and password.
When viewing the status of a claim on Availity Essentials, there may be options available to submit medical records or an itemized bill or dispute the claim.

To follow up on a claim:
Check **Availity.com** for disposition of the claim.
From the Availity Essentials home page, select **Claims & Payments > Claim Status.**

13.3 Provider Claims

Providers should submit claims to Wellpoint as soon as possible after service is rendered. Claims should be filed using the *CMS-1500* (02-12) or *CMS-1450* (UB-04) claim form or filed electronically.

13.4 Billing Differences for Medicare Advantage

CMS-1500 (08-05)

Box 9, 9A-D	Other Insurance, including Medicaid
Box 25	Federal tax ID number
Box 33	State Medicaid number

Hospitals

Hospitals should submit claims to the Wellpoint claims address as soon as possible after service is rendered, using the standard *UB-04* form or by filing electronically.

UB-04/CMS 1450

Box 5	Federal tax ID number
Box 51a	Wellpoint unique provider ID number
Box 51b	State Medicaid number
Box 51c	Medicare ID number

13.5 Coordination of Benefits

Wellpoint and its providers agree that Medicare coverage is secondary, and the Medicaid program is the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicare members. When Wellpoint is aware of third-party resources prior to paying for a medical service, it will follow appropriate coordination of benefits standards by either rejecting a provider's claim and redirecting the provider to bill the appropriate insurance carrier or, if Wellpoint does not become aware of the resource until sometime after payment for the service was rendered, by pursuing post payment recovery of the expenditure. Providers must not seek recovery in excess of the applicable Medicare and/or Medicaid payable amounts.

Wellpoint will follow appropriate coordination of benefits standards for trauma-related claims where third-party resources are identified prior to payment. Otherwise, Wellpoint will follow a pay and pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post-payment to determine likely cases based on information obtained through communications with members and providers. Wellpoint handles the filing of liens and settlement negotiations both internally and externally via its vendors.

13.6 Electronic Submission

Wellpoint encourages the submission of claims electronically through Electronic Data Interchange (EDI). Providers must submit claims within the timely filing limits noted below from the date of discharge for inpatient services or from the date of service for outpatient services.

Market	Timely filing (days)
Arizona	180
Iowa	Refer to your contract for timely filing requirements.
New Jersey	180
New Mexico	90
South Carolina	Refer to your contract for timely filing requirements.
Tennessee	120
Texas	95

Washington	Refer to your contract for timely filing requirements.
West Virginia	90

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

- Submit claims within the number of days specified for each market from the date the service is rendered, or for inpatient claims filed by a hospital, within the number of days specified for each market from the date of discharge.
- In the case of other insurance, submit the claim within the number of days specified for each market after receiving a response from the third-party payer.
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within 90 days from the date the eligibility is added and Wellpoint is notified of the eligibility/enrollment.
- Claims submitted after the market-specific timely filing deadline will be denied.

After filing a claim with Wellpoint, review the daily *EOP*. If the claim does not appear on an *EOP* within 30 business days as adjudicated or you have no other written indication the claim has been received, check the status of your claim by using the Wellpoint website at **provider.wellpoint.com/**or by calling Provider Services at the DSU at **866-805-4589**. If the claim is not on file with Wellpoint, resubmit your claim within 90 days from the date of service, or by the timely filing requirement for your market. If filing electronically, check the confirmation reports for acceptance of the claim you receive from your EDI or practice management vendor.

13.7 Electronic Data Interchange (EDI)

Wellpoint uses Availity as its exclusive partner for managing all electronic data interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835), allows for a faster, more efficient, and cost-effective way for providers and employers to do business.

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/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Availity's EDI submission Options:

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

Your Payer Name is Wellpoint and the Payer ID is WLPNT.
https://apps.availity.com/public-web/payerlist-ui/payerlist-ui/#/
Note: If you use a clearinghouse, billing service, or vendor, please work with them directly to determine the payer ID.

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 rejections as they will not continue through the process and require correction and resubmission. For questions on electronic response reports, contact your Clearinghouse, Billing Vendor, or Availity at **800-AVAILITY (800-282-4548)**.

EDI Submission for Corrected Claims

For corrected electronic claims, use the following frequency code:

- 7 — Replacement of Prior Claim

EDI segments required:

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

Please work with your vendor on how to submit corrected claims.

13.8 Paper Claims Submission

Providers also have the option of submitting paper claims. Wellpoint uses Optical Character Recognition (OCR) technology as part of its front-end claims processing procedures. The benefits include the following:

- Faster turnaround times and adjudication
- Claims status availability within five days of receipt
- Immediate image retrieval by Wellpoint staff for claims information, allowing more timely and accurate response to provider inquiries

To use OCR technology, claims must be submitted on original red claim forms (not black and white or photocopied forms) and laser printed or typed (not handwritten) in a large, dark font. Providers must submit a properly completed *UB-04* or *CMS-1500* (*08-05*) within 90 days from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third-party documents resolution of the claim.
In accordance with the implementation timelines set by CMS and NUCC, Wellpoint requires the use of the *CMS-1500* (*08-05*) for the purposes of accommodating the National Provider Identifier (NPI).

In accordance with the implementation timelines set by CMS and NUBC, Wellpoint requires the use of the new UB-04 CMS-1450 for the purposes of accommodating the NPI.
CMS-1500 (*02-12*) and *UB-04 CMS-1450* must include the following information (*HIPAA*-compliant where applicable):

- Patient's ID number
- Patient's name
- Patient's date of birth
- ICD-10 diagnosis codes/revenue codes
- Date of service
- Place of service
- Description of services rendered CPT-4 codes/HCPC codes/DRGs
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract

- Wellpoint provider number
- NPI of billing provider when applicable
- Name of ordering physician
- NPI of ordering physician when applicable
- Name of performing physician
- NPI of performing provider when applicable
- State Medicaid ID number
- Coordination of Benefits/other insurance information
- Authorization/prior authorization number or copy of authorization/prior authorization
- Name of referring physician
- NPI of referring physician when applicable
- CLIA Identification number when applicable (*CMS-1500* only)
- Any other state-required data

Wellpoint cannot accept claims with alterations to billing information. Claims that have been altered will be returned to the provider with an explanation of the reason for the return. Wellpoint will not accept claims from those providers who submit entirely handwritten claims, except in New Jersey where providers are permitted to submit handwritten claims.

Paper claims must be submitted within the timely filing limits noted below from the date of service:

Market	Timely filing (days)
Arizona	180
Iowa	Refer to your contract for timely filing requirements.
New Jersey	180
New Mexico	90
South Carolina	Refer to your contract for timely filing requirements.
Tennessee	120
Texas	95
Washington	180
West Virginia	90

Submit paper claims to the following address:

Market	Submit paper claims to:
Paper claims for all Medicare markets (Arizona, Iowa, New Jersey, New Mexico, South Carolina, Tennessee, Texas, Washington, and West Virginia)	Wellpoint P.O. Box 61010 Virginia Beach, VA 23466-1010

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

- Submit claims within the number of days specified for each market from the date the service is rendered, or for inpatient claims filed by a hospital, within the number of days specified for each market from the date of discharge.
- In the case of other insurance, submit the claim within the number of days specified for each market after receiving a response from the third-party payer.
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within 90 days from the date the eligibility is added and Wellpoint is notified of the eligibility/enrollment.

- Claims submitted after the market-specific timely filing deadline will be denied.

After filing a claim with Wellpoint, review the daily *EOP*. If the claim does not appear on an *EOP* within 30 business days as adjudicated or you have no other written indication the claim has been received, check the status of your claim by using the Wellpoint website at **provider.wellpoint.com/**or by calling Provider Services at the DSU at **866-805-4589**. If the claim is not on file with Wellpoint, resubmit your claim within 90 days from the date of service, or by the timely filing requirement for your market. If filing electronically, check the confirmation reports for acceptance of the claim you receive from your EDI or practice management vendor.

13.9 Encounter Data

Medicare Advantage Organizations must submit to CMS all data necessary to characterize the context and purpose of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner. Facilities and providers who render services to Wellpoint members are required to submit complete claim and encounter data to Wellpoint. In addition, providers have contractually agreed to submit diagnosis code data that is accurate, complete, and truthful (based on their best knowledge, information, and belief). Data should be submitted through a compliant, electronic 837 submission or on a *CMS-1500/UB-04* form, unless other arrangements are approved by Wellpoint. Claim/encounter submissions should follow industry standards as well as comply with all Wellpoint and CMS requirements.

Electronic 837 industry standards are developed and maintained by the American National Standards Institute and the X12 organization. More information on formatting and compliant submission can be found at **https://x12.org/.**

Claim and encounter data submissions are used in a variety of ways, including collecting data related to Healthcare Effectiveness Data and Information Set (HEDIS®) measures and calculating risk adjustment. Risk adjustment was implemented by CMS to pay Medicare Advantage Organizations more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status. The Medicare Advantage Organization is required to submit diagnosis information collected from encounter and claim data to CMS for the purposes of risk adjustment.

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

Risk Adjustment and Data Submission
Risk adjustment is the process used by CMS to adjust the payment made to the Medicare Advantage Organization based on the health status of the Medicare Advantage Organization's Medicare Advantage members. Risk adjustment was implemented to pay Medicare Advantage 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. As an MA organization, diagnosis data collected from encounter and claim data is required to be submitted to CMS for purposes of risk adjustment. Because CMS requires that Medicare Advantage Organizations submit "all ICD-10 codes for each beneficiary", Wellpoint also collects diagnosis data from the members' medical records created and maintained by the provider.

Under the CMS risk adjustment model, the Medicare Advantage Organization is permitted to submit diagnosis data from an allowable service, including inpatient services, outpatient services, and professional services, delivered via face-to-face encounter between an acceptable risk adjustment provider type and physician specialty.

Supplemental Data
Wellpoint health plans offer provider groups the opportunity to submit supplemental data for submission to CMS to support the collection and submission of complete and accurate diagnosis code data.
Medicare Advantage risk adjustment supplemental files are intended to:

- Allow for submission of additional diagnosis code data to support previously submitted claims; and
- Enhance and/or correct diagnostic information for previously submitted medical claim records.

As a reminder, Supplemental data files are not intended to be the sole source of encounter data or to be used as an alternative to standard claim submission:

- Diagnosis code data must be supported by medical record documentation; and
- Diagnosis code data submitted via supplemental data file should be associated with a claim or encounter for services

13.10 Claims Adjudication

Wellpoint is dedicated to providing timely adjudication of provider claims for services rendered to members. All network and non-network provider claims submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT and ICD manuals. Institutional claims should be submitted using EDI submission methods or a UB-04 or CMS-1450, and provider claims using the *CMS-1500*.
Providers must use *HIPAA*-compliant billing codes when billing Wellpoint. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitted claims. Wellpoint will not pay any claims submitted using noncompliant billing codes.
Wellpoint reserves the right to use code-editing software to determine which services are considered part of, incidental to, or inclusive of the primary procedure. The automated claims auditing system verifies the coding accuracy of claims for CPT and Healthcare Common Procedure Coding System (HCPCS) procedures. This system ensures the same auditing criteria is applied across all claims.

13.11 Clean Claims Payment

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

- Is submitted in a timely manner.
- Is accurate.
- Is submitted on a *HIPAA*-compliant standard claim form, including a *CMS-1500* or *CMS-1450* or successor forms thereto or the electronic equivalent of such claim form.
- Requires no further information, adjustment, or alteration by the provider or by a third party in order to be processed and paid by Wellpoint.

Clean claims are typically adjudicated within 30 calendar days of receipt. If Wellpoint does not adjudicate the clean claim within the time frames specified above, Wellpoint will pay all applicable interest as required by law.

Wellpoint produces and mails an *EOP* on a weekly basis, which delineates for the provider the status of each claim that has been adjudicated during the previous payment cycle. Upon receipt of the requested information from the provider, Wellpoint should complete processing of the clean claim within 30 calendar days.

Paper claims determined to be unclean will be denied to the billing provider, along with a *remittance stating the denial reason*. Electronic claims determined to be unclean will be returned to the Wellpoint contracted clearinghouse that submitted the claim.
In accordance with CMS requirements, Wellpoint will pay at least 95 percent of all clean claims within 30 calendar days of the date of receipt. Wellpoint will pay or deny all other claims within 60 calendar days of the receipt of the request. The date of receipt is the date Wellpoint receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

13.12 Provider Reimbursement

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

To register and manage EFT account changes, visit **https://provider.wellpoint.com/** > Claims > EDI for EFT registration instructions.

Electronic Remittance Advice (835)
The 835 eliminates the need for paper remittance reconciliation.
Use Availity to register and manage ERA account changes with these three easy steps:
1. Log in to **Availity.**
2. Select My Providers.
3. Click on Enrollment Center and select Transaction Enrollment.

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERA's.

Contact Availity
Please contact Availity Client Services with any questions at **800-Availity (282-4548)**.
Wellpoint offers Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) with online viewing capability. Providers can elect to receive Wellpoint payments electronically through direct deposit to their bank account. In addition, providers can select from a variety of remittance information options, including:

- *HIPAA*-compliant data file for download directly to your practice management or patient accounting system.
- Paper remittance printed and mailed by Wellpoint.

Some of the benefits providers may experience include:

- Faster receipt of payments from Wellpoint.
- The ability to generate custom reports on both payment and claim information based on the criteria specified.
- Online capability to search claims and remittance details across multiple remittances.
- Elimination of the need for manual entry of remittance information and user errors.
- Ability to perform faster secondary billing.

To register for ERA/EFT, please visit our website.

Primary Care Provider Reimbursement
Wellpoint reimburses PCPs according to their contractual arrangement.

Specialist Reimbursement
Reimbursement to network specialty care providers and network providers not serving as PCPs is based on their contractual arrangement with Wellpoint.

Specialty care providers must obtain Wellpoint approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized or beyond the scope permitted under this program.
Specialty care provider services will be covered only when there is documentation of appropriate notification or prior authorization, as appropriate, and receipt of the required claims and encounter information to Wellpoint.

13.13 Reimbursement Policies

Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Wellpoint benefit plan. These policies can be accessed at **wellpoint.com/provider** > Provider tools & resources > Reimbursement Policies.

Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.
You must follow proper billing and submission guidelines. You are required to use industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Wellpoint may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Wellpoint reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider state, federal, or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Wellpoint strives to minimize these variations.

Reimbursement Hierarchy
Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity, authorization requirements, or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Review Schedules and Updates
Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements, and/or Wellpoint business decisions. We reserve the right to review and revise our policies when necessary. Reimbursement policies go through a review every two years for updates to state, federal or CMS contracts and/or requirements. When there is an update, we will publish the most current policy at **wellpoint.com/provider** > Provider tools & resources > Reimbursement Policies.

Medical Coding
The Medical Coding department ensures that correct coding guidelines have been applied consistently throughout Wellpoint. Those guidelines include, but are not limited to:

- Correct modifier use
- Effective date of transaction code sets (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.)
- Code editing rules are appropriately applied and within regulatory requirements
- Analysis of codes, code definition, and appropriate use

Wellpoint uses an automated claims auditing system to ensure claims are adjudicated in accordance with industry billing and reimbursement standards. Claims auditing software ensures compliance with an ever-widening array of edits and rules as well as consistency of payment for providers by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, our code editing system determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes and processes those services according to the NCCI. NCCI was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services. In addition to code pair edits, the NCCI includes a set of edits known as Medically Unlikely Edits (MUEs). An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single HCPCS/CPT code billed by a provider on a date of service for a single beneficiary.

Reimbursement by Code Definition
Wellpoint allows reimbursement for covered services based on their procedure code definitions or descriptors, as opposed to their appearance under particular CPT categories or sections, unless otherwise noted by state, federal, or CMS contracts and/or requirements.

13.14 Changes to the Wellpoint Medicare Advantage Rates

Wellpoint compensates providers based on the Wellpoint Medicare Advantage Rate in effect at the time a provider furnishes a covered service. However, when the Wellpoint Medicare Advantage Rate is based on Medicare rates published by CMS, Wellpoint compensates based on the rates that are available in its systems at the time it processes a provider's claim. Wellpoint will use best efforts to promptly implement CMS's changes to Medicare rates prospectively. [Brand Name] will not retroactively adjust claims or otherwise compensate providers for any differences between its compensation and the compensation a provider receives from CMS for traditional Medicare. Such differences have many causes, including (but not limited to): the time needed to implement CMS' changes in Medicare rates; CMS' delay in publishing Medicare rates; CMS' retroactive changes to Medicare rates; CMS finalizing interim values or rates; Medicare demonstration program or quality program rates; or CMS compensation to providers outside of the usual Medicare claims process (including but not limited to bonuses, settlements, and remedies.)

13.15 Overpayment Process

Overpayments or improper payments may be identified either by the payer or voluntarily by the provider. These payments may result from various issues, including:

- Claim miscoding
- Non-compliance with industry standards
- Billing errors
- Duplicate payments

- Payments for services not rendered

When an overpayment is identified, the responsible payer will notify the provider to initiate the refund process. Providers are expected to voluntarily refund any duplicate or erroneous payments, regardless of the cause, within 60 calendar days of either notification or identification. Providers may submit a Refund Notification Form stating the reason for the refund and return the overpayment via check or other approved method. If the overpayment is not refunded within the 60-day timeframe, the payer may:

- Offset the overpayment against future payments due to the provider or facility.
- Employ a third-party collection agency to recover the debt.

If the provider disagrees with the overpayment determination, they should follow the overpayment dispute process outlined in the notice received. Submitting a payment dispute does not suspend the payer's right to pursue recoupment, unless restricted by regulatory requirements.

Per CMS guidelines, the Medicare recovery lookback period is four years. The overpayment recovery process complies with all applicable state and federal regulations.

13.16 Determining Dispute/Appeal Process

Please reference the notification letter received for the proper dispute/appeal process to submit your request. Note the process for appeals is different depending on whether or not the member can be held liable for any payments (member liability).

13.17 Member Liability Appeals

If a provider appeals a decision rendered with member liability, then the appeal follows the CMS Member Liability Appeals process and is processed by the Medicare Complaints, Appeals, and Grievances (MCAG) department. See **Medicare Member Liability Appeals** process.

13.18 Participating Provider Standard Appeals

A participating provider standard appeal is a request for Wellpoint to review a decision by Wellpoint Health Care Management Services that medical necessity was not established, where provider liability was assigned (see original decision letter) for services already rendered. Participating provider standard appeals and participating provider administrative pleas follow different processes, which are described in this Provider Manual. The provider is responsible for sending in all necessary information to adjudicate the standard appeal or administrative plea, and a determination will be rendered based on the information provided.

13.19 Provider Claim Payment Dispute Process

If you disagree with the outcome of a claim, you may begin the Wellpoint provider payment dispute process. Claim Payment Disputes and Provider Administrative Pleas are different processes:

- **Provider Payment Dispute**: The claim has been finalized, but you disagree with the amount that you were paid.
- **Provider Administrative Plea**: The claim has been finalized, but you disagree with the administrative denial that has been applied. An administrative denial is applied within the claims process when it is determined that the provider failed to follow the terms and conditions of their contract. Examples of administrative denials are as follows: denials such as no prior authorization or late notification.

Please be aware, there are two common claim-related issues that are ***not*** considered claim payment disputes. To avoid confusion with claim payment disputes, these are briefly defined below. They are:

- **Claim Inquiry:** A question about a claim, but not a request to change a claim payment.
- **Claims Correspondence:** When Wellpoint requests further information to finalize a claim. Typically, these requests include medical records, itemized bills, or information about other insurance a member may have. A full list of correspondence related materials are in the correspondence section of this provider manual.

Claims that were denied for lack of medical necessity should follow the participating provider standard appeal process. A Medicare participating provider standard appeal is a formal request for review of a previous Wellpoint decision where medical necessity was not established, where provider liability was assigned (see original decision letter) for services already rendered. An example of this appeal scenario would be as follows:

- On clinical review, the services related to the prior authorization request were deemed not medically necessary, but services were rendered, and claim payment was denied.

For more information on each of these claim-related processes, please refer to the appropriate section in this provider manual.
The Wellpoint provider payment dispute process consists of two internal steps. You will **not** be penalized for filing a claim payment dispute, and no action is required by the member:

- **Claim Payment Reconsideration:** This is the first step in the Wellpoint provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
- **Claim Payment Appeal:** The second step in the Wellpoint provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.

A claim payment dispute may be submitted for multiple reason(s) including:

- Contractual payment issues.
- Disagreements over reduced claims or zero-paid claims not related to medical necessity.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues.*

* Timely filing issues — Wellpoint will consider reimbursement of a claim which has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

13.20 Claim Payment Reconsideration

The first step in the Wellpoint claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally, and through our provider website within 120 calendar days from the date on the *Explanation of Payment* (*EOP*) (see below for further details on how to submit). Reconsiderations filed more than 120 days from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect.

The plan encourages providers to use our claims payment reconsideration process if you feel a claim was not processed correctly; however, this optional step is not required prior to filing a claim payment appeal**.**

If a reconsideration requires clinical expertise, it will be reviewed by appropriate clinical Wellpoint professionals.

The plan will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days.
If the decision results in a claim adjustment, the payment and *Explanation of Payment* (*EOP*) will be sent separately. Overturned decisions will result in an adjustment and EPOs.

13.21 Claim Payment Appeal

If you are dissatisfied with the outcome of a Reconsideration determination, you may submit a claim payment appeal. When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. Please note, we cannot process a claim payment appeal without a reconsideration on file.
If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical professionals.

The plan will make every effort to resolve the claim payment appeal within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days. If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

13.22 How to submit a Claim Payment Dispute

We have several options when filing a claim payment dispute:

- **Verbal (reconsideration only):** Verbal submissions may be submitted by calling Provider Services at **866-805-4589.**
- **Online (reconsiderations and claim payment appeals):** Use the secure provider Availity Appeal application at **Availity.com.** Through Availity Essentials, you can upload supporting documentation and receive immediate acknowledgement of your submission:
  - Locate the claim you want to dispute on Availity Essentials using **Claim Status** from the *Claims & Payments* menu. If available, select **Dispute Claim** to initiate the dispute. Go to **Request** to navigate directly to the initiated dispute in the appeals dashboard, add the documentation, and submit.
- **Written (reconsideration and claim payment appeals):** Written reconsiderations and claim payment appeals should be mailed, along with the *Claim Payment Appeal Form* or the *Reconsideration Form* to:
  Provider Payment Disputes
  P.O. Box 61599

Virginia Beach, VA 23466-1599

Required Documentation for Claims Payment Disputes
Wellpoint requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email, and either your NPI or TIN.
- The member's name and their Wellpoint or Medicare 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.

Claim Inquiry
A question about a claim or claim payment is called an Inquiry. Inquiries do not result in changes to claim payments, but outcome of the claim inquiry may result in the initiation of the claim payment dispute. in other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Provider Experience program helps you with claim inquiries. Just call **866-805-4589** and select the claims prompt within our voice portal. We connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim Correspondence
Claim correspondence is different from a payment dispute. Correspondence is when the plan requires more information in order to finalize a claim. Typically, Wellpoint makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, 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.
The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of Issue	What Do I Need to Do?
Rejected Claim(s)	Use the **EDI Hotline** at **800-590-5745** when your claim was submitted electronically but was never paid or was rejected. We're available to assist you with setup questions and help resolve submission issues or electronic claims rejections.
EOP Requests for Supporting Documentation (*Sterilization/ Hysterectomy/Abortion Consent Forms*, itemized bills, and invoices)	Submit a *Claim Correspondence Form*, a copy of your *EOP,* and the supporting documentation to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
EOP Requests for Medical Records	Submit a *Claim Correspondence Form*, a copy of your *EOP,* and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

Type of Issue	What Do I Need to Do?
Need to submit a Corrected Claim due to errors or changes on original submission	Submit a *Claim Correspondence Form* and your corrected claim to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Wellpoint to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI *EOB*.
Submission of coordination of benefits (COB)/third-party liability (TPL) information	Submit a *Claim Correspondence Form*, a copy of your *EOP,* and the COB/TPL information to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

13.23 Provider Payment Disputes and Administrative Plea Processes

If you believe Wellpoint has not paid for your services according to the terms of your provider agreement, submit a request using the *Appeals Form* located online under *Forms* at **wellpoint.com/provider.**
Providers will not be penalized for filing a provider payment dispute. Submit provider payment disputes to:

Provider Payment Disputes
P.O. Box 61599
Virginia Beach, VA 23466-1599

The Provider Disputes Unit will receive, distribute, and coordinate all payment disputes.

Submit a written request with supporting documentation, such as an *EOP* and a copy of the claims or denial letter received along with other written documentation; a full explanation of the dispute is required and must be submitted within 120 days of when Wellpoint notice of initial determination was generated or we will not accept the request; the provider is responsible to submit all necessary documentation at the time of the request.

The Wellpoint Claims department conducts the review, and/or the health plan medical director reviews the second-level dispute if medical information is involved; if additional information is submitted that would support payment, the denial is overturned.
An internal review is conducted and results communicated in a written decision to the provider within 60 calendar days if the decision is upheld; the written decision includes:

- A statement of the provider's dispute.
- The reviewer's decision, along with a detailed explanation of the contractual and/or medical basis for such decision.
- A description of the evidence or document that supports the decision.

14 COORDINATION OF BENEFITS

Wellpoint and its providers agree that Medicare coverage is secondary, and the Medicaid program is the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicare members. When Wellpoint is aware of third-party resources prior to paying for a medical service, it will follow appropriate coordination of benefits standards by either rejecting a provider's claim and redirecting the provider to bill the appropriate insurance carrier or, if Wellpoint does not become aware of the resource until sometime after payment for the service was rendered, by pursuing post payment recovery of the expenditure. Providers must not seek recovery in excess of the applicable Medicare and/or Medicaid payable amounts.

Wellpoint will follow appropriate coordination of benefits standards for trauma-related claims where third-party resources are identified prior to payment. Otherwise, Wellpoint will follow a pay and pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post-payment to determine likely cases based on information obtained through communications with members and providers. Wellpoint handles the filing of liens and settlement negotiations both internally and externally via its subrogation vendor, Optum.

Wellpoint requires members to cooperate in the identification of any and all other potential sources of payment for services. Any questions or inquiries regarding paid, denied, or pended claims should be directed to Provider Services at the DSU at **866-805-4589**.

Provider Obligations — denial notification and member complaints, appeals, and grievances
Providers are required to adhere to CMS and Wellpoint requirements concerning issuing letters and notices. This includes advanced notice of denials that will result in member liability or cost in accordance with Medicare guidelines for Medicare Advantage Plans.

14.1 Skilled Nursing Facilities, CORFs, and Home Health Agencies

The Notice of Medicare Non-Coverage (NOMNC) is a statutorily required notice that is issued to Medicare Advantage members to alert them of a discontinuation of skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), or home health services. This notice explains the determination that continued coverage after a specific effective date will no longer be covered by the plan. A NOMNC should be issued to a Medicare member at least two days prior to discharge, or in advance of the last two covered visits. This notice informs the member their stay or visits no longer meet coverage criteria and will end in two days or after two visits. In most cases, the notice is required to be issued by the provider, and Wellpoint is required to ensure proper delivery and that the member's signature is obtained.

14.2 Wellpoint Contracted SNF Provider Responsibility

Contracted SNF providers are responsible for delivering the NOMNC on behalf of Wellpoint to the member or member representative **and** for obtaining signature(s). The member's signature acknowledges receipt of the notice and is not an agreement with the denial. In the event the member is in need of an authorized representative to acknowledge/sign the NOMNC, and the SNF is unable to deliver it to the authorized representative, the SNF should telephone the representative the same day the NOMNC is issued, to advise them when the member's services are no longer covered. The date of the conversation is the date of the receipt of the notice. The NOMNC must be annotated to note the name of the staff person initiating the contact, the name of the member representative contacted by telephone, the date and time of the telephone contact, and the telephone number called. If agreed by both

parties, the annotated notice can then be emailed or faxed (in accordance with *HIPAA* privacy and security requirements). The notice should be annotated by the person providing the notification to the representative, indicating the date, time, person's name, relation to the member, telephone number called, and that the notice was read to the representative, including all appeal rights. If a member (or representative) elects to exercise their right to an immediate review, the member (or representative) must submit a request to the appropriate Quality Improvement Organization (QIO) for the state by the deadline indicated in the notice. The provider is responsible for submitting any documents or medical records as requested by the QIO or Wellpoint Complaints, Appeals, and Grievance department within the time frame indicated on the request.

14.3 Hospitals

The Important Message from Medicare (IMM) is a statutorily required notice issued to Medicare Advantage members to alert them of a discontinuation of acute inpatient hospital services. Within two days after an admission or at the preadmission visit (but not more than seven calendar days in advance of the admission), the hospital providing the inpatient services is required to issue the IMM. This statutorily required notice explains the Medicare beneficiary's rights as a hospital inpatient, including discharge appeal rights. The hospital is required to deliver the notice in person and obtain the signature of the member or representative, and provide them with a copy at that time. The hospital is also responsible for ensuring the member can comprehend the contents of the notice before obtaining the signature. It is the responsibility of the hospital to explain the notice, if necessary, and be able to answer any questions about the notice the member or representative may have. Notices should not be delivered while the member is receiving emergency treatment, but should be delivered once the patient is stable. If a member refuses to sign the notice, the hospital may annotate the notice to indicate the refusal and document notification was attempted. If in-person notification cannot be provided to a representative, the hospital is responsible for telephonically contacting the representative to advise them of their appeal rights. If agreed by both parties, the notice can be emailed or faxed (in accordance with *HIPAA* privacy and security requirements). Otherwise, the notice must be mailed the same day. In addition, prior to discharge (but not more than two days in advance of discharge), the hospital must deliver another copy of the signed notice to the member or representative in person. If the notice is being given on the day of discharge, the member must be provided at least four hours to consider their rights and to request the QIO review. Hospitals should not routinely provide the notice on the day of discharge. If the member requests additional information on the discharge, the detailed notice can be issued prior to an immediate review request being initiated. If discharge occurs within two calendar days of the original notice, no additional copy needs to be delivered. If a member elects to exercise their right to an immediate review, they must submit a request to the appropriate QIO, as outlined in the notice, by midnight of the day of discharge, either verbally or in writing, before that person leaves the hospital.

14.4 Provider Obligations — In-office Denials

In the event a member disagrees with the provider's decision about a request for service or a course of treatment or is requesting or in need of services that are not covered by the plan or Medicare: At each patient encounter with a Medicare member, the provider must notify the member of their right to receive, upon request, a detailed written notice from Wellpoint regarding the member's services. The provider must request us to provide a detailed notice of a provider's decision to deny a service in whole or part; in turn, we must give the member advanced written notice of the determination, by following the prior authorization process (outlined below).

For services that require prior authorization or are non-covered by the plan (in other words, statutory exclusion), it becomes extremely important that Wellpoint authorization procedures are followed. If a member elects to receive such care, the member cannot be held financially responsible unless notified in advance of the non-covered services. In such cases when the network physician fails to follow Wellpoint authorization protocols, Wellpoint may decline to pay the claim, in which case the provider will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

The CMS has established guidelines concerning *Advance Notices of Non-Coverage* (*ABN*). The *ABN* is an FFS document and cannot be used for Medicare Advantage denials or notifications. Per CMS, the ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). CMS advised Medicare Advantage plans that contracted providers are required to provide a coverage determination for services that are not covered by the member's Medicare Advantage plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. If there is any doubt about whether a service is not covered, please seek a coverage determination from the plan.

A written coverage determination will help ensure that a claim for non-covered care from a contracted provider is paid accurately. According to CMS, if the appropriate written notice of denial of payment is not given to the Medicare Advantage member regarding a non-covered service, the claim may be denied, and the member cannot be held financially responsible. Therefore, your failure to obtain an appropriate coverage determination could result in a denial of payment for the non-covered service.

Please contact Wellpoint prior to services being rendered to comply with this requirement, ensure appropriate claims payment, and allow you to bill the Medicare member in the event of noncoverage. As a contracted provider with Wellpoint, you are prevented from billing the Medicare member for any service that is deemed non-covered if you have not ensured this advanced notification has been issued.

14.5 Provider Obligations — Prior Authorization

Providers are responsible for obtaining prior authorization from Wellpoint before performing certain procedures, when rendering non-covered services, or when referring members to noncontracted providers. Please refer to the *Summary of Benefits* document for those procedures that require prior authorization, or call Provider Services at the DSU at **866-805-4589**. Wellpoint will render a determination on the request within the appropriate time frame and provide notification of the decision. Requests that are denied will generate a notice that includes the denial rationale and applicable appeal rights. Medicare members will receive a denial letter as well that includes appeal rights. Denials that are the result of contractual issues between Wellpoint and the provider will not generate a member denial letter.
An initial *organization* determination is any determination (for example, an approval or denial) made by Wellpoint for coverage of medical services (Part C-covered services).
An initial *coverage* determination is any determination (for example, an approval or denial) made by Wellpoint for coverage of prescription drugs (Part D-covered services).

15 COMPLAINTS, APPEALS, AND GRIEVANCES

15.1 Distinguishing between Provider and Medicare Advantage Member Complaints, Appeals, and Grievances

Wellpoint has separate and distinct processes for requests to reconsider a Wellpoint decision on an authorization or request for payment upon claims submission. On processing each request, assignment of liability for the service is determined. All Medicare member liability denials are subject to the Medicare Complaints, Appeal & Grievances (MCAG) process as outlined in the Medicare Member Liability Appeals and Medicare Member Grievances sections. Disputes between the health plan and the provider that do not involve an adverse determination or liability for the Medicare member follow the Wellpoint participating provider appeals and dispute or nonparticipating provider payment dispute processes. Providers must cooperate with Wellpoint and with members in providing necessary information to resolve the appeals within the required time frames. Providers must provide the pertinent medical records and any other relevant information upon request and when initiating an appeal. In some instances, providers must provide the records and information very quickly in order to allow Wellpoint to make an expedited decision. Your participation in, along with the member's election of the Medicare Advantage plan, are an indication of consent to release those records as part of the healthcare operations.

Medicare Member Liability — Wellpoint has determined that a Medicare member is responsible for payment as the service(s) are determined to be not covered under the plan to which they are enrolled, or is considered Medicare member cost-share. Any time a member liability denial letter is issued, the member appeals process must be followed and **not** the provider appeals process. Medicare member liability is assigned when:

- The Integrated Denial Notice (IDN) is issued as per the CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance with subsequent review by the Independent Review Entity (IRE).
- The Notice of Denial of Medicare Prescription Drug Coverage is issued as per the CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.
- A decision that inpatient hospital care is no longer necessary with delivery of the Important Message from Medicare (IM) as per the CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.
- Notice of Medicare Non-Coverage (NOMNC) is delivered as per the CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance with rights to pursue an appeal via the Quality Improvement Organization (QIO) or the plan directly.
- An *Explanation of Benefits* (*EOB*) indicates there is member responsibility assigned to a claim processed.
- An *Explanation of Payment* (*EOP*) indicates there is member responsibility assigned to a claim processed.

Participating Provider Liability — Wellpoint has determined that the participating provider has failed to follow the terms and conditions of their contract either administratively or by not providing the clinical information needed to substantiate the services being requested for approval of payment. Participating providers are prohibited from billing a Medicare member for services unless the plan has determined member liability and issued the appropriate notices as above.

Nonparticipating Provider Liability — Wellpoint has determined that the nonparticipating provider with the plan has failed to follow Medicare processing guidelines. Nonparticipating providers are prohibited from billing a Medicare member for services unless the plan has

determined member liability and issued the appropriate notices as above and has procedures for nonparticipating provider to follow.

15.2 Participating Provider Standard Appeals

Wellpoint participating providers may initiate provider appeals under the provider appeal procedures. Wellpoint typically determines provider appeals within 60 days when sufficient information is received to make a decision.

Medicare Participating Provider Standard Appeal
A formal request for review of a previous Wellpoint decision where medical necessity was not established, where provider liability was assigned (see original decision letter) for services already rendered.

Participating Provider Standard Appeals Responsibility
All requests must be:

- Submitted in writing.
- Submitted within 180 days* from the Wellpoint decision letter date.

Include a cover letter with:

- Member Identifiable information.
- Date(s) of service in question.
- Specific rationale as to why the services did in fact meet medical criteria and reference specifics within the medical record to refute the original decision.

Include necessary attachments:

- Copy of the original Wellpoint decision
- All applicable medical records

Note: Wellpoint will not request additional records to support the provider's argument and expects the provider to submit the necessary information to substantiate their request for payment.

Appeals should be mailed to:

Medicare Complaints, Appeals, & Grievances (MCAG)
Attention: Medical Necessity Provider Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

Providing the above information will enable the Wellpoint Participating Provider Appeals team to properly and timely review requests within 60 days. Requests that do not follow the above may be delayed.

* Days from original denial date may differ, depending upon the contract and/or state requirements.

15.3 Nonparticipating Provider Payment Disputes

Nonparticipating Provider Payment Disputes

If, after a claim has been adjudicated, a nonparticipating provider contends that our decision to pay for a different service from the one originally billed or believe they would have received a different payment under Original Medicare, the nonparticipating provider payment dispute resolution process can be used. Notification will be provided to the

nonparticipating provider at each step of the process. For more information regarding the disputes process, please see Claims dispute.

15.4 Nonparticipating Provider Appeals Rights

If a claim is partially or fully denied for payment with member liability (see original decision letter), the nonparticipating provider must request a reconsideration of the denial within 65 calendar days from the remittance notification. When submitting the reconsideration of the denial of payment on a claim, a signed *Waiver of Liability* form must be included. To obtain this form, please go to **https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip.** The purpose of the *Waiver of Liability* form is to hold the enrollee harmless regardless of the outcome of the appeal.

With the appeal, the nonparticipating provider should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement. **The appeal must be in writing.**

Please mail the appeal to this address:

Medicare Complaints, Appeals, and Grievances
Mailstop: OH0205-A537
4361 Irwin Simpson Rd
Mason, Ohio 45040

15.5 Member Complaints, Appeals, and Grievances

Distinguishing Between Member Appeals and Member Grievances
Complaints are considered any expression of dissatisfaction to a Medicare health plan, provider, facility, or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. There are two procedures for resolving MA member complaints: the Medicare member **appeals** process and Medicare member **grievance** process. All member concerns are resolved through one of these mechanisms. The member's specific concern dictates which process is used. Thus, it is important for the physician to be aware of the difference between appeals and grievances.

15.6 Medicare Member Liability Appeals

A member appeal is the type of complaint a member (or authorized representative) makes when the member wants Wellpoint to reconsider and change an initial coverage/organization determination (by Wellpoint or a provider) about what services, benefits or prescription drugs are necessary or covered, or whether Wellpoint will reimburse for a service, benefit, or a prescription drug.
An appeal refers to any of the procedures that deal with a request to review a denial of payment or services. If a member believes they are entitled to receive a certain service and Wellpoint denies it, the member has the right to appeal the decision. It is important to follow the directions in the denial letter issued to ensure the proper appeals process is followed.

A member may appeal:

- An adverse initial organization determination by Wellpoint or a provider concerning authorization for or termination of coverage of a healthcare service.
- An adverse initial organization determination by Wellpoint concerning reimbursement for a healthcare service.

- An adverse initial organization determination by Wellpoint concerning a refusal to reimburse for a health service already received if the refusal would result in the member being financially liable for the service.
- An adverse coverage determination by Wellpoint or a provider concerning authorization or payment for prescription drugs.

Appeals should be sent to:

Medicare Complaints, Appeals & Grievances (MCAG)
Attention: Member Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

Fax: **888-458-1406 (Part C)**
888-458-1407 (Part D)

All Medicare member concerns that do not involve an initial determination are considered grievances and are addressed through the grievance process.

Participating Provider Responsibilities in the Medicare Member Appeals Process

Physicians can request expedited or standard pre-service appeals on behalf of their members; however, if not requested specifically by the treating physician, an *Appointment of Representative Form* may be required. The *Appointment of Representative Form* can be found online and downloaded at **cms.hhs.gov/cmsforms/downloads/cms1696.pdf.**
When submitting an appeal, provide all medical records and/or documentation to support the appeal at that time. Please note that if additional information is requested, it will delay processing of the appeal.

Expedited appeals should only be requested if the normal time period for an appeal could jeopardize the member's life, health, or ability to regain maximum function.
The CMS guidelines should be used when requesting services and initiating the appeals process.

Appeal time frames
Members or their authorized representatives have 65 days from the date of the denial of service to file an appeal. The 65-day filing deadline may be extended if good cause can be shown.

Standard Part C pre-service appeals that are not for a Part B drug must be resolved within 30 calendar days from the date the request was received, unless it is in the member's interest to extend the timeframe.

If the normal time period for an appeal could jeopardize the member's life, health, or ability to regain maximum function, a request for an expedited appeals may be submitted orally or in writing. Such appeals are resolved within 72 hours unless it is in the member's interest to extend this time period.

A standard pre-service appeal for the coverage of a Part B drug must be resolved in seven days from the date the request was received. Part B drug appeals timeframes cannot be extended.

Post-service payment appeals must be resolved within 60 calendar days from the date the request was received. All payment appeals must be submitted in writing.

For Part D appeals:

- Part D expedited pre-service appeals must be resolved within 72 hours from receipt. Part D standard pre-service appeals must be resolved within seven days from the date the request was received.
- Part D payment appeals must be resolved within 14 days from the date the request was received.
- Part D appeals timeframes cannot be extended.

**Note: Integrated DSNP plans with unified grievance and appeals procedures for Medicare and Medicaid and MMPs may have different timeframes for Part C appeals.

15.7 Further Appeal Rights

If Wellpoint is unable to reverse the original denial decision for a Part C item or service in whole or part, the following additional steps will be taken:

- Wellpoint will forward the appeal to an Independent Review Organization (IRO) contracted with the federal government. The IRO will review the appeal and make a decision:
  - Within 72 hours if expedited.
  - Within 30 days if the appeal is related to authorization for healthcare that is not a Part B drug.
  - Within seven days if the appeal is related to authorization of a Part B drug.
  - Within 60 days if the appeal involves reimbursement for care (or 30 days for integrated DSNP plans with unified grievance and appeal procedures).
- Part D prescription drug appeals are not forwarded to the IRO by Wellpoint but may be requested by the member or representative; information will be provided on this process during the Wellpoint member appeals process.
- If the IRO issues an adverse decision (not in the member's favor) and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ).
- If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council. If the Medicare Appeals Council refuses to hear the case or issues an adverse decision, the member may be able to appeal to a federal court.

Hospital discharge appeals and QIO review process

Hospital discharges are subject to an expedited member appeal process. CMS has determined that Medicare Advantage members wishing to appeal an inpatient hospital discharge must request an immediate review from the appropriate Quality Improvement Organization (QIO) authorized by Medicare to review the hospital care provided to Medicare patients.

When a Medicare Advantage member does not agree with the physician's decision of discharge from the inpatient hospital setting, then the member must request an immediate review by the QIO. The member or their authorized representative, attorney, or court-appointed guardian must contact the QIO by telephone or in writing. This request must be made no later than midnight of the day of discharge. The QIO will make a decision within one full day after it receives the member's request, the appropriate medical records, and any other information it needs to make a decision. While the member remains in the hospital, Wellpoint continues to be responsible for paying the costs of the stay until noon of the calendar day following the day the QIO notifies the member of its official Medicare coverage decision.

If the QIO agrees with the physician's discharge decision, the member will be responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO provides notification of its decision. If the QIO disagrees with the physician's discharge decision, the member is not responsible for paying the cost of additional hospital days.
If a Medicare Advantage member misses the deadline to file for an immediate QIO review and is still in the hospital, then they may request an expedited pre-service appeal. In this case, the member does not have automatic financial protection during the course of the expedited appeal and may be financially liable for paying for the cost of the additional hospital days if the original decision to discharge is upheld upon appeal.

15.8 Medicare Member Grievances

A Medicare member grievance is the type of complaint a member makes regarding any other type of problem with Wellpoint or a provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room and the cleanliness of the provider's facilities are grievances.

Wellpoint must accept grievances from members orally or in writing within 60 days* of the event. Wellpoint must make a decision and respond to the grievance within 30 days. A member can request an expedited grievance, in which case Wellpoint has 24 hours to respond. An expedited grievance can only be initiated if Wellpoint refuses to grant the member an expedited organization/coverage determination or an expedited reconsideration/redetermination or notifies the member that an extension will be taken in deciding, making an organization determination, or deciding an appeal (when allowed). Wellpoint can request up to 14 additional days to respond to a grievance if it is in the member's best interest.

* Some plans may not limit the time in which a member grievance is filed (for example, certain integrated DSNP plans and MMPs). These plans allow the member to file a grievance at any time.

15.9 Resolving Medicare Member Grievances

If a Medicare member has a grievance about Wellpoint, a provider, or any other issue, providers should instruct the member to call Member Services at the number located on the back of their ID card or send a written grievance to:

Medicare Complaints, Appeals & Grievances (MCAG)
Attention: Member Grievance Unit
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

15.10 Cost Sharing

Billing Members & Balance Billing
An important protection for beneficiaries when they obtain plan-covered services in an HMO, PPO, or RPPO is that they do not pay more than plan-allowed cost-sharing. Providers who are permitted to balance bill must obtain this balance billing from the MAO. Providers may **not** collect any additional payment for cost-sharing obligations from Medicare members other than those specified in a member's plan *Summary of Benefits*.
Note: Under Original Medicare rules, an Original Medicare participating provider (hereinafter referred to as a participating provider) is a provider that signs an agreement with Medicare to always accept assignment. Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full. An Original

Medicare nonparticipating provider (hereinafter referred to as a nonparticipating, or non-par, provider) may accept assignment on a case-by-case basis and indicates this by checking affirmatively field 27 on the *CMS 5010* claims form; in such a case, no balance billing is permitted.

Federal law prohibits providers from charging dually eligible members with full cost sharing coverage under a Medicare Savings Program and members who are in the Qualified Medicare Beneficiary (QMB) program for Medicare cost sharing for covered Part A and Part B services. The chart below indicates how cost sharing is paid, either by Wellpoint or the state Medicaid agency. Wellpoint processes the claim for reimbursement when Wellpoint has an arrangement with state Medicaid to pay Medicare cost sharing for dual-eligible members in its Special Needs Plans (SNP). The state retains responsibility for cost sharing when Wellpoint does not have an arrangement with the state Medicaid agency. In states where Wellpoint pays cost sharing, claims will be processed under the member's account for both Medicare and Medicaid benefits. In the states where Wellpoint does not have an arrangement with the state Medicaid agency, providers should bill cost sharing to the appropriate Medicaid carrier or state Medicaid agency for payment once the claim has been processed by Wellpoint. Please check your *EOP* upon claims adjudication.

15.11 Cost Sharing Responsibility for Special Needs Plan Members

NOTE: Members that are dually eligible, either as full benefit dual eligible or as part of a Medicare Savings Program, are protected from liability of Medicare premiums, deductible, coinsurance, and copayment amounts. Some Medicare Savings Programs cover some but not all of these premium and/or cost sharing amounts. Medicare members who do not receive full Medicare cost sharing assistance under Medicaid may be required to pay some cost sharing amounts for services. In addition, members in the QMB (Qualified Medicare Beneficiary) program have no liability to pay Medicare providers for Medicare Part A or Part B cost sharing. Federal law prohibits providers from charging dually eligible members with full cost sharing coverage and QMBs for Medicare cost sharing for covered Part A and Part B services – even when Medicaid does not fully pay the Medicare cost sharing amount. Providers who balance bill a full eligible dual member or a QMB member are in violation of Federal law and are subject to sanctions. Providers also may not accept dual eligible beneficiaries as 'private pay' in order to bill the patient directly, and providers identified as continuing to bill dual eligible beneficiaries inappropriately will be reported to CMS for further action/investigation. The rules governing balance billing, as well as the rules governing the MA payment of MA-plan, noncontracting, and Original-Medicare, nonparticipating providers are listed below by type of provider.

Contracted provider — There is no balance billing paid by either the plan or the enrollee.

Noncontracting, Original Medicare, participating provider — There is no balance billing paid by either the plan or the enrollee.

Noncontracting, non-(Medicare) participating provider — The MAO owes the noncontracting, nonparticipating (non-par) provider the difference between the member's cost-sharing and the Original Medicare limiting charge, which is the maximum amount that Original Medicare requires an MAO to reimburse a provider. The enrollee only pays plan-allowed cost-sharing, which equals:

- The copay amount, if the MAO uses a copay for its cost-sharing; or
- The coinsurance percentage multiplied by the limiting charge, if the MAO uses a coinsurance method for its cost-sharing.

MA-plan, noncontracting, nonparticipating DME supplier — The MAO owes the noncontracting nonparticipating (non-par) DME supplier the difference between the member's cost-sharing and the DME supplier's bill; the enrollee only pays plan-allowed cost-sharing, which equals:

- The copay amount, if the MAO uses a copay for its cost-sharing; or
- The coinsurance percentage multiplied by the total provider bill, if the MAO uses a coinsurance method for its cost-sharing. Note that the total provider bill may include permitted balance billing.

Additional useful information on payment requirements by MAOs to non-network providers may be found in *MA Payment Guide for Out-of-network Payments* at **cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf.**

MA plans must clearly communicate to enrollees through the *Evidence of Coverage* (*EOC*) and *Summary of Benefits* their cost-sharing obligations as well as their lack of obligation to pay more than the allowed plan cost-sharing as described above.

If you are a noncontracting nonparticipating Medicare provider, who does not accept Medicare assignment, please contact us if there are any questions regarding your claim(s) payments.

15.12 Loss of Medicaid Coverage for Special Needs Plan Members

Medicare Advantage offered by Wellpoint D-SNP (Dual Eligible Special Needs Plan) members are eligible for both Medicare and Medicaid; however, they may have different levels of Medicare cost sharing assistance based on their Medicare Savings Program. DSNP members who do not receive full Medicare cost share assistance and who are not enrolled in the Qualified Medicare Beneficiary (QMB) program may be required to pay cost sharing and copayments for services. Members are encouraged to be cognizant of their eligibility to ensure there is no loss or gap in coverage that would result in liability of cost share.
Note: If the Part A deductible and Part B deductible are not already met at the time of the beneficiary's loss of coverage, the member will be responsible for the extended Length of Services (LOS) per diem cost share for inpatient facilities and/or any coinsurance on professional and outpatient services.

15.13 Wellpoint Self-Service Website and the Provider Inquiry Line

The Wellpoint self-service website at **provider.wellpoint.com/** provides a host of online resources**,** such as our Online Provider Inquiry Tool for real-time claim status, eligibility verification, and prior authorization status. You can also submit a claim or prior authorization request, print referral forms or directories, or obtain a member roster. Detailed instructions for use of the Online Provider Inquiry Tool can be found on our website.

15.14 Toll-Free Automated Provider Services

To support our providers and members, we have established the DSU to assist with questions and concerns about the Medicare Advantage offered by Wellpoint plans. The DSU is comprised of Medicare subject matter experts and specializes in first-call resolution for provider and member inquires. Our DSU representatives can help:

- Resolve payment disputes, some contracted provider appeals, and other claims issues.
- Verify claims status, member eligibility, preauthorization requirements, and the status of healthcare services.
- Identify participating Medicare Advantage offered by Wellpoint providers for referring members to specialty services.

- Refer members to our Condition Care Centralized Care Unit for interpreter services, transitions, care coordination, transfers, and terminations.
- Support noncompliant members (for example, members who repeatedly miss appointments, members who are noncompliant with their treatment plans).

The DSU is available Monday through Friday from 8 a.m. until 10 p.m. Eastern time toll free at **866-805-4589**. Information is available through the automated system, or you can be transferred to the appropriate department for other needs, such as seeking advice in case/care management.

16 MEMBER RIGHTS AND RESPONSIBILITIES

Providers are required to adhere to CMS and Wellpoint requirements concerning issuing letters and notices. Wellpoint members have the right to timely, quality care and treatment with dignity and respect. Each member receives a copy of the *Explanation of Coverage,* which outlines the member's rights and responsibilities. Providers must respect the rights of all Wellpoint members.

Members have the right to:

- Be treated with dignity, respect, and fairness at all times.
- Receive information about the health plan, services, practitioners, providers, and member rights and responsibilities.
- Receive information in a way that works for them (in languages other than English spoken in the plan service area, in Braille, large print, or other alternate formats).
- Ensure the privacy of their medical records and personal health information.
- Choose a plan provider.
- Receive care from a women's healthcare provider.
- Have timely access to their providers and to receive services from specialists when appropriate.
- Obtain information from providers and be advised about all medically appropriate or necessary treatment options available for their condition, regardless of cost or benefit coverage.
- Participate fully in decisions about their healthcare and be informed about any risks involved in their care.
- Refuse treatment, leave a hospital or medical facility, or stop taking medications; the member must accept responsibility and the consequences of their decision.
- Complete an advance directive (living will or power of attorney) to help them with decisions related to their healthcare if they are unable.
- Voice complaints or appeals about the health plan or the care provided.
- Make recommendations regarding the health plan's member rights and responsibilities policy.
- Receive information about the appeals and grievances members have filed against Wellpoint in the past.
- Receive information about the Medicare Advantage plan, plan providers, drugs, healthcare coverage, and costs, including an explanation about any bills received for services or drugs not covered.
- Request information regarding provider compensation by Wellpoint.
- Receive a written or binding advance-coverage determination for healthcare services, even if the care is requested from a nonparticipating provider.

Members have the responsibility to:

- Be familiar with their coverage and the rules they must follow to obtain healthcare.
- Notify Wellpoint if they have additional health insurance coverage.
- Notify providers when seeking care that they are Medicare members and present their Wellpoint member ID cards.
- Provide the health plan, doctors, and practitioners with accurate information to render care and follow the treatment plans and instructions they agreed to with the provider.
- Understand their health problems and participate in identifying mutually agreed-upon treatment goals to the extent possible.
- Treat their provider, their provider's staff, and Wellpoint employees with respect and dignity.

- Not be disruptive in the provider's office.
- Pay their copayment for covered services.
- Notify Wellpoint if they have questions, concerns, problems, or suggestions (members may call Member Services at the DSU at **833-731-2167 [TTY 711]**.)

17 BENEFITS

17.1 Summary of Benefits Tables

Wellpoint member benefits are summarized in the Summary of Benefits. To view the Summary of Benefits tables, visit **https://shop.wellpoint.com/medicare.**

Notations regarding some benefit categories are listed below. Please note availability and limitations of Medicare Advantage supplemental benefits may vary by product and market. Please refer to the appropriate Summary of Benefits documents listed above for detailed information.

Prior authorization requirements are described in later sections and in detail on the Medicare Advantage provider website. All services from noncontracted providers, with the exception of urgent and emergent care and out-of-area dialysis, require prior authorization.
The medical benefits are further explained in the following sections.

17.2 Emergency Care

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

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

Wellpoint covers emergency services if they are:

- Furnished by a provider qualified to provide emergency services.
- Needed to evaluate or stabilize an emergent medical condition in accordance with the prudent layperson standard.

Members with an emergency medical condition should be instructed to call 911 and/or go to the nearest emergency hospital. Prior authorization for an emergency medical condition is not required.

17.3 Urgently Needed Care

Members needing urgent care (but not emergent care) are advised to call their PCP, if possible, prior to obtaining services. However, prior authorization is not required.
Urgently needed services are defined as those that are covered but are not emergent services and are provided:

- When the member is temporarily absent from the Medicare Advantage offered by Wellpoint service area, and such services are medically necessary and immediately required.
- As a result of an unforeseen illness, injury, or condition.
- If it is not reasonable, given the circumstances, to obtain the services through a Medicare Advantage offered by Wellpoint network provider.

Under unusual and extraordinary circumstances, services may be considered urgently needed services when the member is in the service area but the appropriate provider within the Medicare Advantage offered by Wellpoint provider network is temporarily unavailable or inaccessible.

17.4 Out-Of-Area Dialysis Services

Members may obtain medically necessary dialysis services from any qualified provider when they are temporarily absent from the Medicare Advantage offered by Wellpoint service area and cannot reasonably access contracted Medicare Advantage offered by Wellpoint dialysis providers. Members can obtain dialysis services without prior authorization or notification when outside of the Medicare Advantage offered by Wellpoint service area.
We suggest members advise Wellpoint if they will temporarily be out of the service area, so a qualified dialysis provider may be recommended.

17.5 Hospital Services

There are two types of admissions:

- Elective inpatient admissions — prior authorization is required for all elective inpatient admissions
- Emergency admissions — admitting physicians must notify us within 24 hours or by the next business day of the admission

The Wellpoint Health Care Management Services, in coordination with admitting physicians and hospital-based physicians, is in charge of:

- Coordinating and conducting continued-stay coverage reviews.
- Providing appropriate referrals for extended-care facilities.
- Coordinating coverage of all services required for adequate discharge.

Wellpoint case managers assist in coordinating all needed services in the discharge planning process, as well as coordinating the required follow-up by the appropriate providers.

17.6 Preventive Services

The following preventive services are offered to members with no member copays or cost sharing:

- Preventive visit
- Annual physical examination (in addition to the Medicare preventive visits)
- You may bill for one routine annual visit per year (for example, 99385–99387, 99395–99397) with diagnosis code V70.0
- Welcome to Medicare exam
- Annual wellness exam
- Bone mass measurements
- Colorectal screening
- Diabetic monitoring training
- Cardiovascular disease testing
- Mammography screening
- Pap tests, pelvic exams, and clinical breast exams
- Prostate cancer screening exams
- Abdominal aortic aneurysm screening
- Diabetes screening
- EKG screening
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- HIV screenings
- Medical nutrition therapy services
- Pneumococcal shots

- Smoking cessation (counseling to stop smoking)
- Depression screening

17.7 Domestic Violence Services

It is especially important that network providers be vigilant in identifying members who may have been subjected to domestic violence. Domestic violence screening tools are included below. Member Services can help members identify resources to protect themselves from further domestic violence. Providers should report all suspected domestic violence.
An individual can access the National Domestic Violence Hotline number by calling **800-799-7233**. For text telephone assistance, call **800-787-3224**.

17.8 Domestic Violence Screening Tools

Domestic Violence — Framing Statements:

- Because violence is so common in many people's lives, I have begun to ask all my patients about it.
- I'm concerned that someone hurting you may have caused your symptoms.
- I don't know if this is a problem for you, but many of the people I see as patients are dealing with abusive relationships.

Domestic Violence — Direct Verbal Questions:

- Are you in a relationship with a person who physically hurts or threatens you?
- Did someone cause these injuries? Was it your partner or spouse?
- Has your partner or ex-partner ever hit you or physically hurt you? Have they ever threatened to hurt you or someone close to you?
- Do you feel controlled or isolated by your partner?
- Do you ever feel afraid of your partner? Do you feel you are in danger? Is it safe for you to go home?
- Has your partner ever forced you to have sex when you did not want to? Has your partner ever refused to practice safe sex?

Domestic Violence — New Member
Option 1:

- Have you ever been hurt or threatened by your friend, spouse, or partner?
- Have you ever been hit, kicked, slapped, pushed, or shoved by your friend, spouse, or partner?
- Have you ever been hit, kicked, slapped, pushed, or shoved by your friend, spouse, or partner during this pregnancy?
- Have you ever been raped or forced to engage in sexual activity against your will?

Option 2:

- Are you currently or have you ever been in a relationship where you were physically hurt, threatened, or made to feel afraid?

Option 3:

- Have you ever been forced or pressured to have sex when you did not want to?
- Have you ever been hit, kicked, slapped, pushed, or shoved by your friend, spouse, or partner?

17.9 Sexual Abuse

It is required that each provider contact the applicable local state agency when sex abuse is suspected. If a suspected abuse case arises and a referral is required, the provider or member may call a specialty center directly or may call Wellpoint Member Services at **833-731-2167 (TTY 711)** for a list of the specialty centers near them.

17.10 Supplemental Benefits

Supplemental benefits are benefits in addition to the basic Medicare services offered through Medicare Part A and B: they are not benefits offered under the federal Medicare program. Wellpoint offers limited supplemental benefits to covered members as outlined in the *Summary of Benefits* documents. Please refer to the applicable *Summary of Benefits* for specific supplemental benefits being offered for each plan, as well as any limitations and requirements to utilize specific vendors for services. Providers will not be reimbursed for supplemental benefits that they are either not contracted for or that are required to be rendered by a specific vendor under Wellpoint. Members cannot be billed for non-covered services unless notified in advance. See **Provider Obligations — In-office Denials.**
Supplemental benefits vary by plan, product, and state. Below is a list of supplemental benefits we may choose to offer each calendar year in certain states and plans. Please refer to the *Summary of Benefits* documents for details on which plans cover certain supplemental benefits:

- Routine foot and nail care
- Routine eye examinations and eyeglasses
- Routine hearing examinations and hearing aids
- Dental examinations and cleanings
- Coverage of Over-The-Counter (OTC) items
- Generic drugs covered in the Part D coverage gap with the applicable generic prescription
- Nonemergency transportation
- Personal Emergency Response Systems (PERS) coverage for the service and monitoring equipment, but not the actual telephone line
- Routine acupuncture services
- Routine chiropractic care
- Fitness program through Silver Sneakers within their network of centers
- All plans have a Maximum Out-of-Pocket (MOOP) limit for medical services. The MOOP does include out-of-pocket costs for Part B drugs, but does **not** include Part D (pharmacy prescriptions) cost-sharing amounts. Once a member reaches their MOOP limit, all covered medical services will be covered at 100 percent for the remainder of the year.
- Telemonitoring or Electronic Health Monitoring
- Out-of-country emergency care
- Live Health Online

Everyday Extras — allows members to select a benefit to help them achieve their health goals. These benefits may help your patients with meals, mobility, and more. Prior authorization and/or recommendation from a licensed clinician may be required for some of these benefits. Please refer to the member's Evidence of Coverage.
Providers **contracted with the vendor network** associated with that supplemental benefit must bill that vendor directly.

Providers **not contracted with the vendor network** to render such a benefit, please note you will only be reimbursed or able to bill a member for non-covered services if you have provided the member with advanced notice of non-coverage. Please note that contracted providers are required to provide a coverage determination for services that are not covered by the

member's Medicare Advantage plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. As per the Medicare Advantage HMO and PPO Provider Guidebook, CMS has stated that the use of an *Advanced Beneficiary Notice* or a similar document is not sufficient in many instances with Medicare Advantage members. Therefore, you are required to seek a coverage determination prior to rendering such services.

Providers are encouraged to call the toll-free customer service number on the back of the member ID card with any questions around services that may or may not be covered.
Note: Not all supplemental benefits are available in all plans, and some limitations and restrictions apply. Some supplemental benefits must be rendered by the delegated vendor to be covered.

17.11 Dental Services

Some of our plans include preventive dental services that are covered by Wellpoint through a contracted dental vendor, except for dental services covered as emergency services. The Wellpoint managed care programs and dental health benefits complement one another because both emphasize prevention, quality, and cost-effectiveness. Wellpoint works with contracted dental providers to ensure access to the full range of preventive, primary, and specialty oral health services. Please see the *Summary of Benefits* documents for more information on dental benefits.

17.12 Optometry and Audiology Services

Some of our plans include coverage of routine vision and hearing services, including:

- Routine yearly visual exams.
- Screening for glaucoma.
- Hearing screening.

Contracted network providers, assisted by the Wellpoint Case Management Program, coordinate benefits for lenses and hearing aid devices when covered by the plan. Please see the *Summary of Benefits* documents for more information on vision and hearing benefits.

17.13 Over-the-Counter Items

Some of our plans include coverage of OTC items and health-related supplies. For those plans that include this benefit, members are provided with a monthly or quarterly allowance to obtain the items and supplies. For plans with a quarterly allowance, the benefit replenishes at the beginning of each quarter and carries across quarters, but any unused portion of the benefit does not carry over to the next year. For plans with a monthly allowance, the benefit replenishes at the beginning of each month, but any unused portion does not carry over to the next month. OTC products are described in a printed catalogue available to members.

17.14 Nonemergent Transportation

In many markets and benefit plans, Wellpoint provides nonemergent transportation through a contracted vendor. In other markets, these services must be arranged through the Wellpoint Case Management Program. See the ***Summary of Benefits*** documents for more information. Some plans have coverage of trips to obtain the following preventive services:

- Preventive visits:
  - Annual physical examination (in addition to the Medicare preventive visits)
    - You may bill for one routine annual visit per year (for example, 99385–99387, 99395–99397) with diagnosis code V70.0
  - Welcome to Medicare exam

  - Annual wellness exam
- Bone mass measurements
- Colorectal screening
- Diabetic monitoring training
- Cardiovascular disease testing
- Mammography screening
- Pap tests, pelvic exams, and clinical breast exams
- Prostate cancer screening exams
- Abdominal aortic aneurysm screening
- Diabetes screening
- EKG screening
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- HIV screening
- Medical nutrition therapy services
- Pneumococcal shot
- Smoking cessation (counseling to stop smoking)
- Depression screening

17.15 Telemonitoring or Electronic Health Monitoring

Telemonitoring is the coverage of in-home equipment (for example, BP cuff, scale, glucometer, and pulse OC) and telecommunication technology from contracted vendors to monitor enrollees with specific health conditions as determined by their physician. Conditions must be appropriate for this service, such as monitoring of weight for CHF and other chronic conditions that require regular monitoring of vital signs and/or other data as required by a physician. This service requires an initial physician visit and a physician's order for data transmission; however, the data will be transmitted at least on a weekly basis. Physicians are trained on monitoring protocols, and follow-up actions are required. The member is instructed on the use of the equipment, proper transmission, and related processes. Telemonitoring or Electronic Health Monitoring services supplement but do not replace a face-to-face physician visit.

18 PRESCRIPTION DRUG COVERAGE

All Medicare Advantage offered by Wellpoint plans include coverage of Medicare Part D prescription drugs, as well as those covered under Medicare Part B.

18.1 Part D Prescription Drugs

In general, Medicare Part D covers drugs that are only available by prescription, are used or sold in the United States, and must be used for medically accepted indications. Part D prescription drugs covered by Medicare Advantage offered by Wellpoint are listed in the Wellpoint five-tier formulary. Medically Accepted Indication for purposes of Part D is an FDA-labeled indication or an indication supported by citation in either the American Hospital Formulary System (AHFS) or *DRUGDEX®. Exceptions may be possible when used as part of an anti-cancer chemotherapeutic regimen.* The formulary includes most generic drugs covered under the Part D program, as well as many brand-name drugs, nonpreferred brands, and specialty drugs. One can view a copy of the formulary on the Wellpoint website at **wellpoint.com/provider**. From the *Quick Tools* link, select **Pharmacy Tools**, then **Medicare Formularies,** or request a copy from the Provider Relations department. Some of these drugs may require prior authorization, have step-therapy requirements, or have quantity limits. Providers may request a coverage determination, which can include prior authorization, tiering exception (request for a drug to be covered at a lower cost), or for a drug that is not on the formulary, by contacting the Provider Services at the DSU at **866-805-4589**. Members should obtain Part D covered drugs from a network pharmacy pursuant to a physician's prescription.

Please refer to the formulary when prescribing for Wellpoint members. The formulary will tell you if the drug requires prior authorization or has a quantity limit, and, if it is not listed, then it is considered non-formulary and will require a coverage determination. For Medicare Advantage offered by Wellpoint Part B, contact Provider Services at **866-805-4589 Option 5**, from 8 a.m. to 8 p.m. local time, Monday through Friday. For Medicare Advantage offered by Wellpoint Part D, call the CarelonRx pharmacy services phone number on the back of the member ID card.

18.2 Prescription Drugs by Mail Order

Members can use the mail-order service to fill prescriptions for maintenance drugs (in other words, drugs taken on a regular basis for a chronic or long-term medical condition). For mail-order prescriptions, the physician must write on the maintenance drug prescription whether it is for a 30-, 60-, 90-, or 100-day supply. When mailing in a prescription to the mail-order service for the first time, the member should allow up to two weeks for the prescription to be filled. For refills of the same prescription, members should allow up to two weeks for mailing and processing.

If a member runs out of a medication before receiving a new supply from the mail-order pharmacy, please call the DSU at **866-805-4589**. They will assist with obtaining an emergency supply of the member's medication until they receive the new mail-order supply.
Members are not required to use mail-order prescription drug services to obtain an extended supply of maintenance medications. Members also have the option of using a retail pharmacy in the Medicare Advantage offered by Wellpoint network to obtain their maintenance medications. Some retail pharmacies may agree to accept the mail-order reimbursement rate for an extended supply of medication, which may result in no out-of-pocket payment difference to the member. The member pays one copayment for each 30-day supply or a reduced copayment for a 60- or 90-day supply when obtaining maintenance drugs via mail order, unless the member has a Low-Income Subsidy (LIS) level that helps them

pay for their Part D prescription drugs. In such cases, one LIS copayment applies for the transaction.

18.3 Part B Prescription Drugs

Prescription drugs covered under the Medicare Part B benefits are very limited. These include the following:

- Injectable medications provided incidental to a physician's service
- Drugs administered through covered durable medical equipment, such as a nebulizer or infusion pump, in the home
- Certain oral cancer medications
- Antiemetic drugs administered within 48 hours of chemotherapy
- Immunosuppressive drugs prescribed following a Medicare-covered organ transplant
- Erythropoietin for individuals undergoing chronic renal dialysis
- Parenteral nutrition for members with a permanent dysfunction of the digestive tract

Other drugs may be covered under Part B in certain limited situations. Many Part B drugs and injectable medications provided incidental to a physician's service require Prior Authorization from Wellpoint. Please call the DSU for additional information.

18.4 Covered Vaccines

CMS and Wellpoint, through the Medicare Advantage offered by Wellpoint plans, cover vaccines and vaccine administration for Medicare recipients. Listed below are the vaccine benefits covered under Medicare Part B, Medicare Part D, and those covered under either Medicare Part B or Part D coverage.

18.5 Vaccines and Vaccine Administration Coverage Under Medicare Part B (Medical) Benefits

Medicare Part B benefits include the following routine immunizations:

- Pneumococcal pneumonia vaccine
- Influenza virus vaccine
- COVID vaccine

Claims for Medicare Part B benefits should be submitted to Wellpoint for processing and reimbursement at:

Attn: Claims Department
Wellpoint
P.O. Box 61010
Virginia Beach, VA 23466-1010

18.6 Vaccines and Vaccine Administration Coverage Under Medicare Part D (Pharmacy) Benefits

Medicare Part D generally covers vaccines not available under Medicare Part B. Medicare Part D vaccines are included in the Wellpoint Formulary located online at **provider.wellpoint.com/**. From the *Quick Tools* link, select **Pharmacy Tools**, then **Medicare Formularies**. Providers who do not have access to a vaccine on the formulary can call the prescription into a participating pharmacy. If the vaccine is administered in a network pharmacy, the pharmacy will transmit the claim to the Pharmacy Benefit Manager for processing and reimbursement.

Providers who have a supply and administer the vaccine in their office should collect the member's copay at the time of service and submit the claim for the vaccine and administration on a *CMS 1500* (*02-12*) form to:

Attn: Claims Department
Wellpoint
P.O. Box 61010
Virginia Beach, VA 23466-1010

To streamline your claim processing and payment (as applicable) for these and other preventive vaccines covered under Part D, providers may use Transactors, a clearinghouse for claims submission.

To use TransactRX, contact the clearinghouse at the website (**transactrx.com**) or call Customer Service at **866-522-3386**. Physicians, facilities, health clinics, and pharmacies may use this clearinghouse to process Part D claims. There is a service fee of $2.50 for check payments on claims.
For member copayment information, please contact the DSU at **866-805-4589**.

18.7 Vaccines Covered Under Either Part B (Medical) or Part D (Pharmacy) Benefit Coverage

These vaccines may require a coverage determination to determine appropriate coverage. Vaccines administered directly related to the treatment of an injury or direct exposure to a disease or condition would be covered under Part B. Vaccines administered for prevention of an illness and not covered under Medicare Part B (influenza or pneumococcal) would be covered under Part D. Hepatitis B coverage depends on the risk of contracting hepatitis B. Low risk is Part D and moderate or high risk is Part B. Vaccines that may be Part B or Part D are:

- Hepatitis A vaccine
- Hepatitis B vaccine
- Anthrax vaccine
- Rabies vaccine
- Tetanus toxoid, tetanus-diphtheria toxoids

For reimbursement of a vaccine and vaccine administration that could be either Part B or Part D, indicate the reason for immunization (injury and/or direct disease exposure or prevention of an illness) and risk of contracting hepatitis B on a *CMS-1500* (02-12) claims form and submit to:
Wellpoint
P.O. Box 61010
Virginia Beach, VA 23466-1010

Additional information can be found on the CMS website under the Medicare Learning Network General Information page at **cms.gov**.

18.8 Coverage Determinations for Part D Prescription Drug Benefits

Coverage determinations: The first decision made by a plan regarding the prescription drug benefits an enrollee is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request and a decision on the amount of cost sharing for a drug.

A coverage determination is any decision Wellpoint makes regarding:

- A decision about whether to provide or pay for a Part D drug, including a decision not to pay because the drug is not on the plan's formulary, the drug is determined not to be medically necessary, the drug is furnished by an out-of-network pharmacy or we determine the drug is otherwise excluded, but the member believes it may be covered by the plan
- Failure to provide a coverage determination in a timely manner, when a delay would adversely affect the member's health
- A decision concerning a tiering exception request
- A decision concerning a formulary exception request
- A decision on the amount of cost sharing for a drug
- A decision on whether a member has satisfied a prior authorization or other utilization management requirement

Two decisions govern the need for prescription drugs the member has not yet received:

- A standard decision made within the standard 72-hour time frame
- An expedited decision made within 24 hours

An expedited decision can only be requested if the member or any physician believes waiting for a standard decision could jeopardize the member's life, health, or ability to regain maximum function. This is called the expedited criteria.
The member or a physician can request an expedited decision. If a physician requests an expedited decision or supports a member in asking for one, and if the physician indicates the situation meets the expedited criteria, Wellpoint will automatically provide an expedited decision within 24 hours from the initial request.

18.9 Formulary Exceptions

If a prescription drug is not listed in the Wellpoint formulary, please check the updated formulary on the Wellpoint website. The website formulary is updated frequently with any changes. In addition, providers may contact the Wellpoint Pharmacy department to be sure a drug is covered. If the Pharmacy department confirms the drug is not on the formulary, there are two options:

- The prescribing physician can prescribe another drug that is covered on the formulary.
- The patient or prescribing physician may ask Wellpoint to make an exception (a type of coverage determination) to cover the non-formulary drug. If the member pays out-of-pocket for a nonformulary drug and requests an exception, Wellpoint approves, Wellpoint will reimburse the member. If the exception is not approved, the member may appeal the plan's denial. See the **Medicare Member Liability Appeals section** for more information on requesting exceptions and appeals.

In some cases, Wellpoint will contact a member who is taking a drug that is not on the formulary. Wellpoint will give the member the names of covered drugs used to treat their condition and encourage the member to ask their physician if any of those drugs would be appropriate options for treatment. Also, members who recently joined a Wellpoint plan may be able to get a temporary supply of a drug they are taking if the drug is not on the Wellpoint formulary.

18.10 Transition Policy

New members in Wellpoint plans may be taking drugs that are not on the formulary or that are subject to certain restrictions, such as prior authorization or step-therapy. Current members may also be affected by changes in the formulary from one year to the next.

Members are encouraged to talk to their providers to decide if they should switch to a different drug Wellpoint covers or request a formulary exception in order to get coverage for the drug (as described above).

During the period of time members are talking to their providers to determine the right course of action, Wellpoint may provide a temporary supply of the nonformulary drug if those members need a refill for the drug during the first 90 days of new membership in a Wellpoint plan. For current members affected by a formulary change from one year to the next, Wellpoint will provide a temporary supply of the nonformulary drug for members needing a refill for the drug during the first 90 days of the new plan year.

When a member goes to a network pharmacy and Wellpoint provides a temporary supply of a drug that is not on the formulary or that has coverage restrictions or limits (but is otherwise considered a Part D drug), Wellpoint will cover at least a one-time, 30-day supply (unless the prescription is written for fewer days). After we cover the temporary 30-day supply, Wellpoint generally will not pay for these drugs again as part of the transition policy. Wellpoint will provide the member and the provider with a written notice after it covers a temporary supply. The notice will explain the steps the member can take to request an exception and the way to work with the prescribing physician to decide if switching to an appropriate formulary drug is feasible.

If a new member is a resident of a long-term care facility (like a nursing home), Wellpoint will cover a temporary 34-day transition supply (unless the prescription is written for fewer days). If necessary, Wellpoint will cover more than one refill of these drugs during the first 90 days a member is enrolled in our plan. If the member has been enrolled in the plan for more than 90 days and needs a drug that is not on the formulary or is subject to other restrictions, such as step therapy or dosage limits, Wellpoint will cover a temporary 34-day emergency supply of that drug (unless the prescription is for fewer days) while the new member requests a formulary exception.

This policy also applies to current Medicare members who experience a change in the level of their care. For example, if a member leaves the hospital and enters a long-term care facility or leaves hospice status and reverts back to standard care, the member may receive a temporary transition supply of the nonformulary drug for up to 30 days, unless the prescription is written for fewer days.

Please note the Wellpoint transition policy applies only to those prescription drugs that are Part D drugs.

18.11 Medication Therapy Management

The ***Medicare Modernization Act of 2003*** requires ***Medicare Part D*** prescription drug plans to include medication therapy management services delivered by a qualified healthcare professional, including pharmacists. MTM services target beneficiaries who have multiple chronic conditions (such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure), take multiple medications, or are likely to incur annual costs above a predetermined level. Wellpoint supports Medicare MTM in a variety of ways:

- Medication Management Services (Medicare Advantage offered by Wellpoint Members)
- In-House Consults by Wellpoint Pharmacists

19 FRAUD, WASTE, AND ABUSE DETECTION

Wellpoint is committed to protecting the integrity of 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 committing it — or any other person. The attempt itself is fraud, regardless of whether or not it is successful.
- **Waste:** Includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** When healthcare providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

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.**

19.1 Reporting fraud, waste, and abuse

If someone suspects any member or provider (a person who receives benefits) 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 their callback number will be kept in strict confidence by investigators.

Report concerns by:

- Visit **provider.wellpoint.com/,** scroll to the bottom footer and select **Waste, Fraud and Abuse** to be directed to the **fighthealthcarefraud** education site; at the top of the page, select **Report it** and complete the ***Report Waste, Fraud and Abuse*** form.
- Calling Provider Solutions.

Any incident of fraud, waste, or abuse may be reported to Wellpoint anonymously; however, the 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. Wellpoint appreciates referrals for suspected fraud, but be advised that Wellpoint does not routinely update individuals who make referrals, 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
- Obtaining controlled substances from multiple providers
- Relocating to out-of-service Plan area
- Using someone else's 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 fraud, waste, or abuse

Examples of provider fraud, waste, and abuse (FWA):

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

When reporting concerns involving a provider (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 healthcare fraud and how to aid in the prevention of it, visit **fighthealthcarefraud.com.**

19.2 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 requests for repayment or may advise of further action.
- **Medical record review**: Wellpoint reviews medical records to investigate allegations or validate the appropriateness of claims submissions.
- **Edits**: A certified professional coder or investigator evaluates claims and places payment or system edits in the Wellpoint claims processing system. This type of review prevents 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, or legal action.

19.3 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 the attention of Wellpoint 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 their/its peers.

Once a Claim, or a provider or facility, is identified as an outlier or has otherwise come to the attention of Wellpoint 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. The provider or facility will be given the opportunity to request a discussion of their/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.

Finally, 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.

19.4 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

19.5 Recoupment/Offset/Adjustment for Erroneous Payments

Wellpoint shall be entitled to recoup, offset, and adjust an amount equal to any Erroneous Payments (including, but not limited to, any improper payment, duplicate payment, or overpayment) made by Wellpoint to Provider against any payments due and payable by Wellpoint to Provider with respect to any Health Benefit Plan under this Agreement. Provider shall voluntarily refund all Erroneous Payments regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive, or wasteful. Upon determination by Wellpoint that any Erroneous Payment is due from Provider, Provider must refund the amount to Wellpoint within thirty (30) days of when Wellpoint notifies Provider. If such reimbursement is not received by Wellpoint within the thirty (30) days following the date of such notice, Wellpoint shall be entitled to offset such

Erroneous Payment against any payments due and payable by Wellpoint to Provider under any Health Benefit Plan in accordance with Regulatory Requirements. In such event, Provider agrees that all future payments applied to satisfy Provider's repayment obligation shall be deemed to have been paid in full for all purposes, *including the Payment in Full and Hold Harmless section of the Provider Agreement*. Should Provider disagree with any determination by Plan that Provider has received an Erroneous Payment, Provider shall have the right to appeal such determination under Wellpoint's procedures set forth in the provider manual(s), and such appeal shall not suspend Wellpoint's right to recoup the Erroneous Payment amount during the appeal process unless suspension of the right to recoup is otherwise required by Regulatory Requirements. Wellpoint reserves the right to employ a third-party collection agency in the event of non-payment.

20 GLOSSARY OF TERMS

Appeal: As defined by the CMS Parts C & D Grievances, Organization/Coverage Determinations, and Appeals Guidance, the procedures that deal with the review of adverse initial determinations made by the plan on healthcare services or benefits under Part C or D the enrollee believes they are entitled to receive, including delay in providing, arranging for, or approving the healthcare services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 C.F.R. §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council, and judicial review. This process is separate from the participating provider appeals/dispute process.
Balance + Rx Plan: The Balance + Rx Plan provides coverage of major medical services after satisfaction of an annual deductible. Outpatient services, such as primary care and specialist visits, are covered with reasonable copays for professional services outside of the deductible. This includes Medicare Part D prescription coverage. This plan has no out-of-network benefits
Basic benefits: Aervices covered for all Medicare beneficiaries under Medicare Part A and Part B. All Medicare Advantage members receive all basic benefits, including all healthcare services covered under Medicare Part A and B programs, except for hospice services. Wellpoint also provides supplemental benefits not covered by fee-for-service Medicare
CMS: Centers for Medicare & Medicaid Services; the federal agency responsible for administering the Medicare program.
Contracting hospital: A hospital that has a contract to provide services and/or supplies to Medicare members
Contracting medical group: A group of physicians organized as a legal entity for the purpose of providing medical care with a contract to provide medical services to Medicare members
Contracting pharmacy: A pharmacy that has a contract to provide Medicare members with medications prescribed by their providers in accordance with the Wellpoint contract
Cost sharing obligations: Medicare deductibles, premiums, copays, and coinsurance that the state plan is obligated to pay for certain Medicare beneficiaries (QMBs, SLMB-Plus, and other Medicare/Medicaid dual eligibles). For SLMB-Plus and Other Medicare/Medicaid dual eligibles, the state plan is not required to pay Medicare coinsurance on those Medicare services that are not covered by the state plan unless the enrollee is a child under 21 or an SSI beneficiary. No plan can impose cost-sharing obligations on its members greater than those that would be imposed on the member if they were not a member of the plan.
Coverage determination: As defined by the CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, a determination made by a Part D plan sponsor or its delegated entity with respect to the following:

- A decision about whether to provide or pay for a drug that an enrollee believes may be covered by the plan sponsor, including a decision related to a Part D drug that is: not on the plan's formulary; determined not to be medically necessary; furnished by an out-of-network pharmacy; or otherwise excluded under Federal law if applied to Medicare Part D;
- A decision on the amount of cost sharing for a drug;
- Failure to provide a coverage determination in a timely manner when a delay would adversely affect the health of the member;
- A decision about a tiering exception request; or
- A decision about a formulary exception request.

Covered services: Those benefits, services, or supplies that are:

- Provided or furnished by providers or authorized by Wellpoint or its providers

- Emergency services and urgently needed services that may be provided by nonproviders
- Renal dialysis services provided while members are temporarily outside the service area
- Basic and supplemental benefits

Dual-eligible: A Medicare enrollee who is eligible for Medical Assistance from the state under Medicaid and for whom the state may have responsibility for payment of Medicare cost-sharing obligations under the state plan. Dual-eligibles include the following categories of recipients: Qualified Medicare Beneficiary (QMB) Only, QMB Plus, Specified Low-income Medicare Beneficiary (SLMB) Plus, Qualified Disabled and Working Individuals (QDWI), Qualified Individual (QI), or other Full Benefit Dual-Eligible (FBDE) recipients. Check the specific plan's eligibility requirements for those eligible to enroll into the specific plan.

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

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

Emergency services: Covered inpatient or outpatient services furnished by a provider qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition in accordance with the prudent layperson standard

Experimental procedures and items: Procedures and items determined by Wellpoint and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, Wellpoint will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or CMS guidance already made by Medicare. Section 1862(a)(1)(E) of the *Social Security Act*, prohibits payment for procedures that are deemed experimental and/or investigational in nature

Exceptions: An exception request is a type of coverage determination request. Through the exception process, the member can request an off-formulary drug, an exception to the Wellpoint tiered cost-sharing structure or an exception to the application of a cost utilization management tool (for example, step therapy requirement, dose restriction or prior authorization requirement).

Fee-for-service Medicare: Medicare coverage managed by the federal government and not through a CMS-contracted private health plan (also known as traditional and/or original Medicare)

Full Benefit Dual-Eligible (FBDE): An individual who is eligible for both Medicare Part A and/or Part B and for state benefits (services), including those who are categorically eligible and those who qualify as medically needy under the state plan.

Grievance: As defined by the CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, an expression of dissatisfaction with any aspect of the operations, activities, or behavior of a plan or its delegated entity in the provision of healthcare items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination, coverage determination, or LEP determination.

Home health agency: A Medicare-certified home health agency is one that provides intermittent skilled nursing care and other therapeutic services in a member's home when medically necessary, when members are confined to their home, and when authorized by their primary care physician

Hospice: A Medicare-certified organization or agency primarily engaged in providing pain relief, symptom management, and support services to terminally ill people and their families
Hospital: A Medicare-certified institution licensed by the state that provides inpatient, outpatient, emergency, diagnostic, and therapeutic services. The term hospital does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily custodial care, including training in routines of daily living
Independent practice association: A group of physicians that functions as a contracting medical provider/group, but in which the individual member physicians operate their respective independent medical offices
Medicaid: The federal health insurance program established by *Title XIX* of the *Social Security Act* and administered by states for low-income individuals
Medicaid-Only Dual Eligibles (Non QMB, SLMB, QDWI, QI): An individual who is entitled to Medicare Part A and/or Part B and is eligible for full Medicaid benefits. A Medicaid-Only Dual Eligible is not eligible for Medicaid as a QMB, SLMB, QDWI, or QI. Typically, the individual needs to spend down to qualify for Medicaid or fall into a Medicaid eligibility poverty group that exceeds the limits listed above. Medicaid provides full Medicaid benefits and pays for Medicaid services provided by Medicaid providers, but Medicaid will only pay for services also covered by Medicare if the Medicaid payment rate is higher than the amount paid by Medicare, and, within this limit, will only pay to the extent necessary to pay the beneficiary's Medicare cost sharing liability. Payment by Medicaid of Medicare Part B premiums is a State option; however, States may not receive federal financial participation (FFP) for Medicaid services also covered by Medicare Part B for certain individuals who could have been covered under Medicare Part B had they been enrolled. The Federal government will pay its cost share according to the standard Federal medical assistance percentage (FMAP).
Medically necessary: Medical services or hospital services determined by Wellpoint to be:

- Rendered for the diagnosis or treatment of an injury or illness.
- Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards.
- Not furnished primarily for the convenience of the member, the attending provider, or other provider of service.

We make determinations of medical necessity based on peer-reviewed medical literature, publications, reports, and evaluations; regulations and other types of policies issued by federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by Wellpoint. *Section 1862(a)(1)(A)* of the *Social Security Act*, states that Medicare payment can only be made for services/items that are medically necessary and reasonable.
Medicare: The federal health insurance program established by *Title XVIII* of the *Social Security Act* and administered by the federal government for elderly and disabled individuals
Medicare Part A: Medicare Part A covers hospital insurance benefits, including inpatient hospital care, skilled nursing facility care, home health agency care, and hospice care offered through Medicare.
Medicare Part A premium: Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers, and by part of the self-employment tax paid by self-employed persons. If members are entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, island, or local government employment to be insured, they do not have to pay a monthly premium. If members do not qualify for premium-free Part A benefits, members may buy the coverage from Social Security if they are at least 65 years old and meet certain other requirements.
Medicare Part B: Optional, supplemental medical insurance requiring a monthly premium. Medicare Part B covers physician (in both hospital and nonhospital settings) and certain nonphysician services. Other Part B services include lab testing, durable medical equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services, and blood products not covered under Part A.

Medicare Part B premium: A monthly premium paid to Medicare (usually deducted from a member's Social Security check) to cover Part B services. Members must continue to pay this premium to Medicare to receive covered services, whether members are covered by a Medicare Advantage plan or by original Medicare.
Medicare Part C: Optional coverage that can be elected by the Medicare beneficiary. Coverage under Part C is provided by private healthcare plans. The health plan must provide all Part A and B services and may offer additional benefits to the beneficiary. Also known as Medicare Advantage.
Medicare Part D: The prescription drug coverage provided by a Medicare Advantage (MA) plan or by a stand-alone Prescription Drug Plan (PDP) contracted with CMS. The MA plan or PDP may charge the beneficiary premiums and cost sharing for this coverage. Wellpoint offers MA-PD plans in specific markets.
Medicare Advantage (MA) agreement: The agreement between Wellpoint and CMS to provide Medicare Part C and other health plan services to Wellpoint members.
Medicare Advantage (MA) plan: A policy or benefit package offered by a Medicare Advantage Organization (MAO) in which a specific set of health benefits are offered at a uniform premium level of cost sharing to all Medicare beneficiaries residing in the corresponding service area. An MAO may offer more than one benefit plan in the same service area. The Medicare Advantage offered by Wellpoint plan is a kind of MA plan.
Member: A Medicare beneficiary entitled to receive covered services who has voluntarily elected to enroll in the Medicare Advantage offered by Wellpoint plan and whose enrollment has been confirmed by CMS
Noncontracting medical provider or facility: Any professional person, organization, health facility, hospital, or other person or institution that is licensed and/or certified by the state and/or Medicare to deliver or furnish healthcare services; and that is neither employed, owned, operated by, nor under contract with Wellpoint to deliver covered services to Medicare members.
Provider: Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the state and/or Medicare to deliver or furnish healthcare services. This individual or organization has a contract directly or indirectly with Wellpoint to provide services directly or indirectly to Medicare members pursuant to the terms of the participating provider agreement.
Provider liability appeal: A request for Wellpoint to review a decision by the Wellpoint Health Care Management Services to deny payment without member liability for services already rendered.
Provider payment dispute: A formal request from a provider contesting the paid amount on a claim, which does not include a medical necessity or administrative denial, and claims payment determinations have already been rendered. The claim has been finalized, but the provider disagrees with the amount paid.
Primary Care Provider (PCP): A provider physician selected by a member to coordinate the member's healthcare. The PCP is responsible for providing covered services for Medicare members and coordinating referrals to specialists. PCPs usually practice internal medicine, family practice, or general practice medicine.
Qualified Disabled and Working Individual (QDWI): An individual who has lost their Medicare Part A benefits due to their return to work. A QDWI is eligible to purchase Medicare Part A benefits, have income of 200 percent of the FPL or less, and resources that do not exceed twice the limit for SSI eligibility, and is not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only. The federal government will pay its cost-share according to the standard Federal medical assistance percentage (FMAP).
Qualifying Individuals (QI): An individual who is entitled to Medicare Part A, have income of at least 120 percent of the FPL, but less than 135 percent of the FPL, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only. The federal government will pay its cost-share according to the standard Federal medical assistance percentage (FMAP) at 100 percent.

Qualified Medicare Beneficiary (QMB): An individual who is entitled to Medicare Part A, has income that does not exceed 100 percent of the FPL, and whose resources do not exceed twice the SSI limit. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance, and copays (except for Medicare Part D). Collectively, these benefits (services) are called QMB Medicaid benefits (services). Categories of QMBs are as follows:

- QMB Only — QMB who is not otherwise eligible for full Medicaid
- QMB Plus — QMB who also meets the criteria for full Medicaid coverage and is entitled to all benefits (services) under the state plan for fully eligible Medicaid recipients

Specified Low-income Medicare Beneficiary (SLMB) without full Medicaid (SLMB only): An individual who is entitled to Medicare Part A, has an income of greater than 100 percent of the Federal Poverty Level (FPL) but less than 120 percent of the FPL, and their resources do not exceed twice the limit for Supplement Security Income (SSI) eligibility and who is not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.

Specified Low-income Medicare Beneficiary with full Medicaid (SLMB Plus): An individual who is entitled to Medicare Part A, has an income of greater than 100 percent of the FPL but less than 120 percent of the FPL, and their resources do not exceed twice the limit for SSI eligibility, and who is eligible for full Medicaid benefits. Medicaid pays their Medicare Part B premiums and provides full Medicaid benefits.

Service area: A geographic area approved by CMS within which an eligible individual may enroll in a Medicare Advantage plan. The geographic area for each Medicare Advantage plan is located in the Summary of Benefits document.

Special Needs Plan (SNP): A type of Medicare Advantage plan that also incorporates services designed for a certain class of members. Plans offering SNPs receive special approval from CMS. A SNP also provides Medicare Part D drug coverage.

Dual Coordination, Dual Premier, and Dual Secure Plan: The Wellpoint dual-eligible special needs plan available to dual-eligibles. Although this plan has cost sharing for certain services, cost sharing may be paid by the state Medicaid agency or by Wellpoint through an arrangement with Medicaid. There are low copays for Medicare Part D prescription coverage. This plan has no out-of-network benefits.

Urgently needed services: Those covered services provided when the member is temporarily absent from the Medicare Advantage service area, or under unusual and extraordinary circumstances, services provided when the member is in the service area but the member's PCP is temporarily unavailable or inaccessible, when such services are medically necessary and immediately required as a result of an unforeseen illness, injury or condition; and it is not reasonable given the circumstances to obtain the services through the PCP.

21 FORMS

Forms can be found on our website **wellpoint.com/provider**.

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GN=J9?=´HJGNA<=<´:Q[´ÅF´ JARGF9[´4=ÐHGAFL´1=P9K[´ÅF;n´4=ÐHGAFL´,@AG[´ÅF;n´GJ´4=ÐHGAFL´ÅFKMJ9F;=´ GEH9FQ[´ÅF´ÅGO9[´4=ÐHGAFL´ÅGO9[´ÅF;n´ÅF´+=O´'=JK=Q[´4=ÐHGAFL´+=O´'=JK=Q[´ÅF;n´GJ´4=ÐHGAFL´ÅFKMJ9F;=´ GEH9FQ[´ÅF´0GML@´ 9JGÐAF9[´4=ÐHGAFL´0GML@´ 9JGÐAF9[´ÅF;n´ÅF´1=FF=KK==[´ÅF;n´GJ´4=ÐHGAFL´1=FF=KK==[´ÅF;n´GJ´4=ÐHGAFL´ÅFKMJ9F;=´ GN=J9?=n´ÅF´1=P9K[´4=ÐHGAFL´ÅFKMJ9F;=´ GEH9FQ´GJ´4=ÐHGAFL´1=P9K[´ÅF;n´ÅF´49K@AF?LGF[´4=ÐHGAFL´49K@AF?LGF[´ÅF;n´O@G´HJG>GMF<ÐQ´9;CFGOÐ=<?=K´9F<´J=KH=;LK´L@=´AF@=J=FL´KGN=J=A?FLQ´G>´L@=´>=<=J9ÐQ´J=;G?FAR=<´1JA:=K´AF´49K@AF?LGF´KL9L=n´ÅF´GMJ´=»GJLK´LG´HJGEGL=´@A?@£IM9ÐALQ´@=9ÐL@;9J=n´O=´@GFGJ´L@=´1JA:9Ð´JA?@L´G>´K=Ð£?GN=JF9F;=n´@GÐ<AF?´AF´<==H´=KL==E´L@=´?GN=JFE=FL£LG£?GN=JFE=FL´J=Ð9LAGFK@AH´=PAKLAF?´:=LO==F´L@=´KL9L=´9F<´L@=´1JA:=K[´9´:GF<´J=AL=J9L=<´:Q´L@=´ =FL=FFA9Ð´ ;;GJ<´9F<´=KL9:ÐAK@=<´:Q´/ 4´_^Y^baN´4=´@=9JLAQ´;GEEAL´LG´=F@9F;AF?´GMJ´;GGJ<AF9LAGF[´;GÐ9:GJ9LAGF[´9F<´J=;G?FALAGF´G>´L@=´<==HÐQ´JGGL=<´LJ9<ALAGFK´9F<´N9ÐM=K´G>´L@=´1JA:9Ð´;GEEMFALA=K[´ÅF´4=KL´3AJ?AFA9[´4=ÐHGAFL´4=KL´3AJ?AFA9[´ÅF;n