
Overview

The Plan provides reimbursement to participating providers for inpatient or outpatient hospital services. Care provided to eligible members includes those services that are primarily for the treatment of acute illness, injury, or impairment or for maternity care.

WellCare establishes reimbursement limitations as required by the Georgia state contract to ensure medical necessity of services rendered and utilization control.

Medically necessary services are those that are:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition;
- Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Compatible with the standards of acceptable medical practice in the community;
- Not provided solely for the convenience of the member or the convenience of the Plan or hospital;
- Not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage; and
- No other effective, more conservative or substantially less costly treatment, service or setting may be available.

Coverage is provided for eligible members for preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. Care must be rendered under the direction of a doctor or by an institution which is licensed or formally approved as a hospital by an officially designated state standard-setting authority. The provider must be qualified to participate under Title XIX (Medicaid) of the Social Security Act.

SCOPE OF SERVICES

Section 7

In compliance with Section 1902 (a) (57) of the Social Security Act, hospitals must:

- Provide written information to patients regarding their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
- Provide written information to individuals regarding the institution's or program's written policies respecting the implementation of the right to formulate advance directives;
- Document in the patient's medical record whether or not an advance directive has been executed;
- Comply with all requirements of state law respecting advance directives;
- Provide (individually or with others) education for staff and the community on issues concerning advance directives; and
- Not condition the provision of care or otherwise discriminate against an individual who has executed an advance directive.

WellCare defines an *inpatient* as a patient who has been admitted to a participating hospital on recommendation of a licensed doctor and is receiving room, board and professional services in the hospital on a continuous 24-hour-a-day basis. Transfers between units within the hospital are not considered new admissions, unless it is a transfer from a medical unit to a psychiatric unit. Refer to the **Utilization Management and Care Coordination section** for more information.

WellCare defines an *outpatient* as a patient who is receiving professional services at a participating hospital, but who is not provided room and board and professional services on a continuous 24-hour-a-day basis. Observation services are also considered outpatient. Observation services usually do not exceed 24 hours.

However, some patients may require 48 hours of outpatient observation services. Refer to the **Utilization Management and Care Coordination section** for more information.

Free-standing (satellite) clinics, which are not operated as part of a hospital, are considered doctors' offices by WellCare. Services provided in these clinics and other away-from-hospital settings are not covered as hospital services.

Hospital-based clinics, which are operated as part of a hospital, are considered outpatient hospital-based facilities by WellCare. As such, these facilities must follow authorization rules for hospital based services. Refer to the **Utilization Management and Care Coordination section** for more information.

Level of care determinations will be based on InterQual™ Criteria and Medical Director review.

Documentation and Coding Requirements

WellCare's requirements for documentation and coding dictate that written records must be maintained and fully disclose the extent, medical necessity and appropriateness of the setting for services provided. The records must identify the member, support the diagnosis, justify the treatment and document the course of care and results accurately. Written records are subject to audit by WellCare, and coding will be evaluated against chart documentation for accuracy. Refer to the **Utilization Management and Care Coordination section** for more information on retrospective review.

Medical records for WellCare members must include the following:

- Identity of the patient;
- Medical history of the patient;
- Report of relevant physical examination;
- Diagnostic and therapeutic orders;

SCOPE OF SERVICES

Section 7

- Evidence of appropriate informed consent;
- Clinical observations, including the results of therapy;
- Reports and results of procedures and tests;
- Conclusions at termination of hospitalization, evaluation or treatment;
- Condition of the patient upon discharge and instructions given to the patient and family; and
- Signature and date for each entry.

Inpatient medical care records must contain at least the following:

- Identification data including the patient's name, address, date of birth, next of kin and a number that identifies the patient and the patient's medical record;
- Medical history completed within 24 hours of admission, including the chief complaint, details of the present illness, relevant past, social and family histories and an inventory of body systems;
- Relevant obstetrical records and prenatal information;
- Report of the physical examination, completed within 24 hours of admission;
- A statement of conclusions or impressions drawn from the admission history and physical examination;
- A statement of the course of action planned for the patient while in the hospital including a periodic review of the planned course of action, as appropriate;

SCOPE OF SERVICES

Section 7

- Diagnostic and therapeutic orders written by medical staff members (verbal orders must be authenticated);
- Appropriate informed consent;
- Clinical observations;
- Progress notes by the medical staff which give a chronological report of the patient's course in the hospital and reflect changes in condition and the results of treatment;
- Consultation reports that contain the consultant's written opinion and reflect, when appropriate, an actual examination of the patient and the patient's medical record;
- Nursing notes and entries by non-physicians that contain medically relevant observations and information;
- Reports of procedures, tests and their results;
- A pre-operative diagnosis recorded prior to surgery by the individual responsible for the patient;
- Operative report dictated or written on the medical record immediately after surgery containing a description of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis and the name of the primary surgeon and any assistants;
- Reports of pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatment, anesthesia records and any other diagnostic or therapeutic procedures;
- Clinical summary at termination of hospitalization which recapitulates the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient upon discharge and any significant instructions

given to the patient and family;

- In teaching hospitals, the medical record must make it clear that the attending physician is providing professional services independently of the student or resident and that the notes of the student or resident only reflect his/her role as student or resident. At a minimum, the medical record must contain signed or countersigned notes which clearly specify that the physician personally reviewed the history, gave a physical examination and confirmed or revised the diagnosis and prescribed treatment. The attending physician must be recognized by the member as the member's personal physician; and
- Documentation on the discussion of advance directives and/or a completed advance directive form.

WellCare requires all participating hospitals to properly code all relevant diagnoses and surgical and obstetrical procedures on all inpatient and outpatient claims submitted. WellCare utilizes the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) for all coding. In addition, the Physicians' Current Procedural Terminology, Fourth Edition (CPT-4) coding and/or HCPCS is required for all outpatient surgical, obstetrical, injectable drugs, diagnostic laboratory and radiology procedures. When coding, the hospital must select the code(s) that most closely describe(s) the diagnosis(es) and procedure(s) performed. When a single code is available for reporting multiple tests or procedures, that code must be utilized rather than reporting the tests or procedures individually.

WellCare tracks billing codes and providers who continue to apply incorrect coding rules. Providers will be educated on the proper use of codes as a part of the retrospective review process. Should a provider continue to repeat the inappropriate coding practice, the provider will be subject to an adverse action.

WellCare utilizes the National Uniform Billing Form for billing (inpatient and outpatient) hospital services.

See the **UB04 Submission Sample** in the **Forms** section for details on how to file a claim for hospital services.

Inpatient Services

Prior authorization is the process of obtaining authorization in advance of rendering a service which may or may not require a medical record review and is **required** for elective or non-urgent services designated by the Plan. Prior authorization is conducted prior to a member's admission, stay, other service or course of treatment in a hospital or other facility. The attending physician is responsible for obtaining the prior authorization of the elective and/or non-urgent admission. An authorization is the approval necessary for payment to be granted for covered services and is provided only after the Plan agrees the treatment is necessary and a covered benefit. Refer to the **Utilization Management and Care Coordination** section for more information.

Hospitals should use inpatient-qualifying criteria such as InterQual™ to determine the appropriateness of an inpatient admission as well as conduct concurrent review of the patient's condition. The patient should remain hospitalized until the same criteria indicate hospitalization is no longer necessary. WellCare will notify providers at least 30 days prior to the date of any changes in the criteria or version of criteria being used to certify inpatient admissions via posting to WellCare Web site or other means.

In determining if a member's condition requires inpatient care, WellCare looks to the medical necessity using inpatient-qualifying criteria such as those published by InterQual™. If the member is admitted, he/she must remain hospitalized until concurrent review performed by the hospital indicates discharge is necessary.

There is no limit on the number of days Medicaid allows for medically necessary inpatient hospital care with the exception of a limitation for psychiatric care. If a member is re-admitted to the hospital for the same or related problem within three days of discharge, it is considered the same admission. All admissions are subject to medical justification and WellCare may request documentation to substantiate medical necessity and appropriateness of

setting. Documentation must be provided upon request in pre-payment or post-payment review. Failure to show appropriate medical justification may be cause for denial, reduction or recoupment of reimbursement.

WellCare defines *inpatient emergency medical services* as those that are medically necessary as a result of a sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily part or death of the individual.

For additional reimbursement for cost outliers or unusually expensive admissions, WellCare follows Georgia's Department of Community Health (DCH) guidelines when determining payment for each submitted case.

Hospital admission for diagnostic purposes is covered only when the services cannot be performed on an outpatient basis.

Certain services may only be reimbursed when performed on an outpatient basis unless medical necessity for an inpatient admission is documented and authorized. Diagnostic procedures such as chest x-rays are covered as part of the inpatient admitting process only when:

- The test is specifically ordered by a physician responsible for the patient's care;
- The test is medically necessary for the diagnosis or treatment of the individual patient's condition;
- The test does not unnecessarily duplicate the same test done on an outpatient basis before admission, or done in connection with a recent admission; or
- The test is billed with the admission.

Any outpatient services performed three days prior to or after an inpatient admission are included in the inpatient reimbursement.

If a hospital determines that an outpatient hospital setting would have met the medical needs of a member after the services were provided in an inpatient setting, the services may be billed to WellCare as outpatient if the claim is received within 180 days of the ending date of the service month. If the claim is received more than 180 days after the ending date, the services are not covered.

To substantiate the determination, a physician's order must document the member's status at the time of admission and any changes in the member's status.

Reimbursement for psychiatric services is limited to short term acute care. The maximum length of stay considered for reimbursement by WellCare, or WellCare's Delegated Behavioral Health Agent, is 30 days. Psychiatric admissions which have a length of stay in excess of 30 days will be denied reimbursement.

If a member is admitted as an inpatient for less than 24 hours in duration, the admission is subject to a medical necessity of admission review by WellCare. A length of stay less than 24 hours is considered observation and is therefore considered an outpatient service. Outpatient services billed as inpatient are subject to denial or recoupment after review for medical necessity.

Intermediate care (i.e., step-down units) is reimbursable at the semi-private room rate.

Observation

WellCare defines *observation services* as those services furnished by a hospital, including use of a bed and periodic monitoring by a hospital's nursing or other staff. Observation services are covered when it is determined they are reasonable and necessary to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient.

Such services are covered only when provided by the order of a physician or another individual authorized to admit patients to the hospital or to order outpatient tests. Observation services usually do not exceed 24 hours, however, some patients may require 48 hours of outpatient observation services.

SCOPE OF SERVICES

Section 7

In only rare and exceptional cases, outpatient observation services span more than 48 hours.

When a member is placed under observation by a hospital, the patient is considered an outpatient until the patient is admitted as an inpatient. While under observation, the hospital may determine the patient needs further care as an inpatient admission or the patient may improve and be released. When medical necessity dictates an inpatient admission of a patient in observation, this should be billed under revenue code 762, as referred to in the billing instructions, (see the **Forms** section) which reflects this transaction. Observation is a covered revenue code on an inpatient claim.

WellCare does not cover outpatient observation services in the following situations:

- Complex cases requiring inpatient care, post-operative monitoring during the standard recovery period;
- Routine preparation services furnished prior to diagnostic testing in the hospital outpatient department and the recovery afterwards; or
- Observation billed concurrently with therapeutic services such as chemotherapy, physical therapy, etc.

A member may only transfer from outpatient status to inpatient status if it is determined that that inpatient services are medically necessary and meet InterQual™ criteria. In order for the services to be covered, certification must be obtained within one business day of the beginning date of this episode of care. To receive authorization for an inpatient admission, WellCare must receive documentation indicating the admission is medically necessary and appropriate.

The date of the inpatient admission will be the actual date the patient is formally admitted as an inpatient and will count as the first inpatient day. When a patient is admitted to the hospital from outpatient observation, all observation charges must be combined and billed with the inpatient

SCOPE OF SERVICES

Section 7

charges beginning from the date of initial observation. Outpatient observation services should not be used for services for which an overnight stay is normally expected. Services such as complex surgery, clearly requiring inpatient care may not be billed as outpatient.

WellCare only covers services that are medically appropriate and necessary. Failure to obtain the required authorization will result in denial of reimbursement of all services provided and extends to all professional services, not just the hospital.

Medical appropriateness and necessity including that of the medical setting must be clearly substantiated in the member's medical record. If it is determined the outpatient observation is not covered, then all services provided in the observation setting are also not covered. Services provided for the convenience of the patient or physician and that are not reasonable or medically necessary for the diagnosis are not covered.

Hospital-Based Physicians, Certified Registered Nurse Anesthetists and Nurse Practitioners

All inpatient and outpatient professional services must be billed on the physician's claim form.

Hospital-based physicians, Certified Registered Nurse Anesthetists (CRNAs), specified nurse practitioners and Physician Assistants (PAs), may designate the hospital as payee by agreement. The hospital must maintain each agreement authorizing such payments on file.

Services rendered to eligible members by hospital-based physicians, CRNAs, designated nurse practitioners and PAs will be covered both on an inpatient and outpatient basis as long as the services are medically necessary and within the contractual or financial agreement with the hospital. These services are subject to retrospective review by WellCare or its authorized agents.

Transplant Services

WellCare covers all services and supplies related to covered transplant services for eligible members. All transplants for eligible WellCare members under the age of 21 are covered as required by the DCH contract.

SCOPE OF SERVICES

Section 7

Heart, lung and heart/lung transplants are not covered for members ages 21 and older.

Prior authorization is required for all transplants regardless of the member's age.

Dialysis

Services for dialysis require prior authorization and must be rendered at a contracted facility.

Rehabilitation Services

Rehabilitation services as defined by federal regulation are not covered by WellCare. However, short-term rehabilitation services are covered by WellCare for members if services are received immediately following treatment for acute illness, injury or impairment. Short-term rehabilitation services include physical therapy, occupational therapy and speech therapy and are covered when the conditions listed below are met:

- The member's physician must establish a written treatment plan that includes the services received as well as identifies the rehabilitation potential, sets realistic goals and measures progress. The plan must also include the type of modalities and procedures, frequency of visits, estimated duration, diagnosis, functional goals and recovery potential.
- Authorizations must be obtained by the physician every five business days to ensure the services rendered are necessary. When requesting an extended authorization, the physician must include the date of the initial acute illness, injury or impairment, the diagnosis and an estimate of the duration of service.
- The services must be of such a level of complexity and sophistication or the member's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified therapist.
- The physician's prognosis must include an expectation that the member's condition will improve significantly in a reasonable period of time,

or the development of an effective maintenance program relies on the services being provided to treat a specific disease state.

- The plan for the member's treatment must include an amount, frequency and duration of services that are reasonable under accepted standards of practice.

Hospitalist Program

Hospitalists provide attending physician coverage in selected markets for members admitted to contracted facilities. Hospitalists provide the following services:

- Emergency room assessment of a member;
- Direct admissions to facilities where the PCP may not provide that service;
- Manages care as needed throughout the inpatient medical admission for members, excluding obstetrical and gynecological cases; and
- Refer members to the PCP upon discharge for follow-up care and communicating the treatment/discharge plan verbally within 24 hours and in writing within seven days.

Emergency Room and Outpatient Services

Emergency services shall be available 24 hours a day, seven days a week to treat an emergency medical condition.

An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms. An *emergency medical condition* is a medical or mental health 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:

- Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in

SCOPE OF SERVICES

Section 7

- serious jeopardy;
- Serious impairment to bodily functions;
 - Serious dysfunction of any bodily organ or part;
 - Serious harm to self or others due to an alcohol or drug abuse emergency;
 - Injury to self or bodily harm to others; or
 - With respect to a pregnant woman having contractions: (i) that there is not adequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

WellCare provides payment for emergency services when furnished by a qualified provider, regardless of whether that provider is in the WellCare network. These services are not subject to prior authorization requirements. WellCare will pay for all emergency services that are medically necessary until the member is stabilized. WellCare will also pay for any medical screening examination conducted to determine whether an emergency medical condition exists.

WellCare will consider the following criteria when processing claims for emergency health care services:

- The age of the patient;
- The time and day of the week the patient presented for services;
- The severity and nature of the presenting symptoms;
- The patient's initial and final diagnosis; and
- Any other criteria prescribed by the Department of Community Health, including criteria specific to patients less than 18 years of age.

The attending emergency room physician, or the provider

SCOPE OF SERVICES

Section 7

actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding to WellCare, who shall be responsible for coverage and payment.

WellCare will not retroactively deny a claim for an emergency medical screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature. The determining factor for payment liability shall be whether the member had acute symptoms of sufficient severity at the time of presentation. Payment shall be at either the rate negotiated under the provider agreement, or the rate paid by WellCare under the Medicaid Fee-for-Service Agreement.

WellCare may establish guidelines and timelines for submittal of notification regarding provision of emergency services, but will not refuse to cover an emergency service based on the emergency room provider, hospital or fiscal agent's failure to notify the member's PCP, or WellCare representative, of the member's screening and treatment within said time frames.

The member can not be billed for the screening and/or treatment needed to stabilize the patient.

Once the member's condition is stabilized, unplanned urgent admissions must be followed by:

1. Notification to WellCare by calling the Provider Hotline and reporting the urgent or emergent admission within 24 hours of the admission.

The caller should provide the following:

- a) Member's name
 - b) WellCare member ID number
 - c) Name of admitting hospital
 - d) Referring physician
 - e) Diagnosis of member
2. Additional clinical information must be submitted to WellCare by the next business day for use in

SCOPE OF SERVICES

Section 7

making a final authorization determination.
If available, clinical information may be provided
at the time of notification.

Emergency room visits that cannot be documented as true medical emergencies or potential medical emergencies will be reimbursed at the applicable triage rate, or as otherwise specified in the Hospital contract. The triage rate covers all ancillary services rendered as well as the fee for use of the emergency room. This triage rate may be subject to the hospital's contracted reimbursement rate; in other words, the triage rate may not be the reimbursement rate in all cases. This triage rate includes any applicable member co-payment. The triage rate is for the medical screening examination and stabilization services provided in the emergency room without regard to prior authorization.

If the hospital believes the medical record supports the existence of a true emergency situation, but the initial presenting information on the claim may not be identified as a true emergency, the claim may be submitted by hard copy with documentation. The claim will pend for medical review retrospectively against the prudent layperson criteria, and additional criteria outlined previously, and applicable payment applied.

If a triage rate was received, and the presenting claim did not clearly provide information for determining the presence of an emergency, additional documentation may be submitted for a medical retrospective review. A single form can be submitted with one or multiple claims. Each claim submitted should contain new information which provides complete insight on the member's visit to the ER. All claims will be reviewed and a follow-up letter of determination (upheld or overturned) will be sent for each claim. In the event a claim decision is overturned based on the additional documentation, WellCare will automatically reprocess the claim at the appropriate ER payment rate determined by the provider contract. In the event the ER Triage decision is upheld through this informal ER reconsideration process, you can still submit the claim for review under the formal appeals process. Submit all retrospective ER review requests utilizing the **ER Medical Review Request form**.

If, after medical review, the determination is made that an emergency or potential emergency did in fact exist, the services will be reimbursed at the hospital's specific outpatient contracted rate. Accurate coding is critical to ensure proper reimbursement.

In non-emergency situations where the provider may be able to identify a chronic abuser of the emergency room, the provider may exercise its right to advise the member that they will not be accepted as a WellCare member and in the event the member elects to receive services, the member will be responsible for all charges incurred.

If a member is not accepted for treatment as a WellCare member, hospitals should offer the following alternatives to the member:

- Refer the member to a specific alternate health care setting where he/she can obtain care the same day or next day;
- Instruct the member as to the generally appropriate setting for treatment for such a condition in the future.

There is no limit imposed on the number of visits allowed per day per member in true medical emergencies. However, more than one non-emergency visit, by the same member, to the same hospital, in one day is subject to review for medical necessity and possible denial depending on the individual situation.

**Non-Covered
Inpatient
Services**

WellCare does not cover the services and procedures listed below. In addition, any services related to, required in preparation for, or as a result of non-covered services are also not covered.

- Services and supplies which are inappropriate or not medically necessary as determined by WellCare or other authorized agent;
- Services or procedures performed which are not in compliance with the policies and procedures

contained in this handbook;

- Miscellaneous and non-specific charges;
- Non-acute levels of care;
- Utilization review;
- Differential service charges; i.e., "STAT" or priority, after-hours or "call-back" fees;
- Late charges defined as a portion of the charges for a given service omitted from the original billing, which included some of the charges for that given service, are non-covered. If the total charges for a given service were omitted from the original billing, a positive adjustment may be requested.
- Services mandated to be performed only on an outpatient basis;
- Clinic services while the member is an inpatient;
- Inpatient leave of absence;
- Patient or family education or supplies;
- Nursing services, including services traditionally accepted as nursing care even though provided by other ancillary departments;
- Private duty nurses, sitters or companions;
- Service charges for individual areas within the hospital; i.e., pharmacy dispensing fee, IV admixture fee (except for hyper alimentation), cover charge for central supply, charges for handling and distribution of supplies, transportation within the hospital, equipment installation, specimen collection, venipuncture, standby equipment, staff time and evaluations;
- Resuscitation, code, CPR (cardiopulmonary resuscitation), etc. are non-covered. However, supplies associated with this service will be

reimbursed.

- Investigational items and experimental services, drugs or procedures;
- Any services or items furnished for which the hospital does not normally charge;
- Services provided by an institution for mental disease or special disorders;
- Separately billed equipment and supplies which are integral parts of hospital care and the area in which care is being provided; i.e., cardiac monitor in ICU, light source in or, call system, blood pressure cuffs and monitors, specimen collection devices and containers, etc.;
- Hospital based therapy services for treatment of chronic conditions;
- Private rooms are non-covered services. However, if the member has a condition that requires an isolation room or special care unit (ICU, CCU), those are reimbursable. All other accommodations are reimbursed at the semiprivate room rate.

Upon admission, members should be notified that private rooms are non-covered services. Members who request a private room after being informed of WellCare's policy will be responsible for the difference between the hospital's semi-private and private room rates.

If the member has a condition that requires an isolation room or special care unit or if the hospital only offers private rooms or only has private rooms available, the member cannot be billed for the difference between the semi-private room rate paid by WellCare and the private room rate.

- Services which are not medically necessary to the patient's well-being; i.e., television, telephone, combs, brushes, guest meals, cots, etc.;

SCOPE OF SERVICES

Section 7

- Non-consumable multiple supply items; i.e., bath basins, admission kits, disposable pillows, etc.;
- Take-home prescription drugs, medical supplies, durable medical equipment and artificial limbs and appliances are non-covered;
- Cosmetic surgery or mammoplasties for aesthetic purposes;
- Infertility procedures and related services;
- Some situations concerning abortions, sterilizations and hysterectomies. See **Limits to Abortions, Sterilizations and Hysterectomy Coverage** for details.
- Tubal reanastomosis procedures pertaining to sterilizations and vasectomies;
- Preventive health care; Members under age 21 may receive this care through the EPSDT screening process.
- The ICD-9-CM procedure codes listed below.
 - 08.9 Other operations on eyelids
 - 08.91 Electrosurgical epilation of eyelid
 - 08.92 Cryosurgical epilation of eyelid
 - 08.93 Other epilation of eyelid
 - 18.01 Piercing of ear lobe
 - 18.5 Surgical correction of prominent ear
 - 18.9 Other operations on external ear
 - 20.95 Implantation of electromagnetic hearing aid
 - 23.3 Restoration of tooth by inlay
 - 63.82 Reconstruction of surgically divided vas deferens
 - 63.84 Removal of ligature of vas deferens
 - 64.5 Operations for sex transformation, not elsewhere classified
 - 64.94 Fitting of external prosthesis of penis
 - 64.95 Insertion or replacement of non-inflatable penile prosthesis
 - 64.97 Insertion or replacement of inflatable

- penile prosthesis
- 66.79 Other repair of fallopian tube
- 83.92 Insertion or replacement of skeletal muscle stimulator
- 85.5 Augmentation mammoplasty
- 85.50 Augmentation mammoplasty, not otherwise specified
- 85.51 Unilateral injection into breast for augmentation
- 85.52 Bilateral injection into breast for augmentation
- 85.53 Unilateral breast implant
- 85.54 Bilateral breast implant
- 85.99 Other
- 86.64 Hair transplant
- 86.82 Facial rhytidectomy
- 86.92 Electrolysis and other epilation of skin

Non-Covered Emergency Room and Outpatient Services

Not all emergency room and outpatient services are covered benefits for WellCare members.

Those listed below as well as any services related to these services are non-covered:

- Services or procedures performed which are not in compliance with the policies and procedures contained in this handbook;
- Routine physical examinations;
- Investigational items and experimental services, drugs or procedures;
- Services provided free of charge to the public by the hospital, county health departments, state laboratory or other state agencies; i.e., immunizations, metabolic screens for members under one year of age, etc.;
- Any services and supplies which WellCare or an authorized agent deems as inappropriate or not medically necessary;
- Any services or items furnished for which the

SCOPE OF SERVICES

Section 7

hospital does not normally charge;

- Services non-covered or denied by WellCare because they were provided on an inpatient basis;
- Non-acute levels of care;
- Separately billed equipment and supplies which are integral parts of hospital care and the area in which care is being provided, i.e., cardiac monitor in ICU, light source in or, call system, blood pressure cuffs and monitors, specimen collection devices and containers, etc.;
- Late charges defined as a portion of the charges for a given service omitted from the original billing, which included some of the charges for that given service, are non-covered. If the total charges for a given service were omitted from the original billing, a positive adjustment may be requested;
- Take-home prescription drugs, medical supplies, appliances and durable medical equipment are also non-covered;
- Differential service charges; i.e., "STAT" or priority, after-hours or "call-back" fees;
- Resuscitation, code, CPR (cardiopulmonary resuscitation), etc. are non-covered. However, supplies associated with this service will be reimbursed;
- Service charges for individual areas within the hospital; i.e., pharmacy dispensing fee, IV admixture fee (except for hyper alimentation), cover charge for central supply, charges for handling and distribution of supplies, transportation within the hospital, equipment installation, specimen collection, venipuncture, standby equipment, staff time and evaluations;
- Nursing services, including services traditionally accepted as nursing care even though provided by

other ancillary departments;

- Some situations concerning abortions, sterilizations and hysterectomies. See **Limits to Abortions, Sterilizations and Hysterectomy Coverage** for details;
- Tubal reanastomosis procedures pertaining to sterilizations and vasectomies;
- Infertility procedures and related services;
- Patient or family education or supplies; and
- Cosmetic surgery or mammoplasties for aesthetic purposes.

Out-of-State Providers and Service Limitations

Out-of-state hospital providers not contracted with WellCare will be reimbursed for covered services provided to eligible WellCare members while out-of-state if the claim is received within 180 days from the date of service, and if at least one of the following conditions is met:

- The hospital provider preauthorized the service through WellCare; or
- The service was provided to the WellCare member as a result of an emergency or life-endangering situation occurring out of state. If the out-of-state provider believes the medical record supports the existence of an emergency situation but the diagnosis does not justify an emergency, the claim must be submitted with a copy of the medical record.

While out-of-state providers are eligible for reimbursement, the Medicaid program does not reimburse providers located outside the continental United States.

Routine health care or elective surgery provided by out-of-state providers is not covered unless prior authorization is obtained from WellCare. In order to receive prior authorization, the referring in-state provider is required to request prior approval by documenting in writing the medical necessity of obtaining services

out-of-state and providing the name and address of the out-of-state medical provider. Provider reimbursement and coverage of out-of-state services are determined in accordance with current policies and procedures of WellCare and are contingent upon the patient's eligibility at the time services are provided.

Requests for prior approval or questions regarding out-of-state services must be directed to WellCare's Provider Hotline. See the **Quick Reference Guide** for contact information.

If services are pre-authorized, a copy of the authorization letter from WellCare must be attached to out-of-state claims submitted for reimbursement.

Services rendered due to an emergency or life-endangering situation do not have to be pre-authorized. Any emergency service, rendered by a non-par provider and identified by WellCare as emergent, is reimbursable at current Medicaid rates for these services.

Limits to Abortion, Sterilization, and Hysterectomy Coverage

Abortion

Abortions are covered for eligible WellCare members if the life of the mother would be endangered if the fetus were carried to term, or if the mother was a victim of rape or incest.

Abortions are not covered if used for family planning purposes.

A Certificate of Necessity for Abortion, form DMA-311, must be properly executed and submitted to WellCare with the provider's claim. This form may be filled out and signed by the physician. See the **Forms** section for a copy of this form. Claims for payment will be denied if the required consent is not attached or if incomplete or inaccurate documentation is submitted. Prior authorization is required for the administration of an abortion to validate medical necessity per federal regulations. The consent form does not need to be submitted with the request for authorization.

In addition to the above-mentioned documentation,

SCOPE OF SERVICES

Section 7

WellCare also requires the submission of History, Physical and Operative Report and the Pathology Report with all claims that have the following ICD-9-CM codes to ensure that abortions are not being billed through the use of other procedure codes:

- 69.0 Dilation and curettage of uterus
- 69.02 Dilation and curettage following delivery or abortion
- 69.09 Other dilation and curettage
- 69.5 Aspiration curettage of uterus
- 69.52 Aspiration curettage following delivery or abortion
- 69.59 Other aspiration curettage of uterus
- 69.6 Menstrual extraction or regulation
- 69.93 Insertion of Laminaria
- 70.0 Culdocentesis
- 72.7 Vacuum extraction
- 72.71 Vacuum extraction with episiotomy
- 72.79 Other vacuum extraction
- 74.99 Other cesarean section of unspecified type
- 96.49 Genitourinary installation

The following procedure codes require abortion certifications:

- 69.01 Dilation and curettage for termination of pregnancy
- 69.51 Aspiration curettage of uterus for termination of pregnancy
- 74.91 Hysterectomy to terminate pregnancy
- 75.0 Intra-amniotic injection for abortion

Sterilizations

WellCare will not and is prohibited from making payment for sterilizations performed on any person who:

- Is under 21 years of age at the time he/she signs the consent;
- Is not mentally competent; or
- Is institutionalized in a correctional facility, mental hospital or other rehabilitation facility.

SCOPE OF SERVICES

Section 7

See the **Forms** section for a copy of the required consent form (DMA-69). Prior authorization is not required for sterilization procedures. However, WellCare will deny any provider claims submitted without the required consent form or with an incomplete or inaccurate consent form. Documentation meant to satisfy informed consent requirements, which has been completed or altered after the service was performed, will not be accepted.

For sterilization procedures, the mandatory waiting period between signed consent and sterilization is 30 calendar days. The signed consent form expires 180 calendar days from the date of the member's signature.

In the case of premature delivery or emergency abdominal surgery performed within 30 calendar days of signed consent, the physician must certify that the sterilization was performed less than 30 calendar days but not less than 72 hours after informed consent was obtained. Although these exceptions are provided, the conditions of the waiver will be subject to review.

In the case of premature delivery or emergency abdominal surgery, the sterilization consent form must have been signed by the member 30 calendar days prior to the originally planned date of sterilization. A sterilization consent form must be properly filled out and signed for all sterilization procedures and attached to the claim at the time of submission to WellCare. The member must sign the consent form at least 30 calendar days, but not more than 180 calendar days, prior to the sterilization. The physician must sign the consent form after the sterilization has been performed.

The following is a list of ICD-9-CM procedure codes associated with sterilization. All claims with these procedure codes will be reviewed prior to payment to ensure proper coding and to ensure that the sterilization consent form is attached to those claims requiring a form.

Always Requires Sterilization Consent Form:

- 63.70 Male sterilization procedure, not otherwise specified

SCOPE OF SERVICES

Section 7

- 66.39 Other bilateral destruction or occlusion of fallopian tubes

If Done for Sterilization Purposes Requires Sterilization Consent Form:

- 63.7 Vasectomy and ligation of vas deferens
- 63.73 Vasectomy
- 65.6 Bilateral Salpingo-oophorectomy
- 65.61 Removal of both ovaries and tubes at same operative episode
- 65.62 Removal of remaining ovary and tube
- 66 Operations on fallopian tubes
- 66.0 Salpingostomy
- 66.2 Bilateral endoscopic destruction or occlusion of fallopian tubes
- 66.21 Bilateral endoscopic ligation and crushing of fallopian tubes
- 66.22 Bilateral endoscopic ligation and division of fallopian tubes
- 66.29 Other bilateral endoscopic destruction or occlusion of fallopian tubes
- 66.3 Other bilateral destruction or occlusion of fallopian tubes
- 66.31 Other bilateral ligation and crushing of fallopian tubes
- 66.32 Other bilateral ligation and division of fallopian tubes
- 66.4 Total unilateral salpingectomy
- 66.5 Total bilateral salpingectomy
- 66.51 Removal of both fallopian tubes at same operative episode
- 66.52 Removal of remaining fallopian tube
- 66.6 Other salpingectomy
- 66.63 Bilateral partial salpingectomy, not otherwise specified
- 66.69 Other partial salpingectomy

Hysterectomy

WellCare reimburses providers for hysterectomy procedures only when the following requirements are met:

- The provider ensured that the individual was informed, verbally and in writing, prior to the hysterectomy that she would be permanently incapable of reproducing (this does not apply if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy);
- Prior to the hysterectomy, the member/individual and the attending physician must sign and date the Patient's Acknowledgement of Prior Receipt of Hysterectomy Information form DMA-276.
- In the case of prior sterility or emergency hysterectomy, a member is not required to sign the consent form; and
- The provider submits the properly executed Patient's Acknowledgement of Prior Receipt of Hysterectomy Information form with the claim prior to submission to WellCare. See **Forms** section for a copy of this form. WellCare will deny payment on any claims submitted without the required documentation or with incomplete or inaccurate documentation. WellCare does not accept documentation meant to satisfy informed consent requirements which has been completed or altered after the service was performed.

Regardless of whether the requirements listed above are met, a hysterectomy is considered a payable benefit when performed for medical necessity and not for the purpose of family planning, sterilization, hygiene or mental incompetence. Prior authorization is required for the administration of a hysterectomy to validate medical necessity. The consent form does not need to be submitted with the request for authorization but does need to be submitted with the claim.

The following is a list of ICD-9-CM procedure codes associated with hysterectomies. All claims with these procedure codes will be reviewed prior to payment to ensure proper coding and to ensure that the hysterectomy acknowledgement form is attached. All hysterectomy

codes listed require a hysterectomy acknowledgement form.

- 68.3 Subtotal abdominal hysterectomy
- 68.4 Total abdominal hysterectomy
- 68.5 Vaginal hysterectomy
- 68.6 Radical abdominal hysterectomy
- 68.7 Radical vaginal hysterectomy
- 68.8 Pelvic evisceration
- 68.9 Other unspecified hysterectomy

**Prior
Authorization
Requirements**

For details on the notification, prior authorization, concurrent review and retrospective review process refer to the **Utilization Management and Care Coordination section.**