

UTILIZATION MANAGEMENT AND CARE COORDINATION

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Overview

The focus of WellCare's Utilization Management (UM) Program is to provide members access to quality care and to monitor the appropriate utilization of services.

WellCare's UM Program has five principal functions:

1. Admission and continued stay review;
2. Data gathering;
3. Retrospective assessment;
4. Case management; and
5. Discharge coordination.

Program Objectives

- To ensure that a WellCare member receives care in the most appropriate and cost-effective setting for the treatment of his/her medical condition;
- To ensure that participating WellCare providers render appropriate, cost-effective quality services;
- To appropriately treat the member's medical condition through services determined to be medically necessary;
- To ensure that participating hospitals monitor patient care by establishing and administering effective utilization review plans;
- To ensure that members receive necessary services that meet currently accepted professional quality standards of medical practices;
- To track a member's care to ensure he/she is not subject to over-utilization or under-utilization of medical services.

Activities and Services Encompassed by the Program

WellCare's UM Program includes, but is not limited to:

- Plan of treatment;
- Discharge planning and coordination;

- Oversight of hospital utilization review committee monitoring activities;
- Authorization of need for acute care;
- Review of need for continued stay;
- Post payment review and assessment, including length of stay and ancillary service review;
- Data gathering; and
- Referral for educational services.

**Review
Functions
for Authorized
Hospitals**

Hospitals must meet the federal and state requirements for control of utilization of inpatient services including:

- Authorization and re-authorization of the need for acute care;
- Treatment pursuant to a plan of care; and
- Operation of utilization review plans.

At the time a WellCare member is admitted into a hospital for inpatient services, the admitting physician must certify that the inpatient services are medically necessary. The authorization must be made at the time of admission, or in the case of pending eligibility, before Medicaid payment is authorized. This requirement can be met by a comprehensive note in the medical record at the time of admission.

The attending physician, or authorized representative, must re-certify that inpatient services continue to be medically necessary and appropriate to the acute care setting. This requirement can be met by a comprehensive progress note in the medical record at least every two days.

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WellCare requires that a written plan of care be completed and submitted for each member:

- Prior to authorization for payment before admission to a hospital for elective admissions, or
- By the next business day for emergency admissions

The plan should be multi-disciplinary and should include at least the attending physician and the nursing staff. The plan must include:

- Diagnoses, symptoms or complaints indicating the need for admission;
- A description of the functional level of the individual;
- Medication or treatment orders;
- Diet and activity level;
- Plans for hospital course; and
- Plans for discharge.

Services Which Require Prior Authorization

In order to provide the best care possible for members, the Plan requires that all planned inpatient hospital admissions/observations and all outpatient procedures be prior approved.

For services requiring prior authorization, and for the telephone number of the Utilization Management Department, refer to the Quick Reference Guide.

The goal of prior authorization is to ensure that medically necessary, cost-effective services are provided to eligible WellCare members. Prior authorization is necessary for reimbursement; however, it does not guarantee payment. In addition, the requirement for prior authorization pertains to medical necessity and appropriateness of setting. The member must be eligible with the Plan at the time the service is rendered. The hospital medical record must

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substantiate the medical necessity including the appropriateness of the setting for the services provided and billed to WellCare. All services are subject to review for medical necessity.

The Plan has up to 14 calendar days to determine whether a service requested is a medically appropriate and covered service. When possible, decisions on prior authorization will be rendered by the Plan within two business days after adequate medical information has been received to determine medical necessity and appropriate level of care.

FAILURE TO OBTAIN REQUIRED AUTHORIZATION WILL RESULT IN DENIAL OF THE CLAIM.

Procedures for Obtaining Prior Authorization for All Medical Services Except Dental Services and Transplants

The attending physician or hospital staff is responsible for obtaining prior authorization from WellCare and for providing the prior authorization number to each WellCare provider associated with the case; i.e., assistant physician, hospital, etc. Failure to obtain prior authorization will result in denial of payment.

Requests for prior authorization should be submitted at least 10 business days prior to the planned admission or procedure. Once a procedure is approved, the approval is only valid for 90 days from the date of issuance.

In cases when prior authorization has been obtained for an outpatient procedure, and during the procedure it is determined that the member requires an additional or different procedure, the procedure will be considered an urgent procedure. The hospital's request for an update of the prior authorization will be considered timely if received within one business day of the date of the procedure.

When prior authorization has been obtained for an outpatient procedure, and after the procedure has been performed it is determined that the member requires inpatient services, the admission should be considered an emergency. The hospital should notify WellCare of the

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admission within 24 hours, and the request for a clinical update should be considered timely if received within one business day of the beginning date of the episode of care.

Hospital requests for updates of authorization and retroactive authorizations of inpatient admissions following a procedure will be denied if it is determined that the procedure clearly required an inpatient level of care that should have been anticipated.

When it is determined that a member with outpatient observation status requires inpatient services, the request for authorization must be received within one business day of the beginning of the episode of care.

Procedures for Obtaining Prior Authorization for Dental Services Requiring Hospitalization

Prior authorization is required for any dental service requiring inpatient or outpatient hospitalization. It is the responsibility of the attending dentist to obtain prior authorization and to provide the prior authorization number to the hospital. The failure of the attending dentist to obtain the correct prior authorization number will result in denial of payment.

For prior authorization of Dental Services requiring hospitalization, contact the Plan's Utilization Management department at the telephone number listed on the Quick Reference Guide.

Procedures for Obtaining Prior Authorization for Transplants

In order to receive prior authorization for a transplant, a written request with medical records must be received by WellCare for review. This pertains to liver, bone marrow, kidney and cornea transplants as well as medically necessary heart, lung and heart/lung transplants for members under the age of 21. These records must include current medical history, pertinent laboratory findings, X-ray and scan reports, social history and test results that exclude viremia and other relevant information.

Transplant procedures and related services must be approved by WellCare prior to the transplant, regardless of the age of the member. Once a transplant procedure is

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approved, a prior authorization number will be assigned. The member must be eligible at the time services are provided, and these services cannot be approved retroactively.

For requests for approval of coverage of all transplant services, contact the Plan's Utilization Management department at the telephone number listed on the Quick Reference Guide.

Procedures for Obtaining Prior Authorization for Observation Services

All observation services require authorization. Observation should be considered if the patient does not meet acute care criteria, and any of the following apply:

- Diagnosis, treatment, stabilization and discharge can reasonably be expected within 24 to 48 hours;
- The clinical condition is changing and a discharge decision is expected within 48 hours;
- Complications or extended observation post ambulatory surgery/procedure;
- Symptoms unresponsive to at least four hours emergency room treatment; or
- Psychiatric crisis intervention/stabilization with observation every 15 minutes;

At 48 hours, if the patient is not stable for discharge, acute care criteria will be applied.

The decision to admit a patient continues to be the responsibility of the treating provider. If cases arise where the circumstances would pose a hazard to the patient's health and/or safety and the appropriate setting is in question, then the case should be referred to secondary review.

**FAILURE TO OBTAIN REQUIRED AUTHORIZATION
WILL RESULT IN DENIAL OF THE CLAIM.**

Concurrent Review

The Plan's concurrent review involves oversight of members admitted to hospitals, rehabilitation centers, skilled nursing facilities and other inpatient settings. The concurrent review nurse follows the clinical status of the member on an ongoing basis through telephonic or onsite chart review and communication with the physicians and/or other health care professionals involved in the member's care. The concurrent review process incorporates the use of clinical guidelines developed from peer-reviewed, evidence-based literature to assess quality care and the appropriate level of care for continued medical treatment. Reviews are performed by licensed nurses under the direction of the Plan medical director.

Integral to the concurrent review process is **notification** by the hospital of unplanned (usually urgent or emergent) inpatient and observation status admissions.

- Hospitals must notify WellCare by phone by the next business day following the admission. No medical authorization will be made at this time, unless all clinical information is provided. Clinical information must be provided on the next business day if not already presented at the time of notification.
- WellCare has staff available 24 hours a day, seven days a week. If a hospital would like to have an immediate authorization decision rendered, and is able to provide clinical information at the time of notification, the call will be transferred to the nurse review staff (or on-call nurse) to provide a response within one hour.
- A WellCare nurse will review the clinical information, and will respond to the facility with an authorization status decision within one day after reviewing the information.
- If a member is admitted, and subsequently discharged before the next business day (i.e., over

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a weekend) the facility must still notify WellCare, and provide clinical information so that an authorization decision can be made.

- Facilities must notify WellCare of admissions for the delivery of newborn or stillborn babies. Notification should be by fax, using the **Inpatient Authorization Form**, by the next business day following the birth. Baby clinical information (gender, weight, date of birth) must be provided no later than the next business day, if not included in the initial notification. WellCare will respond to the facility with an authorization number within two business days of the receipt of complete information.
- Failure of a hospital(s) to notify WellCare of a member's inpatient admission by the next business day, or failure to communicate information related to service(s) rendered to a member will result in the denial of the submitted claim(s) associated with said admission or service(s).

Based on professionally generated criteria, WellCare will review all admissions to and services provided in an acute care setting. All participating hospital reviews must be in compliance with procedures outlined in the hospital's utilization review plan. An entry must be made in the utilization review notes on the review date, indicate the name and title of the reviewer and be signed by the reviewer. This entry must also indicate the severity of illness/intensity of service (SI/IS) criteria that was met for medical necessity of the hospital stay. Failure to document the SI/IS criteria in the utilization review notes may result in the denial of reimbursement of your claim.

If the hospital utilizes an electronic entry system for utilization review, the entry must indicate a unique identifier with the name and title of the reviewer on file as well as the date the entry was made.

After-Hours Utilization

The Plan provides authorization of inpatient admissions 24 hours a day, seven days a week. Physicians requesting

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after-hours authorization for inpatient admission should refer to their **Quick Reference Guide** for the number to contact an after-hours nurse. Discharge planning needs that may occur after normal business hours will be handled by the Plan's after-hours nurse.

**Plan Criteria for
Utilization
Management
Decisions**

The Plan's UM department utilizes various criteria, which may include the following, when making coverage determinations:

- Member benefits
- Local and federal statutes and laws
- InterQual
- Medicaid/Medicare guidelines
- Hayes Health Technology Assessment

**Retrospective
Review**

Retrospective authorization review is performed when a service has been provided, the claim has been adjudicated and no authorization has been given. Determinations for authorization involving health care services that have been delivered will be made within 30 calendar days of receipt of necessary information. All services are subject to retrospective review. Prior authorization or concurrent review decisions will not be reversed unless the Plan receives information that contradicts the information given when the initial determination was made.

WellCare will also conduct retrospective medical record reviews. WellCare will request medical records, usually once per month, and perform a random audit of the records. The review will focus on identifying conflicts in the coded claims compared to the information documented in the medical record. Depending on the situation, WellCare will communicate via phone and letter outlining the specific coding errors. Additional follow-up will occur in the event the coding trends continue after education and review with the respective facility.

**Expedited
Organization
Determination**

The Plan has up to 14 calendar days to determine whether a service requested is a medically appropriate and covered service. In some cases, a member has the right to

a decision within 24 hours of a request. Plan members can get an expedited decision if their health or ability to function could be seriously harmed by waiting 14 days for a standard decision.

If a member desires an expedited decision, the request for such must be submitted through a verbal or written request to the Plan, or requested by the referring provider. The receipt of the request will be documented by the Plan. If the member's request is determined to be valid, and a delayed decision would negatively impact the member's health, the Plan will deliver an expedited decision. If the member's health is not likely to be impacted by a wait of up to 14 days for a decision, the request will be processed within 14 days. If any physician requests an expedited decision, it will be granted.

**Extension for
Standard
Organization
Determination**

An extension of up to 14 calendar days for the Plan to render an authorization decision is permitted, if the extension of time benefits the member. For example, if the member requires additional time to obtain and provide the Plan with requested documents, the Plan could offer an extension on the decision for authorization.

**Case
Management and
Disease
Management**

While the provision of health care services and the exercise of professional medical judgment is the purview of treating physicians and other health care providers, case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes. Case management emphasizes continuity of care for the members through the coordination of care among physicians and other providers. Case management is not an episode but occurs across a continuum of care, addressing ongoing individual needs rather than being restricted to a single practice setting.

- PCPs serve as principal case manager and

coordinator of care. The Plan's Case Management team serves a support capacity to the PCP and assists in coordinating care actively linking the member to providers, medical services and residential, social and other support services where needed.

- The Case Management team is comprised of specially qualified nurses who, through the case management process, assess the member's risk factors, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the treatment plan.
- The Plan has incorporated Case Management programs that manage members with specific health care needs such as catastrophic diseases (adult and pediatric), transplants, wounds, HIV and obstetrics. A physician or hospital clinician may call to request case management services for any of the Plan members.

WellCare's Disease Management Program focuses on providing education for members with chronic conditions and empowering the member to make behavior changes to ensure the choices they make will improve their health and reduce the complications of their disease. WellCare's Disease Management Program pro-actively identifies members with chronic conditions using an algorithm that addresses utilization, cost, and severity of illness.

WellCare's Disease Management Program includes:

- Educating members and their caregivers regarding the standards of care for chronic conditions, triggers to avoid, and medications.
- Providing suggestions for interventions and education that can improve the quality of life of member, improving health outcomes and decreasing medical costs.
- Forwarding educational mailings to members

enrolled in Disease Management with an opportunity to request additional educational material specific to their condition or needs.

**Discharge
Coordination**

Discharge coordination or planning is an essential part of the concurrent review process. It may include coordinating services required to assist in arranging for and implementing a member's transition to a more appropriate or lower level of care, as needed. The concurrent review nurse coordinates services with the PCP, attending physician and/or the discharge planning personnel at the hospital.

If a member requires a transfer from an acute care setting to a nursing care facility or home care setting, the hospital will coordinate with WellCare to identify alternative services and to maintain continuity of care.

When relinquishing members, the Company will cooperate with the receiving Health Plan regarding the course of on-going care with a specialist or other provider.

When the Company becomes aware that a covered member will be disenrolled from WellCare and will transition to a GA Medicaid FFS program or another CMO, a WellCare Review Nurse/Case Manager who is familiar with that member will provide a Transition of Care (TOC) report to the receiving plan, or appropriate contact person for the designated FFS program.

When a covered member is hospitalized, and is disenrolled from WellCare during the hospital stay, the Company shall maintain responsibility for the coordination of care, and discharge planning for that member.

When a covered newborn remains hospitalized, and is disenrolled from a WellCare during the hospitalization, the Company shall remain responsible for the coordination of care and discharge planning, until the child has been appropriately discharged from the hospital and placed in

an appropriate care setting.

Lock-In Members WellCare may “lock in” or restrict the number of providers from whom a member may receive services. Members who have demonstrated a pattern of utilization abuse are placed in the program once they have failed to correct the behavior even after notification from WellCare and counseling.

In the “lock-in” program, a member who has consistently utilized services at a frequency or amount that is not medically necessary is locked in to a single physician and pharmacy provider selected by the Plan. The provider chosen will be geographically situated to give reasonable access to the member. The initial lock-in period will not exceed 12 months. Following the lock-in period, the member’s usage is re-evaluated to determine if continuation of the restriction is necessary. A member facing lock-in will be given notice of a hearing prior to the lock-in. A lock-in does not apply to emergency services or if a specialized provider is medically necessary.

The physician and pharmacy selected by WellCare to participate in the lock-in will be contacted by the Plan prior to the start of the lock-in period, and that physician and/or pharmacy may decline to participate.

Claims submitted for a lock-in member by providers other than those selected will be denied.

If a hospital suspects a member seeking services of a non-emergent nature is in the lock-in program, the hospital should contact the physician listed on the member’s Medicaid ID card. The physician listed on the ID card is to be considered the member’s attending physician and should be consulted prior to providing services of a non-emergent nature. Hospitals should be alert to possible abuse of emergency room services to prevent the hospital from incurring costs for non-reimbursable expenditures.

Further, hospitals are asked to identify and report emergency room abuse by Medicaid members who are



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not currently monitored by the "lock-in" program to WellCare. See the Quick Reference Guide for contact information.