WellCare®
of North Carolina by Celtic Insurance Company

Provider and Billing Manual

2025

marketplace.wellcarenc.com

WellCare of North Carolina is underwritten by Celtic Insurance Company, which is a Qualified Health Plan issuer in the North Carolina Health Insurance Marketplace.

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WellCare of North Carolina by Celtic Insurance Company

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WELLCARE OF NORTH CAROLINA HEALTH PROVIDER MANUAL REVISIONS

Date	Section Header	Sub-Header	Page	Change
1/1/2025	Covered Services	Preventive Colonoscopy	35-36	New section
1/1/2025	Medical Management	Care Management	38-39	Updated language
1/1/2025	Regulatory Matters	Non-Discrimination Notice	120	Updated sub-header
1/1/2025	Appendix	Appendix V: Common Business EDI Rejection Codes	126-128	Updated error descriptions
1/1/2025	Appendix	Appendix VII: Billing Tips and Reminders – Reproductive Health Services	170-171	New sub-section
1/1/2025	Appendix	Appendix VII: Billing Tips and Reminders – Telehealth Services	172	New sub-section
1/1/2025	Appendix	Appendix IX: EDI Companion Guide Overview – Identification Codes and Numbers	178	Removed sub-section *Federal Tax Identifiers*
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WELCOME

Welcome to WellCare of North Carolina by Celtic Insurance Company. Thank you for participating in our network of high-quality physicians, hospitals, and other healthcare professionals.

WellCare of North Carolina's Health Insurance Marketplace plans target a consumer population of lower income, previously uninsured individuals, and families who, prior to having this health insurance, may have been Medicaid-eligible or unable to access care due to financial challenges.

Partnering with WellCare of North Carolina provides an opportunity for you to access a previously untapped consumer population by providing coverage to those who qualify for generous premium and cost sharing subsidies. WellCare of North Carolina has been very successful in attracting and retaining our target population and continues to focus on engaging and acquiring these subsidy-eligible consumers through its unique plan designs, incentive programs, and effective communication.

WellCare of North Carolina is a Qualified Health Plan (QHP) as defined in the Affordable Care Act (ACA). WellCare of North Carolina is offered to consumers through the Health Insurance Marketplace, also known as the Exchange. The Health Insurance Marketplace makes buying health insurance easier.

The Affordable Care Act is the law that has changed healthcare. The goals of the ACA are:

- To help more Americans get health insurance and stay healthy; and
- To offer consumers a choice of coverage leading to increased health care engagement and empowerment.

HOW TO USE THIS PROVIDER MANUAL

WellCare of North Carolina is committed to assisting its provider community by supporting their efforts to deliver well-coordinated and appropriate health care to our members. WellCare of North Carolina is also committed to disseminating comprehensive and timely information to its providers through this provider manual regarding WellCare of North Carolina's operations, policies, and procedures. Updates to this manual will be posted on our website at marketplace.wellcarenc.com. Additionally, providers may be notified via bulletins and notices posted on the website and potentially on Explanation of Payment notices. Providers may contact our Provider Services department at 1-833-925-2861 to request that a copy of this manual be mailed to you. In accordance with the Participating Provider Agreement, providers are required to comply with the provisions of this manual. WellCare of North Carolina routinely monitors compliance with the various requirements in this manual and may initiate corrective action, including denial or reduction in payment, suspension, or termination if there is a failure to comply with any requirements of this manual.

Dental and Vision Provider Manuals

Centene Dental and Centene Vision provider manuals are available on the Secure Provider Portal. Providers may visit www.CenteneDental.com or www.CenteneVision.com and log on or contact us for these provider manuals.

Ancillary Provider Manuals

Additional provider manuals are available on the Secure Provider Portal. Providers can contact Provider Services at 1-833-925-2861 for more information.

NONDISCRIMINATION OF HEALTH CARE SERVICE DELIVERY

WellCare of North Carolina complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and instructions for accessing language services in all significant member materials and physical locations that serve our members.

All providers who join the WellCare of North Carolina Provider Network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR).

WellCare of North Carolina requires providers to deliver services to WellCare of North Carolina members without regard to race, color, national origin, age, disability, or sex. Providers must not discriminate against members based on their payment status and cannot refuse to serve based on varying policy and practices and other criteria for the collecting of member financial responsibility from WellCare of North Carolina members.

Newborns and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth. Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96- hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission. The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours). Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "self-insured.") The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply. All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

KEY CONTACTS AND IMPORTANT PHONE NUMBERS

The following table includes several important telephone and fax numbers available to providers and their office staff. When calling, it is helpful to have the following information available:

1. The provider's NPI number
2. The practice Tax ID Number
3. The member's ID number

HEALTH PLAN INFORMATION	
WellCare of North Carolina	WellCare of North Carolina 3128 Highwoods Boulevard, Suite 200 Raleigh, NC 27604 Phone: 1-833-925-2861 Fax: 1-833-596-2772 marketplace.wellcarenc.com

Department	Phone	Fax/Web Address
Provider Services	1-833-925-2861	N/A
Member Services		N/A
Medical Management Inpatient and Outpatient Prior Authorization		1-833-897-0322
Concurrent Review/Clinical Information		1-833-897-0323
Admissions/Census Reports/ Facesheets		N/A
Assessments		1-833-897-0326
Care Management		1-833-298-4301
Medical Records		1-833-897-0324
Behavioral Health Prior Authorization - Inpatient		1-833-538-2371
Behavioral Health Prior Authorization - Outpatient		1-833-538-2372
24/7 Nurse Advice Line		N/A
Centene Pharmacy Services		1-800-977-4170

HEALTH PLAN INFORMATION		
Centene Vision		CenteneVision.com
Centene Dental		CenteneDental.com
Transplant Services		1-833-897-0327
Interpreter Services		N/A
Advanced Imaging (MRI, CT, PET) (NIA)	1-800-642-7339	www.RadMD.com
Cardiac Imaging (NIA)	1-800-642-7339	www.RadMD.com
Therapy Services	1-800-642-7339	www.RadMD.com
To report suspected fraud, waste and abuse	1-866-685-8664	N/A
EDI Claims assistance	1-800-225-2573 ext. 6075525	e-mail: EDIBA@centene.com

SECURE PROVIDER PORTAL

WellCare of North Carolina offers a robust Secure Provider Portal with functionality that is critical to serving members and to ease administration for the WellCare of North Carolina product for providers.[1] The Portal can be accessed at marketplace.wellcarenc.com.

FUNCTIONALITY

- All users of the Secure Provider Portal must complete a registration process. Once registered, providers may:
- Check eligibility and view member roster.
- View the specific benefits for a member.
- Check member benefit limitations and usage.
- Check authorization requirements.
- Verify members remaining yearly deductible and amounts applied to plan maximums.
- View status of all claims that have been received, regardless of how submitted.
- Update provider demographic information (address, office hours, etc.)
- For primary care providers, view, and print patient lists. The patient list will indicate the member's name, id number, date of birth, care gaps, disease management enrollment, and product in which they are enrolled.
- Submit authorizations and view the status of authorizations that have been submitted for members.
- View, submit, copy, and correct claims.
- Submit batch claims via an 837 file.
- View and download explanations of payment (EOP)
- View a member's health record, including visits (physician, outpatient hospital, therapy, etc.), medications, and immunizations.
- View gaps in care specific to a member, including preventive care or services needed for chronic conditions.
- Send and receive secure messages with WellCare of North Carolina staff.

[1] Providers submitting initial authorization for services for WellCare of North Carolina must submit authorization by phone or fax. Once providers receive first claims remittance provider may register with our secure online web portal. Providers much receive a claims payment to register with our online portal.

- Access both patient and provider analytic tools

Manage Account Access allows you to perform functions as an account manager such as adding portal accounts needed in your office.

DISCLAIMER

Providers agree that all health information, including that related to patient conditions, medical utilization, and pharmacy utilization available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

CREDENTIALING AND RECREDENTIALING

The credentialing and recredentialing process exists to verify that participating practitioners and providers meet the criteria established by WellCare of North Carolina, as well as applicable government regulations and standards of accrediting agencies.

If a practitioner/provider already participates with WellCare of North Carolina in the Medicaid or a Medicare product, the practitioner/provider will NOT be separately credentialed for the WellCare of North Carolina product.

Notice: To maintain a current practitioner/provider profile, practitioners/providers are required to notify WellCare of North Carolina of any relevant changes to their credentialing information in a timely manner but in no event later than 10 days from the date of the change.

Whether standardized credentialing form is utilized, or a practitioner has registered their credentialing information on the Council for Affordable Quality Health (CAQH) website, the following information must be on file:

- Signed attestation as to correctness and completeness, history of license, clinical privileges, disciplinary actions, and felony convictions, lack of current illegal substance use and alcohol abuse, mental and physical competence, and ability to perform essential functions with or without accommodation.
- Completed ownership and control disclosure form unless otherwise prohibited by state requirement.
- Current malpractice insurance policy face sheet, which includes insured dates and the amounts of coverage.
- Current controlled substance registration certificate, if applicable
- Current drug enforcement administration (DEA) registration certificate for each state in which the practitioner will see WellCare of North Carolina members.
- Completed and signed W-9 form (initial credentialing only)
- Current educational commission for foreign medical graduates (ECFMG) certificate, if applicable
- Curriculum vitae listing, at minimum, a five-year work history if work history is not completed on the application with no unexplained gaps of employment over six months for initial applicants.
- Signed and dated release of information form not older than 120 days
- Current clinical laboratory improvement amendments (CLIA) certificate, if applicable

WellCare of North Carolina will primary source verify the following information submitted for credentialing and recredentialing:

- License through appropriate licensing agency.
- Board certification, or residency training, or professional education, where applicable.
- Malpractice claims and license agency actions through the national practitioner data bank (NPDB);
- Federal sanction activity, including Medicare/Medicaid services (OIG-Office of Inspector General).

For providers (hospitals and ancillary facilities), a completed Facility/Provider – Initial and Recredentialing Application and all supporting documentation as identified in the application must be received with the signed, completed application.

Once the clean application is received, the Credentialing Committee will usually render a decision on acceptance following its next regularly scheduled meeting in accordance with state and federal regulations.

ELIGIBLE PROVIDERS

All eligible providers are required to complete the credentialing process. All eligible providers must be recredentialed every 36 months.

- Professional providers including but not limited to: MD, DO, PsyD, PHD, AUD, BCBA, OD, DC, CNM, DPM, LCSW, LCPC, LMFT, PA, APN, APRN ANP and CNP, CNS, RD, LAC and DN
- Institutional providers: Hospitals and Ancillary

NON REGISTERED CAQH PROVIDERS

Primary care providers cannot accept member assignments until they are fully credentialed.

Practitioners/Providers should self-register with CAQH ProView at https://proview.caqh.org. The CAQH will email the provider a Welcome kit with registration instructions. Practitioners/Providers receive a personal CAQH Provider ID, allowing them to register on the CAQH website at proview.caqh.org and obtain immediate access to the ProView database via the Internet.

Once obtaining authenticating key information, practitioners/providers will have the opportunity to create their own unique username as well as password to begin utilizing the system at any time.

CREDENTIALING COMMITTEE

The Credentialing Committee, including the Medical Director or their physician designee, has the responsibility to establish and adopt necessary criteria for participation, termination, and direction of the credentialing procedures. Committee meetings are typically held at least monthly and more often as deemed necessary.

Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

RECREDENTIALING

WellCare of North Carolina conducts practitioner/provider recredentialing at least every 36 months from the date of the initial credentialing decision or most recent recredentialing decision. The purpose of this process is to identify any changes in the practitioner's/provider's licensure, sanctions, certification, competence, or health status which may affect the practitioner's/provider's ability to perform services under the contract. This process includes all practitioners, facilities, and ancillary providers previously credentialed and currently participating in the network.

In between credentialing cycles, WellCare of North Carolina conducts provider performance monitoring activities on all network practitioners/providers. WellCare of North Carolina reviews monthly reports released by both Federal and State entities to identify any network practitioners/providers who have been newly sanctioned or excluded from participation in Medicare or Medicaid. WellCare of North Carolina also reviews member complaints/grievances against providers on an ongoing basis.

A provider's agreement may be terminated if at any time it is determined by the WellCare of North Carolina Credentialing Committee that credentialing requirements or standards are no longer being met.

PRACTITIONER RIGHT TO REVIEW AND CORRECT INFORMATION

All practitioners participating within the network have the right to review information obtained by WellCare of North Carolina to evaluate their credentialing and/or recredentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank, CAQH, malpractice insurance carriers, and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Practitioners have the right to correct any erroneous information submitted by another party (other than references, personal recommendations, or other information that is peer review protected) in the event the provider believes any of the information used in the credentialing or recredentialing process to be incorrect or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner. WellCare of North Carolina will inform providers in cases where information obtained from primary sources varies from information provided by the practitioner. To request release of such information, a written request must be submitted to your Provider Relations Representative. Upon receipt of this information, the practitioner will have 30 days from the initial notification to provide a written explanation detailing the error or the difference in information to the Credentialing Committee.

The WellCare of North Carolina Credentialing Committee will then include this information as part of the credentialing or recredentialing process.

PRACTITIONER RIGHT TO BE INFORMED OF APPLICATION STATUS

All practitioners who have applied to join have the right to be informed of the status of their application upon request. To obtain application status, the practitioner should contact the Credentialing Department at 1-833-925-2861.

PRACTITIONER RIGHT TO APPEAL OR RECONSIDERATION OF ADVERSE CREDENTIALING DECISIONS

Applicants who are existing providers and who are declined continued participation due to adverse credentialing determinations (for reasons such as appropriateness of care or liability claims issues) have the right to request an appeal of the decision. Requests for an appeal must be made in writing within 30 days of the date of the notice.

New applicants who are declined participation may request a reconsideration within 30 days from the date of the notice. All written requests should include additional supporting documentation in favor of the applicant's appeal or reconsideration for participation in the network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting and/or no later than 60 days from the receipt of the additional documentation in accordance with state and federal regulations.

Written requests to appeal or reconsideration of adverse credentialing decisions should be sent to:

WellCare of North Carolina
Attn: Credentialing Manager
7700 Forsyth Boulevard
St. Louis, MO 63105

PROVIDER ADMINISTRATION AND ROLE OF THE PROVIDER

PROVIDER TYPES THAT MAY SERVE AS PCPS

Providers who may serve as primary care providers (PCP) include:

- OB/GYN.
- Internal Medicine.
- Pediatrics.
- General Medicine.
- Family Practice.
- Physician Assistants; and
- Nurse Practitioners.

The PCP may practice in a solo or group setting or at a Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Department of Health Clinic, or similar outpatient clinic. With prior written approval, WellCare of North Carolina may allow a specialist provider to serve as a PCP for members with special health care needs, multiple disabilities, or with acute or chronic conditions if the specialist is willing to perform the responsibilities of a PCP as outlined in this Manual.

MEMBER PANEL CAPACITY

All PCPs have the right to state the number of members they are willing to accept into their panel. WellCare of North Carolina does not and is not permitted to guarantee that any provider will receive a certain number of members.

The PCP to member ratio shall not exceed the following limits:

Practitioner Type	Ratio
General/Family Practitioners	One per 2,500 members
Pediatricians	One per 2,500 members
Internists	One per 2,500 members

If a PCP has reached the capacity limit for their practice and wants to make a change to their open panel status, the PCP must notify WellCare of North Carolina 30 days in advance of their inability to accept additional members. Notification can be in writing or by calling the Provider Services Department 1-833-925-2861. A PCP

must not refuse new members for addition to their panel unless the PCP has reached their specified capacity limit.

In no event will any established patient who becomes a member be considered a new patient. Providers must not intentionally segregate members from fair treatment and covered services provided to other nonmembers.

MEMBER SELECTION OR ASSIGNMENT OF PCP

WellCare of North Carolina members will be directed to select a participating Primary Care Provider (PCP) at the time of enrollment. In the event a WellCare of North Carolina member does not make a PCP choice, WellCare of North Carolina will usually select a PCP based on:

1. **A previous relationship with a PCP.** If a member has not designated a PCP within the first 30 days of being enrolled in WellCare of North Carolina, WellCare of North Carolina will review and assign the member to that PCP.
2. **Geographic proximity of PCP to member residence.** The auto-assignment logic is designed to select a PCP for whom the members will not travel more than the required access standards.
3. **Appropriate PCP type.** The algorithm will use age, gender, and other criteria to identify an appropriate match, such as children assigned to pediatricians.

Pregnant members should be encouraged to select a pediatrician or other appropriate PCP for their newborn baby before the beginning of the last trimester of pregnancy. In the event the pregnant member does not select a PCP, WellCare of North Carolina will auto-assign one for their newborn.

The member may change their PCP at any time with the change becoming effective no later than the beginning of the month following the member's request for change. Members are advised to contact the Member Services Department at 1-833-925-2861 for further information.

WITHDRAWING FROM CARING FOR A MEMBER

Providers may withdraw from caring for a member. Upon reasonable notice and after stabilization of the member's condition, the provider must send a certified letter to WellCare of North Carolina Member Services detailing the intent to withdraw care. The letter must include information on the transfer of medical records as well as emergency and interim care.

PCP COORDINATION OF CARE TO SPECIALISTS

When medically necessary care is needed beyond the scope of what the PCP can provide, PCPs are encouraged to initiate and coordinate the care members receive from specialist providers. Paper referrals are not required.

In accordance with federal and state law, providers are prohibited from making referrals for designated health services to healthcare providers with which the provider, the member, or a member of the provider's family or the member's family has a financial relationship.

SPECIALIST PROVIDER RESPONSIBILITIES

Specialist providers must communicate with the PCP regarding a member's treatment plan and referrals to other specialists. This allows the PCP to better coordinate the member's care and ensures that the PCP is aware of the additional service request.

To ensure continuity and coordination of care for the member, every specialist provider must:

- Maintain contact and open communication with the member's referring PCP.
- Obtain authorization from the Medical Management Department, if applicable, before providing services
- Coordinate the member's care with the referring PCP.
- Provide the referring PCP with consultation reports and other appropriate patient records within five business days of receipt of such reports or test results.
- Be available for or provide on-call coverage through another source 24 hours a day for management of member care.
- Maintain the confidentiality of patient medical information
- Actively participate in and cooperate with all quality initiatives and programs.

APPOINTMENT AVAILABILITY AND WAIT TIMES

WellCare of North Carolina follows the accessibility and appointment wait time requirements set forth by applicable regulatory and accrediting agencies. WellCare of North Carolina monitors participating provider compliance with these standards at least annually and will use the results of appointment standards monitoring to ensure adequate appointment availability and access to care and to reduce inappropriate emergency room utilization. The table below depicts the appointment availability for members:

Appointment Type	Access Standard
PCPs – Routine visits	30 business days
PCPs – Adult Sick Visit	48 hours
PCPs – Pediatric Sick Visit	24 hours
Behavioral Health – Non-life Threating Emergency	6 hours
Specialist	Within 30 business days
Urgent Care Providers	24 hours
Behavioral Health Urgent Care	48 hours
After Hours Care	Office number answered 24 hours/7 days a week by answering service or instructions on how to reach a physician
Emergency Providers	Immediately (available 24 hours a day, three hundred sixty-five (365) days a year).

WAIT TIME STANDARDS FOR ALL PROVIDER TYPES

It is recommended that office wait times do not exceed 30 minutes before a WellCare of North Carolina member is taken to the exam room.

TRAVEL DISTANCE AND ACCESS STANDARDS

WellCare of North Carolina offers a comprehensive network of PCPs, specialist physicians, hospitals, behavioral health care providers, diagnostic and ancillary services providers to ensure every member has access to covered services.

The travel distance and access standards that WellCare of North Carolina utilizes to monitor its network adequacy are in line with both state and federal regulations. For the standard specific to your specialty and county, please reach out to your Provider Services department.

Providers must offer and provide WellCare of North Carolina members appointments and wait times comparable to that offered and provided to other commercial members. WellCare of North Carolina routinely

monitors compliance with this requirement and may initiate corrective action, including suspension or termination, if there is a failure to comply with this requirement.

COVERING PROVIDERS

PCPs and specialist providers must arrange for coverage with another provider during scheduled or unscheduled time off. In the event of unscheduled time off, the provider must notify the Provider Services department of coverage arrangements as soon as possible. For scheduled time off, the provider must notify the Provider Services department prior to the scheduled time off. The provider who engaged the covering provider must ensure that the covering physician has agreed to be compensated in accordance with the WellCare of North Carolina fee schedule in such provider's agreement.

PROVIDER PHONE CALL PROTOCOL

PCPs and specialist providers **must**:

- Answer the member's telephone inquiries on a timely basis.
- Schedule appointments in accordance with appointment standards and guidelines set forth in this manual.
- Schedule a series of appointments and follow-up appointments as appropriate for the member and in accordance with accepted practices for timely occurrence of follow-up appointments for all patients
- Identify and, when possible, reschedule cancelled and no-show appointments.
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or persons with cognitive impairments)
- Adhere to the following response times for telephone call-back wait times:
    - After hours for non-emergent, symptomatic issues: within 30 minutes
    - Same day for all other calls during normal office hours
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal office hours.
- Have protocols in place to provide coverage in the event of a provider's absence.
- Document after-hours calls in a written format in either in the member's medical record or an after-hours call log and then transfer to the member's medical record.

NOTE: If after-hours urgent or emergent care is needed, the PCP, specialist provider, or their designee should contact the urgent care center or emergency department to notify the facility of the patient's impending arrival. WellCare of North Carolina does not require prior authorization for emergent care.

WellCare of North Carolina will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program (QIP).

PROVIDER DATA UPDATES AND VALIDATION

WellCare of North Carolina believes that providing easy access to care for our members is extremely important. When information (for instance address, office hours, specialties, phone number, hospital affiliations, etc.) about your practice, your locations, or your practitioner changes, it is your responsibility to provide timely updates to WellCare of North Carolina. WellCare of North Carolina will ensure that our systems are updated quickly to provide the most current information to our members.

Additionally, WellCare of North Carolina, and our contracted vendors, perform regular audits of our provider directories. This may be done through outreach to confirm your practice information. Access to care is critical to ensuring the health and well-being of our members, and to provide reliable access to care, it is important to respond to the outreach. Without a response, we are unable to accurately make your information available to patients and you may be at risk of being removed from the WellCare of North Carolina Provider Directory.

We need your support and participation in these efforts. CMS may also be auditing provider directories throughout the year, and you may be contacted by them as well. Please be sure to notify your office staff so that they may route these inquiries appropriately.

24-HOUR ACCESS TO PROVIDERS

PCPs and specialist providers are required to maintain sufficient access to needed health care services on an ongoing basis and must ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours; and
- A member must be able to access their provider after normal business hours and on weekends; this may be accomplished through the following:
- A covering physician.
- An answering service.
- A triage service or voicemail message that provides a second phone number that is answered; or
- If the provider's practice includes a high population of Spanish speaking members, it is recommended that the message be recorded in both English and Spanish.

Examples of unacceptable after-hours coverage include, but are not limited to:

- Calls received after-hours are answered by a recording telling callers to leave a message.
- Calls received after-hours are answered by a recording directing patients to go to an emergency room for any services needed; or

- Not returning calls or responding to messages left by patients' after-hours within 30 minutes.

The selected method of 24-hour coverage chosen by the provider must connect the caller to someone who can render a clinical decision or reach the PCP or specialist provider for a clinical decision. Whenever possible, PCP, specialist providers, or a covering professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

WellCare of North Carolina will monitor provider's compliance with this provision through scheduled and unscheduled visits and audits conducted by WellCare of North Carolina staff.

HOSPITAL RESPONSIBILITIES

WellCare of North Carolina has established a comprehensive network of hospitals to provide services to members. Hospital services and hospital-based providers must be qualified to provide services under the program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth by accrediting agencies, if any, and WellCare of North Carolina.

Hospitals must:

- Notify the PCP immediately or no later than the close of the next business day after the member's emergency room visit.
- Obtain authorizations for all inpatient and selected outpatient services listed in the Pre-Auth Needed tool available at marketplace.wellcarenc.com, except for emergency stabilization services.
- Notify the Medical Management department by either calling or sending an electronic file of the ER admission within one business day; the information required includes the member's name, member ID, presenting symptoms/diagnosis, date of service, and member's phone number.
- Notify the Medical Management department of all admissions via the ER within one business day.
- Notify the Medical Management department of all newborn deliveries within one day of the delivery; notification may occur by our Secure Provider Portal, fax, or by phone; and
- Adhere to the standards set in the Timeframes for Prior Authorization Requests and Notifications table in the Medical Management section of this manual.

PROVIDER DATA UPDATES AND VALIDATION

WellCare of North Carolina believes that providing easy access to care for our members is extremely important. When information (for instance address, office hours, specialties, phone number, hospital affiliations, etc.) about your practice, your locations, or your practitioners' changes, it is your responsibility to provide timely updates to WellCare of North Carolina . WellCare of North Carolina will ensure that our systems are updated quickly to provide the most current information to our members.

Additionally, WellCare of North Carolina, and our contracted vendors, perform regular audits of our provider directories. This may be done through outreach to confirm your practice information. Access to care is critical to ensuring the health and well-being of our members, and to provide reliable access to care, it is important to respond to the outreach. Without a response, we are unable to accurately make your information available to patients and you may be at risk of being removed from the WellCare of North Carolina Provider Directory.

We need your support and participation in these efforts. CMS may also be auditing provider directories throughout the year, and you may be contacted by them as well. Please be sure to notify your office staff so that they may route these inquiries appropriately.

WELLCARE OF NORTH CAROLINA BENEFITS

OVERVIEW

There are many factors that determine which plan a WellCare of North Carolina member will be enrolled in. The plans vary based on the individual liability limits, including their deductibles, maximum out-of-pocket responsibilities, and/or cost share (copay and/or coinsurance) expenses for benefits to the member.

Essential Health Benefits (EHBs) are the same within every plan. This means that every health plan will cover the minimum, comprehensive benefits as outlined in the Affordable Care Act, and in line with all applicable state regulations.

The EHBs outlined in the Affordable Care Act are as follows:

- Preventive and wellness services and chronic disease management
- Maternity and newborn care
- Pediatric services including pediatric vision.
- Outpatient or ambulatory services
- Laboratory services
- Various therapies (such as physical therapy and devices)
- Hospitalization
- Emergency services
- Mental health and substance use services, both inpatient and outpatient
- Prescription drugs

WellCare of North Carolina covers services described in the Schedule of Benefits and Evidence of Coverage (EOC) document for each WellCare of North Carolina plan type. If there are questions as to a covered service or required prior authorization, please contact WellCare of North Carolina Provider Services at 1-833-925-2861. Prior authorization criteria and a quick check tool are also available on our website.

Detailed information about benefits and services can be found in the current year EOC available at marketplace.wellcarenc.com on the "Our Health Plans" page.

ADDITIONAL BENEFIT INFORMATION

WellCare of North Carolina has a variety of PPO, HMO, and EPO benefit plans offerings based on geographic location. Depending on the benefit plan and any subsidies that the member may receive, plans contain copays, coinsurance, and deductibles (cost shares). As stated elsewhere in this manual, cost shares may be collected at the time of service. Review the "Verifying Member Benefits, Eligibility, and Cost Shares" section of this

manual to determine if the WellCare of North Carolina Member has an HMO, EPO, or PPO plan and their associated cost share for services.

PPO

To receive the highest level of benefits at the lowest cost share amounts, members who are enrolled with WellCare of North Carolina PPO plans are incented to utilize in-network participating providers. If a member receives care from an out-of-network provider, they will receive benefits, and they can be balanced bill for additional charges above what has been reimbursed from the health plan. Members and providers can identify participating providers by visiting our website at marketplace.wellcarenc.com and clicking on Find-A-Provider.

HMO

Members who are enrolled in HMO plans with WellCare of North Carolina must utilize in-network participating providers. Members and providers can identify other participating providers by visiting our website at marketplace.wellcarenc.com and clicking on Find-A-Provider. When an out-of-network provider is utilized, except in the case of emergency services, the member will be 100% responsible for all charges.

INTEGRATED DEDUCTIBLE PRODUCTS

Some WellCare of North Carolina products contain an integrated deductible, meaning that the medical and prescription deductible are combined. In such plans,

- A member will reach the deductible first, then pay coinsurance until they reach the maximum out-of-pocket for their plan.
- Most copays will be collected before the deductible for services that are not subject to the deductible.
- Other copays are subject to the deductible, and the copay will be collected only after the deductible is met.
- Services counting towards the integrated deductible include medical costs, physician services, hospital services, essential health benefit covered services including pediatric vision, mental health services, and pharmacy benefits.
- Claims information including the accumulators will be displayed on the Secure Provider Portal

NON- INTEGRATED DEDUCTIBLE PRODUCTS

Some WellCare of North Carolina products contain a non-integrated deductible, meaning that the medical and prescription deductible are not combined. In such plans:

- A member will reach the medical deductible separately from the prescription deductible, then pay cost share (either copay or coinsurance) until they reach the maximum out-of-pocket for their plan.
- Copays will be collected before the deductible for services that are not subject to the deductible.
- Other copays are subject to the deductible, and the copay will be collected only after the deductible is met.

- Services that will not count towards the non-integrated prescription deductible include medical costs, physician services, hospital services, essential health benefit covered services including pediatric vision and mental health services, and any other medical benefits.
- Only claims for pharmacy benefits will count towards the non-integrated prescription deductible.
- Claims information including the accumulators will be displayed on the Secure Provider Portal

MAXIMUM OUT-OF-POCKET EXPENSES

All WellCare of North Carolina benefit plans contain a maximum out-of-pocket expense. Maximum out-of-pocket is the highest or total amount that must be paid by the member toward the cost of their health care (excluding premium payments). Maximum out-of-pocket costs can be determined on the Member's Schedule of Benefits document available through marketplace.wellcarenc.com on the "Our Health Plans" page. Below are some rules regarding maximum out-of-pocket expenses:

- A member will reach the deductible first and will continue to pay coinsurance/copay then pay coinsurance until they reach the maximum out-of-pocket for their WellCare of North Carolina benefit plan.
- Copays or coinsurance will be collected before and after the deductible is met; or until the maximum out-of-pocket is met.
- Only medical costs/claims are applied to the deductible. (For those benefit plans that contain routine adult vision and routine dental coverage, these expenses would not count towards the deductible).
- All out-of-pocket costs, including copays, deductibles, and coinsurance apply to the maximum out-of-pocket. (As mentioned previously, this excludes premium payments).
- WellCare of North Carolina will continue to pay claims and provide 100% of contracted payment after the member/family policy has met their maximum out-of-pocket costs.

COVERED SERVICES

Please visit the WellCare of North Carolina website for information on services, the member's coverage status and other information about obtaining services. Please refer to our website and the "Medical Management & Prior Authorization" section of this manual for more information about clinical determination and prior authorization procedures.

BENEFIT LIMITS

In general, most benefit limits for services and procedures follow state and federal guidelines. Benefits limited to a certain number of visits per year are based on a calendar year (January through December). Please check to be sure the member has not already exhausted benefit limits before providing services by checking our Secure Provider Portal or calling WellCare of North Carolina Member and Provider Services.

PREVENTIVE SERVICES

Preventive care services are covered in accordance with the Affordable Care Act (ACA). The ACA requires health plans (non-grandfathered) to cover certain identified services under the preventive care benefit without cost sharing to members (copayments, coinsurance amounts, and deductibles do not apply), when obtained from an in-network provider. ACA required preventive care coverage includes:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

NOTE: The complete list of recommendations and guidelines can be found at https://www.healthcare.gov/preventive-care-benefits

Preventive benefits do not generally include services intended to treat an existing illness, injury, or condition. Benefits will be determined based on how the bill is submitted. Claims must be submitted with the appropriate diagnosis and/or procedure code to be paid at the 100% benefit level. If during a preventive care visit a member receives services to treat an existing illness, injury, or condition, he/she may be required to pay a copayment, deductible and/or coinsurance for those covered non-preventive services.

For a listing of services that are covered at 100% and associated preventative benefits, please visit marketplace.wellcarenc.com.

PREVENTIVE COLONOSCOPY

WellCare of North Carolina reimburses for preventive colonoscopy in accordance with state mandates and CMS guidelines. Colonoscopies, which are initiated as a screening colonoscopy, during which a polyp/tumor or other procedure due to an abnormality is discovered, should be considered a preventive service. To ensure appropriate reimbursement, the preventative colonoscopy CPT code should be billed with an ICD-10 diagnosis code corresponding to the pathology found rather than the special screening for malignant neoplasms of the colon.

The preventive colonoscopy diagnosis should be entered as the primary diagnosis and the diagnosis codes for any discovered pathology should be entered as the secondary diagnosis on all subsequent claim lines.

Follow the below billing tips to appropriately identify the colonoscopy service to be considered for reimbursement.

- Preventive Colonoscopy Screening
- One preventive every ten years when billed with preventive screening procedure and preventive diagnosis (must be billed in diagnosis 1 field); and
- Does not require modifier PT or 33 to be billed.
- High Risk Colonoscopy Screening
- One preventive every 24 months when billed with a high-risk procedure code and a high-risk diagnosis code; and
- Does not require modifier to be billed.
- Diagnostic Colonoscopy Service
- When billed with modifiers PT or 33, will be treated as preventive.
- When a modifier is not billed, it indicates the service is diagnostic.

NOTIFICATION OF PREGNANCY

Providers should notify WellCare of North Carolina/Marketplace/SBEs immediately of any member who are expecting. We do not require that a physician or other healthcare provider obtain prior authorization for the delivery of the newborn. However, an inpatient stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require prior authorization. Please refer to the provider authorization tool marketplace.wellcarenc.com to check if any authorizations are required for additional services.

This notification of pregnancy allows WellCare of North Carolina members to take advantage of the Start Smart for your Baby Program that provides education and care management techniques. The program offers support for pregnant women and their babies through the first year of life by providing educational materials as well as incentives for going to prenatal, postpartum, and well child visits.

NOTIFICATION OF PREGNANCY SURROGACY

Providers should notify WellCare of North Carolina/Marketplace/SBEs immediately of any member intending to come into a contractual agreement or is expecting because of surrogacy. All pregnancy related services provided to a surrogate mother are not covered, including but not limited to charges related to the baby's birth, hospitalization, or care because of surrogacy. Please see the WellCare of North Carolina Evidence of Coverage for additional details.

Adding a Newborn or an Adopted Child

Coverage applicable for children will be provided for a newborn child or adopted child of a WellCare of North Carolina member from the moment of birth or moment of placement for adoptions if the eligible child is enrolled timely as specified in the member's Evidence of Coverage.

Non-Covered Services

Please refer to the member Evidence of Coverage for a listing of non-covered (excluded) services.

TRANSPLANT SERVICES

Please refer to the member Evidence of Coverage for a listing of covered and non-covered (excluded) services related to transplants:

Transplants are a covered benefit when a member is accepted as a transplant candidate. *Prior authorization* must be obtained through the *"Center of Excellence" before* an evaluation for a transplant. WellCare of North Carolina may require additional information such as testing and/or treatment before determining medical necessity for the transplant benefit. *Authorization* must be obtained prior to performing any related services to the transplant *surgery*. Transplant services must meet medical criteria as set by Medical Management Policy.

Claims submission shall be followed related to transplant services is available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own coverage program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this contract will be provided for both you and the donor. In this case, payments made for the donor will be charged against enrollee's benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this contract will be provided for you. However, no benefits will be provided for the recipient.

- If lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a covered benefit.

For additional questions or information on Prior Authorizations please review the Medical Management section of this manual for guidelines.

TRIBAL PROVIDER (AIAN) AMERICAN INDIAN ALASKA NATIVE

For Indian Health Services (I.H.S) and Tribal 638 facilities, most services are paid at the Office of Management and Budget (OMB) Rate, using the UB claim form and either a revenue code for dental clinic (0512) or for physical health clinic (0519). For a Behavioral Health practitioner service revenue code 0919 is used. Some services are not part of the Office of Management Budget rate and are billed on the CMS 1500 form and paid at regular fee schedule rates. Note: Dental claims are not a covered service unless related to an emergency.

WellCare of North Carolina American Indian and Alaska Natives members may use an Indian healthcare as a primary care provider or choose to use a network primary care provider to get healthcare services. To avoid paying extra, member must obtain a referral from their Indian healthcare provider or from the network primary care provider for any specialty or other services not provided by your Indian healthcare provider.

WellCare of North Carolina claims billed by a network primary care provider or specialist on behalf of an American Indian and Alaska Native member are required to bill with modifier Q4 to indicate that these services are an extension of services not provided by an Indian healthcare provider but billed by a network primary care provider or specialist.

WellCare of North Carolina requires that all Tribal 638 facilities billing on CMS 1500 forms be billed with a place of service as recognized by CMS as indicated below:

- **05 Indian Health Service Free-Standing Facility** - A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
- **06 Indian Health Service Provider-Based Facility** - A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
- **07 Tribal 638 Free-Standing Facility** - A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
- **08 Tribal 638 Provider-Based Facility** - A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.

WellCare of North Carolina requires that all other non-Indian Health Services or Tribal providers billing on UB and CMS 1500 forms be billed in a place of services as recognized by CMS. Please visit www.cms.gov/Medicare/Coding for additional details.

MEMBER ADMINISTRATIVE GUIDELINES

It is imperative that providers verify benefits, eligibility, and cost shares each time a WellCare of North Carolina member is scheduled to receive services.

MEMBER BENEFITS

In general, most benefit limits for services and procedures follow state and federal guidelines. Benefits limited to a certain number of visits per year are based on a calendar year (January through December). In addition to verifying member benefits, eligibility and cost share, there may be further steps needed to help WellCare of North Carolina members maximize their benefit coverage before treatment is rendered. Marketplace.wellcarenc.com offers a Pre-Auth Check tool to determine if a pre-authorization is needed before services are rendered. This tool can be located at the marketplace.wellcarenc.com under the "For Providers" section of the site. This is in addition to other helpful tools and information WellCare of North Carolina offers. Please check to be sure the member has not already exhausted benefit limits before providing services by checking our Secure Provider Portal or calling WellCare of North Carolina Member and Provider Services.

MEMBER IDENTIFICATION CARD

All members will receive a WellCare of North Carolina member identification card.

Below is a sample member identification card. The ID card may vary due to the features of the health plan selected by the member.

(The above is a reasonable facsimile of the Member Identification Card)

NOTE: Presentation of a member ID card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are required.

PREFERRED METHOD TO VERIFY BENEFITS, ELIGIBILITY, AND COST SHARES

To verify member benefits, eligibility, and cost share information, the preferred method is the WellCare of North Carolina Secure Provider Portal found at marketplace.wellcarenc.com. Using the Portal, any registered provider can quickly check member eligibility, benefits, and cost share information. Eligibility and cost share information loaded onto this website is obtained from and reflective of all changes made within the last 24 hours. The eligibility search can be performed using the date of service, member name, and date of birth or the member ID number and date of birth.

When searching for eligibility on the Secure Provider Portal, you will see one of the following statuses:

- Member is eligible for services performed on this date of service.
- Member is not eligible for services performed on this date of service.
- Members premium payment is in delinquent status. Claims will be processed.
- Members premium payment is past due status. Claims may be denied.

Additional information regarding member premium grace period rules may be found further down in this manual.

OTHER METHODS TO VERIFY BENEFITS, ELIGIBILITY AND COST SHARES	
24/7 Toll Fee Interactive Voice Response (IVR) Line at 1-833-925-2861	The automated system will prompt you to enter the member ID number and the month of service to check eligibility.
Provider Services at 1-833-925-2861	If you cannot confirm a member's eligibility using the secure portal or the 24/7 IVR line, call Provider Services. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will require the member's name or member ID number and date of birth to verify eligibility.

ORTANCE OF VERIFYING BENEFITS, ELIGIBILITY, AND COST SHARES

Benefit Design

As mentioned previously in the Benefits section of this Manual, there are variations on the product benefits and design. To accurately collect member cost shares (coinsurance, copays, and deductibles), you must know the

benefit design. A member cost-sharing level and copayment is based on the member's health plan. You can collect the copayment amounts from the member at the time of service. The Secure Provider Portal found at marketplace.wellcarenc.com will provide the information needed.

Premium Grace Period for Members Receiving Advanced Premium Tax Credits (APTCs)

A provision of the Affordable Care Act requires that WellCare of North Carolina allow members receiving Advance Premium Tax Credit's (APTC) a three-month grace period to pay premiums before coverage is terminated.

Members for whom WellCare of North Carolina is not receiving an (APTC) will have a grace period of 30 days.

When providers are verifying eligibility through the Secure Provider Portal during the first month of grace period, the provider will receive a message that the member is delinquent due to nonpayment of premium; however, claims may be submitted and will be paid during the first month of the grace period. During months two and three of the grace period, the provider will receive a message that the member is in a suspended status. If payment of all premiums due is not received from the member at the end of the grace period, the member policy will automatically terminate to the last date through which premium was paid. The member shall be held liable for the cost of Covered Services received during the grace period, as well as any unpaid premium. In no event shall the grace period extend beyond the date the member policy terminates. More discussion regarding the three-month grace period for non-payment of premium may be found in the "Billing the Member" section of this manual.

MEDICAL MANAGEMENT

The components of the WellCare of North Carolina Medical Management program are Utilization Management, Care Management and Concurrent Review, Health Management and Behavioral Health. These components will be discussed in detail below.

CARE MANAGEMENTARE MANAGEMENT

Care Management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs, using communication and available resources to promote quality, cost effective outcomes. Service/Care Coordination and Care Management is member-centered, goal-oriented, culturally relevant, and logically managed processes to help ensure that a member receives needed services in a supportive, effective, efficient, timely, and cost-effective manner.

WellCare of North Carolina's Care Management teams support physicians by tracking compliance with the Care Management plan and facilitating communication between the PCP, member, managing physician, and the Care Management team. The Care Manager also facilitates referrals and links to community providers, such as behavioral health providers, local health departments and school-based clinics. The managing physician maintains responsibility for the member's ongoing care needs. The WellCare of North Carolina Care Manager will contact the PCP and/or managing physician if the member is not following the plan of care or requires additional services.

WellCare of North Carolina will provide individual Care Management services for members who have high-risk, high-cost, complex, or catastrophic conditions. The WellCare of North Carolina Care Manager will work with all involved providers to coordinate care and provide referral assistance and other care coordination as required. The WellCare of North Carolina Care Manager may also assist with a member's transition to other care, as indicated, when WellCare of North Carolina benefits end.

Start Smart for Your Baby® (Start Smart) is a Care Management program available to members who are pregnant or who have just had a baby. Start Smart is a comprehensive program that covers all phases of the pregnancy, postpartum, and newborn periods including perinatal and postnatal depression. The program includes mailed educational materials for newly identified pregnant members and new mothers after delivery. The initial mailing also includes an Edinburgh Depression Screening which is scored, and members identified as needing assistance with depression are contacted for care management services.

Telephonic Care Management by registered nurses, licensed mental health professionals and social services specialists as well as Marketplace Coordinators is available. WellCare of North Carolina's Care Managers work with the member to create a customizable plan of care to promote healthcare as well as adherence to Care Management plans. Care Managers will coordinate with physicians, as needed, to develop and maintain a plan of care to meet the needs of all involved.

All WellCare of North Carolina members with identified needs are assessed for Care Management enrollment. Members with needs may be identified via clinical rounds, referrals from other WellCare of North Carolina staff

members, via hospital census, via direct referral from providers, via self-referral, or referral from other providers.

To refer a member for Care Management:

- Call WellCare of North Carolina at 1-833-925-2861; or
- Visit online at marketplace.wellcarenc.com.

HEALTH MANAGEMENT EALTH MANAGEMENT

Health management is the concept of reducing health care costs and improving quality of life for individuals with a chronic condition through ongoing integrated care. Health management supports the physician or practitioner/patient relationship and plan of care; it emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

WellCare of North Carolina's Member Wellbeing Survey

WellCare of North Carolina members are requested to complete a Wellbeing Survey upon enrollment with us. WellCare of North Carolina utilizes the information to better understand the member's health care needs to provide customized, educational information and services specific to their needs. WellCare of North Carolina members can login to their secure online account at marketplace.wellcarenc.com to complete their Wellbeing survey or they can call our Member Services at 1-833-925-2861.

WellCare of North Carolina's My Health Pays Member Rewards Program

Our My Health Pays™ rewards program gives members the opportunity to earn reward dollars for taking charge of their health. This program provides incentives when they take advantage of their preventive care benefits by helping them earn reward dollars.

When members take an active role in their healthcare, you can help them experience healthier outcomes.

Members earn My Health Pays™ rewards by completing healthy behaviors. These include:

- Completing their Member Wellbeing Survey, which verifies demographic information and health information.
- Getting their annual wellness exam.
- Receiving their flu vaccine in the fall.
- Plus, much more! Visit our website for more information marketplace.wellcarenc.com.

These rewards are automatically added to a Visa® Prepaid Card or My Health PaysTM rewards card. Members can redeem their rewards to help offset costs such as:

- Doctor copays[2]
- Deductibles
- Coinsurance
- Monthly premium payments

- Other spend options are available to our members. Visit our website for more information marketplace.wellcarenc.com.

- Together we can help members take advantage of their preventive services and earn rewards; and Visa® Prepaid Card is issued by The Bancorp Bank pursuant to a license from Visa U.S.A. Inc. The Bancorp Bank; Member FDIC. Card cannot be used everywhere Visa debit cards are accepted. See Cardholder Agreement for complete usage restrictions.

UTILIZATION MANAGEMENT TILIZATION MANAGEMENT

The WellCare of North Carolina Utilization Management initiatives are focused on optimizing each member's health status, sense of well-being, productivity, and access to appropriate health care while at the same time actively managing cost trends. The Utilization Management Program's goals are to provide covered services that are medically necessary, appropriate to the member's condition, rendered in the appropriate setting, and meet professionally recognized standards of care. WellCare of North Carolina does not reward providers, employees who perform utilization reviews, or other individuals for issuing denials of authorization. Neither network inclusion nor hiring and firing practices influence the likelihood or perceived likelihood for an individual to deny or approve coverage. There are no financial incentives to deny care or encourage decisions that result in underutilization.

Prior authorization or Prospective Review is the request to the Utilization Management Department for approval of certain services before the service is rendered. Authorization must be obtained prior to the delivery of certain elective and scheduled services. Failure to obtain authorization will result in denial of coverage.

- [2] My Health Pays™ rewards cannot be used for pharmacy copays

Medically Necessary

Medically Necessary means any medical service, supply, or treatment authorized by a physician to diagnose and treat a member's illness or injury which:

- Is consistent with the symptoms or diagnosis.
- Is provided according to generally accepted medical practice standards.
- Is not custodial care.
- Is not solely for the convenience of the physician or the member.
- Is not experimental or investigational.
- Is provided in the most cost-effective care facility or setting.
- Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; and
- When specifically applied to a hospital confinement, it means that the diagnosis and treatment of the medical symptoms or conditions cannot be safely provided as an outpatient.

Utilization Determination Timeframes

Authorization decisions are made as expeditiously as possible. Below is a list of specific timeframes utilized by WellCare of North Carolina. In some cases, it may be necessary for an extension to extend the timeframe below. You will be notified if an extension is necessary. Please contact WellCare of North Carolina if you would like a copy of the policy for UM timeframes.

Type	Timeframe
Prospective/Urgent	Within 72 hours of receipt of all information needed to complete the review. If all information is not received by the end of the 48 hours a determination will be made based on available information.
Prospective/Non-Urgent	Within three (3) business days of receipt of all information needed to complete the review. If all information is not received by the 14th day of the request a determination will be made based on available information.
Concurrent/Urgent	Concurrent determinations are made within twenty-four (24) hours of receipt of request when all necessary information is available. Extension: A onetime extension may be granted up to 72 hours. If all information is not received by the end of the 72-hour extension, a determination will be made based on available information.
Concurrent/Non-Urgent	Concurrent determinations are made within twenty-four (24) hours of receipt of request when all necessary information is available.

	Extension: A onetime extension may be granted up to 72 hours. If all information is not received by the end of the 72 hours a determination will be made based on available information.
Retrospective	30 calendar days

Utilization Review Criteria

Utilization management decision-making is based on appropriateness of care and service and the existence of coverage. WellCare of North Carolina does not reward providers or other individuals for issuing denials of authorizations.

WellCare of North Carolina has adopted the following utilization review criteria to determine whether services are medically necessary services for purposes of plan benefits:

Services	Criteria
Medical Services	InterQual® Adult, Clinical Policies and Pediatric Guidelines and internally developed criteria by WellCare of North Carolina health care professionals and related specialists.
Behavioral Health Services	InterQual® Behavioral Health Criteria (Adult and Geriatric or Child and Adolescent Psychiatry) and internally developed criteria by WellCare of North Carolina behavioral health care professionals and related specialists.
High Tech Imaging and Therapy Services	Internally developed criteria by National Imaging Associates (NIA). Criteria developed by representatives in the disciplines of radiology, internal medicine, nursing, and cardiology. The criteria are available at www.RadMD.com.
Substance Use Disorder Services	American Society for Addiction Medicine (ASAM) Patient Placement Criteria. The criteria are available at www.asam.org.

WellCare of North Carolina's Medical Director, or other health care professionals who have appropriate clinical expertise in treating the member's condition or disease, review all potential adverse determinations and will make a decision in accordance with currently accepted medical or health care practices, considering special circumstances of each case that may require deviation from InterQual® or other criteria as mentioned above. Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical

Management department at 1-833-925-2861. Providers can discuss any adverse decisions with a WellCare of North Carolina physician or other appropriate reviewer at the time of the notification to the requesting provider of an adverse determination. The Medical Director may be contacted by calling WellCare of North Carolina at 1-833-925-2861 and asking for the Medical Director. A WellCare of North Carolina Care Manager may also coordinate communication between the Medical Director and the requesting provider

Participants or healthcare professionals, with the Participant's consent, may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally by calling WellCare of North Carolina at 1-833-925-2861 (TTY 711) or in writing to:

(For Physical Health related authorization appeals)
WellCare of North Carolina
Attn: Appeals and Grievances Department
PO Box 10341
Van Nuys, CA 91410-0341
Fax: 1-833-886-7956

(For Behavioral Health related authorization appeals)
WellCare of North Carolina
Attn: BH Appeals Department
PO Box 10378
Van Nuys, CA 91410-0378
Fax: 1-866-714-7991

CONCURRENT REVIEW

The WellCare of North Carolina Medical Management Department will concurrently review the treatment and status of all members who are inpatient through contact with the hospital's Utilization and Discharge Planning Departments and when necessary, the member's attending physician. An inpatient stay will be reviewed as indicated by the member's diagnosis and response to treatment. The review will include evaluation of the member's status, proposed plan of care, discharge plans, and subsequent diagnostic testing or procedures.

PRIOR AUTHORIZATIONS

SERVICES REQUIRING PRIOR AUTHORIZATION

To verify if a service requires prior authorization, please visit the WellCare of North Carolina website at marketplace.wellcarenc.com and use the "Pre-Auth Needed" tool under For Providers – Provider Resources or call the Utilization Management Department with questions. Failure to obtain the required prior authorization or pre-certification will result in a denied claim. Note: All out of network services require prior authorization, excluding emergency room services.

It is the responsibility of the facility in coordination with the rendering practitioner to ensure that an authorization has been obtained for all inpatient and selected outpatient services, except for emergency stabilization services. All inpatient admissions require prior authorization.

Any anesthesiology, pathology, radiology, or hospitalist services related to a procedure or hospital stay requiring a prior authorization will be considered downstream and will not require a separate prior authorization.

Services related to an authorization denial will result in denial of all associated claims.

TIMEFRAMES FOR PRIOR AUTHORIZATION REQUESTS AND NOTIFICATIONS

The following timeframes are required of the ordering provider for prior authorization and notification:

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five (5) days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five (5) days prior to the elective outpatient service date
Emergent inpatient admissions	Notification within 24 hours
Observation – 48 hours or less	Notification within one (1) day for non-participating providers
Observation – greater than 48 hours	Requires inpatient prior authorization within one (1) business day
Maternity admissions	Notification within 24 hours
Newborn admissions	Notification within 24 hours
Neonatal Intensive Care Unit (NICU) admissions	Notification within 24 hours
Outpatient Dialysis	Notification within 24 hours
Organ transplant initial evaluation	Prior Authorization required at least 30 days prior to the initial evaluation for organ transplant services.
Clinical trials services	Prior Authorization required at least 30 days prior to receiving clinical trial services.

Secure Portal

The preferred method for submitting authorizations is through the Secure Provider Portal at marketplace.wellcarenc.com.[3] The provider must be a registered user on the Secure Provider Portal. If a provider is already registered for the Secure Provider Portal for one of our other products, that registration will grant the provider access to WellCare of North Carolina. If the provider is not already a registered user on the Secure Provider Portal and needs assistance or training on submitting prior authorizations, the provider should contact their dedicated Provider Partnership Manager. Other methods of submitting the prior authorization requests are as follows:

Phone

Call the Medical Management Department at 1-833-925-2861. Our 24/7 Nurse Advice line can assist with urgent prior authorizations after normal business hours.

Fax

Fax prior authorization requests utilizing the Prior Authorization fax forms posted on the WellCare of North Carolina website at marketplace.wellcarenc.com. Please note faxes will not be monitored after hours and will be responded to on the next business day. Please contact our 24/7 Nurse Advice Line at 1-833-925-2861 for after hour urgent admissions, inpatient notifications, or requests.

The requesting or rendering provider must provide the following information to request prior authorization (regardless of the method utilized):

- Member's name, date of birth and ID number.
- Provider's Tax ID, NPI number, taxonomy code, name, and telephone number.
- Facility name if the request is for an inpatient admission or outpatient facility services.
- Provider location if the request is for an ambulatory or office procedure.
- The procedure code(s); Note: If the procedure codes submitted at the time of authorization differ from the services performed, it is **required** within 72 hours or prior to the time the claim is submitted

[3] Providers submitting initial authorization for services for WellCare of North Carolina must submit authorization by phone or fax. Once providers receive first claims remittance provider may register with our secure online web portal. Providers much receive a claims payment to register with our online portal.

that you phone Medical Management at 1-833-925-2861 to update the authorization; otherwise, this may result in claim denials.

- Relevant clinical information (e.g., Past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed);
- Admission date or proposed surgery date if the request is for a surgical procedure.
- Discharge plans.
- For obstetrical admissions, the date and method of delivery, targeted admission date, and information related to the newborn or neonate.

EVOLENT AUTHORIZATIONS MAGELLANAUTHORIZATIONS

Evolent provides an interactive website, RadMD.com, which should be used to obtain on-line authorizations. For urgent authorization requests please call 1-800-642-7339 and follow the prompt for radiology authorizations. For more information call our Provider Services department.

Advanced Diagnostic Imaging

As part of a continued commitment to further improve advanced imaging and radiology services, WellCare of North Carolina is using Evolent to provide prior authorization services and utilization management for advanced imaging and radiology services. Evolent focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT /CTA/CCTA,
- MRI/MRA, and
- PET.

Key Provisions:

- Emergency room, observation, and inpatient imaging procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization; and
- Providers rendering the above services should verify that the necessary authorization has been obtained; failure to do so may result in denial of all or a portion of the claim.

To reach Evolent and obtain authorization, please call 1-800-642-7339 and follow the prompt for radiology authorizations. Evolent also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information or call our Provider Services department.

CARDIAC SOLUTIONS

WellCare of North Carolina in collaboration with Evolent Magellan, will launch a cardiac imaging program to promote health care quality for patients with possible cardiac disease.

Under this program, prior authorization will be required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a patient's diagnosis or treatment—and to recommend an alternate approach when indicated. By supporting the most efficient diagnosis and management of cardiac disease, Evolent Magellan addresses unnecessary procedures and promotes the least invasive, most medically appropriate approach.

Evolent Magellan has developed proprietary utilization management guidelines for these cardiac modalities. These consensus-based guidelines draw on current literature, American College of Cardiology (ACC) appropriateness criteria, recommendations from the American Heart Association, and input from our Cardiac Advisory Board and other experts. Our guidelines are transparent and available throughout our programs. Evolent Magellan also includes references to the Choosing Wisely campaign by the American Board of Internal Medicine (ABIM) Foundation, which provides specialty society considerations for the selection of appropriate tests.

How does this program improve patient health?
Managing cardiac studies will promote the use of optimal diagnostic methods in the assessment and treatment of cardiac diseases. Based on criteria adapted from the ACC and AMA, this program will minimize patients' radiation exposure by using the most efficient and least invasive testing options available.

Program Components

- Evidence-based clinical guidelines and proprietary algorithms to support clinically appropriate diagnostic options for each patient.
- Consultations with cardiologists related to elective cardiac diagnostic imaging, when needed.
- Quality assessment of imaging providers to ensure the highest technical and professional standards.

How the Program Works
In addition to the other procedures that currently require prior authorization for members, prior authorization will be required for the following cardiac procedures:

- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Echocardiography
- Stress Echocardiography

The following services do not require authorization through Evolent Magellan:

- Inpatient advanced radiology services
- Observation setting advanced radiology services.
- Emergency Room radiology services

To reach Evolent and obtain authorization, please call 1-800-642-7339 and follow the prompt for radiology and cardiac authorizations. Evolent also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information.

Habilitation, Rehabilitation Services

As part of a continued commitment to further improve habilitation and rehabilitation services, WellCare of North Carolina is using Evolent to provide prior authorization services and utilization management for therapy services. Evolent focuses on assisting providers in managing habilitation, rehabilitation, and pain management services in the most effective way possible and consistent with nationally recognized clinical guidelines.

Prior authorization is required for the following home, inpatient, and outpatient therapy procedures:

- Physical Therapy, Occupational Therapy, Speech Therapy

Key Provisions:

- It is the responsibility of the ***ordering*** physician to obtain authorization; and
- Providers rendering the above services should verify that the necessary authorization has been obtained; failure to do so may result in denial of all or a portion of the claim.

How the Program Works

Outpatient physical, occupational and speech therapy requests are reviewed by Evolent's peer consultants to determine whether the services meet policy criteria for medically necessary and appropriate care. The medical necessity determinations are based on a review of objective, contemporaneous, and clearly documented clinical records that may be requested to help support the appropriateness of care. Clinical review helps determine whether such services are both medically necessary and eligible for coverage. Although prior authorization for the therapy evaluation alone is not required, additional services provided at the time of the evaluation and for any ongoing care is required through Evolent. There is no need to send patient records in advance. Evolent will contact the provider via phone and fax if additional clinical information is needed to complete the request. If the clinical documentation fails to establish that care is medically necessary, is not received, or is not received in an appropriate amount of time, it may result in non-certification of the authorization request.

Under terms of the agreement between WellCare of North Carolina and Evolent, WellCare of North Carolina oversees the Evolent Therapy Management program and continues to be responsible for claims adjudication. If Evolent therapy peer reviewers determine that the care provided fails to meet our criteria for covered therapy services, you and the patient will receive notice of the coverage decision.

Should you have questions, please contact WellCare of North Carolina Provider Services at 1-833-925-2861.

INTERVENTION PAIN MANAGEMENT

Evolent manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures. It is the responsibility of the ordering physician to obtain authorization for all IPM procedures outlined below. Outpatient IPM procedures requiring prior authorization include:

- Spinal Epidural Injections
- Paravertebral Facet Joint Injections or Blocks
- Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)
- Sacroiliac Joint Injections
- Spinal Cord Stimulators

Note: A separate prior authorization number is required for each procedure ordered. Prior authorization is not required through Evolent for services performed in the emergency department, on an inpatient basis or in conjunction with a surgery. Prior authorization and/or notification of admission is still required through New

Hampshire Healthy Families. To obtain authorization through Evolent, visit RadMD.com or call 1-800-424-4801.

MUSCULOSKELETAL CARE MANAGEMENT (MSK)

In keeping with our commitment of promoting continuous quality improvement for services provided to WellCare of North Carolina members, WellCare of North Carolina has partnered with Evolent to implement a Musculoskeletal Care Management (MSK) program. This program includes prior authorization for non-emergent MSK procedures for WellCare of North Carolina members. This decision is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

How the Program Works

MSK Surgeries: Prior authorization will be required for the following non-emergent inpatient and outpatient hip, knee, shoulder, lumbar and cervical surgeries:

Hip

- Revision/Conversion Hip Arthroplasty
- Total Hip Arthroplasty/Resurfacing
- Femoroacetabular Impingement (FAI) Hip Surgery (includes CAM/pincher & labral repair)
- Hip Surgery – Other (includes synovectomy, loose body removal, debridement, diagnostic hip arthroscopy, and extra-articular arthroscopy knee)

Knee

- Revision Knee Arthroplasty
- Total Knee Arthroplasty (TKA)
- Partial-Unicompartmental Knee Arthroplasty (UKA)
- Knee Manipulation under Anesthesia (MUA)
- Knee Ligament Reconstruction/Repair
- Knee Meniscectomy/Meniscal Repair/Meniscal Transplant

- Knee Surgery – Other (includes synovectomy, loose body removal, diagnostic knee arthroscopy, debridement with or without chondroplasty, lateral release/patellar realignment, articular cartilage restoration)

Shoulder

- Revision Shoulder Arthroplasty
- Total/Reverse Shoulder Arthroplasty or Resurfacing
- Partial Shoulder Arthroplasty/Hemiarthroplasty
- Shoulder Rotator Cuff Repair
- Shoulder Labral Repair
- Frozen Shoulder /Adhesive Capsulitis Repair
- Shoulder Surgery – Other (includes debridement, manipulation, decompression, tenotomy, tenodesis, synovectomy, claviculectomy, diagnostic shoulder arthroscopy)

Cervical

- Cervical Anterior Decompression with Fusion –Single & Multiple Levels
- Cervical Posterior Decompression with Fusion –Single & Multiple Levels
- Cervical Posterior Decompression (without fusion)
- Cervical Artificial Disc Replacement – Single & Two Levels
- Cervical Anterior Decompression (without fusion)

Lumbar

- Lumbar Microdiscectomy
- Lumbar Decompression (Laminotomy, Laminectomy, Facetectomy & Foraminotomy)
- Lumbar Spine Fusion (Arthrodesis) With or Without Decompression – Single & Multiple Levels
- Lumbar Artificial Disc – Single & Multiple Levels

Sacroiliac

- Sacroiliac Joint Fusion

As a part of the Evolent clinical review process, actively practicing, orthopedic surgeon specialists (hip, knee, and shoulder) or neurosurgeons (spine) will conduct the medical necessity reviews and determinations of musculoskeletal surgery cases.

Please refer to the "Solutions" tab on the Evolent home page (https://www.RadMD.com) for additional information on the MSK program. Checklists and tip sheets are available there to help providers ensure surgical procedures are delivered according to national clinical guidelines.

Should you have questions, please contact Evolent at 1-800-327-0641.econd Opinion

Members or a healthcare professional with the member's consent may request and receive a second opinion from a qualified professional within the WellCare of North Carolina network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out of network provider only upon receiving a prior authorization from the WellCare of North Carolina Utilization Management Department.

PREVENTIVE HEALTH CARE

WellCare of North Carolina is committed to the promotion of the lifelong benefits of preventive care. Members may see a network provider, who is contracted with WellCare of North Carolina to provide health care services directly, without prior authorization for:

- Medically necessary maternity care.
- Preventive care (well care) and general examinations.
- Gynecological care; or
- Follow-up visits for the above services.

If the member's health care provider diagnoses a condition that requires a prior authorization to other specialists or hospitalization, prior authorization must be obtained in accordance with WellCare of North Carolina's prior authorization requirements.

RETROSPECTIVE REVIEW

Retrospective review is an initial review of services after services have been provided to a member. This may occur when authorization or timely notification to WellCare of North Carolina was not obtained due to extenuating circumstances (i.e., member was unconscious at presentation, member did not have their WellCare of North Carolina ID card or otherwise indicated other coverage, services authorized by another

payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly.

If a claim is denied for lack of authorization for a service that requires authorization, WellCare will not retrospectively review the request for authorization, as this type of request does not meet the WellCare retrospective review guidelines of extenuating circumstances. If a clinical review is warranted due to extenuating circumstances, a decision will be made within 30 calendar days following receipt of all necessary information.

EMERGENCY CARE

Emergency care means medical services provided after the sudden or unexpected onset of a medical condition manifesting itself by acute symptoms, including injury caused by an accident, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

- The patient's life or health would be placed in serious jeopardy.
- Vital bodily functions would be seriously impaired; and
- There would be serious and permanent dysfunction of a bodily organ or part.

PHARMACY

The pharmacy benefits for WellCare of North Carolina members vary based on the plan benefits. Information regarding the member's pharmacy coverage can be best found via our Secure Provider Portal. Additional resources available on the website include the WellCare of North Carolina Formulary, the Envolve Pharmacy Solutions (Pharmacy Benefit Manager) Provider Manual, and Medication Request/Exception Request forms.

The WellCare of North Carolina formulary is designed to assist contracted healthcare prescribers with selecting the most clinically and cost-effective medications available. The formulary provides instruction on the following:

- Which drugs are covered, including restrictions, prior authorization requirements, and limitations.
- The pharmacy management program requirements and procedures.
- An explanation of limits and quotas.
- How prescribing providers can make an exception request; and
- How WellCare of North Carolina conducts generic substitution, therapeutic interchange, and step-therapy.

The WellCare of North Carolina formulary does not:

- Require or prohibit the prescribing or dispensing of any medication.
- Substitute for the professional judgment of the physician or pharmacist; or
- Relieve the physician or pharmacist of any obligation to the member.

The WellCare of North Carolina formulary will be approved initially by the Pharmacy and Therapeutics Committee (P&T), led by the Pharmacist and Medical Director, with support from community-based primary care providers and specialists. Once established, the Formulary will be maintained by the P & T Committee, through quarterly meetings, to ensure WellCare of North Carolina members receive the most appropriate medications. The WellCare of North Carolina formulary contains those medications that the P & T Committee has chosen based on their safety and effectiveness. If a physician feels that a certain medication merits addition to the list, the Formulary Change Request policy can be used as a method to address the request. The P & T Committee reviews the request, along with supporting clinical data, to determine if the drug meets the safety and efficacy standards established by the Committee. Copies of the formulary are available on our website, marketplace.wellcarenc.com. Providers may also call Provider Services at 1-833-925-2861 for hard copies of the pharmaceutical management procedures formulary to be sent by mail, fax, or email.

Envolve Pharmacy Solutions is simplifying the prescriber process with a streamlined prior authorization process that can be accessed online through CoverMyMeds. CoverMyMeds automates drug prior authorizations for any medication and allows prescribers to begin the process electronically. This site can be accessed at https://pharmacy.envolvehealth.com/pharmacists.html under the "CoverMyMeds" link.

CLAIMS

The appropriate Center for Medicare and Medicaid Services (CMS) billing form is required for paper and electronic data interchange (EDI) claim submissions. The appropriate CMS billing forms are CMS 1450 for facilities and CMS 1500 for professionals. In general, WellCare of North Carolina follows the CMS billing requirements for paper, EDI, and secure web-submitted claims. WellCare of North Carolina is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements to ensure timely processing of claims and to avoid unnecessary upfront rejections or denials. Reimbursement Policy can be viewed on our website and in the Appendix of this Manual.

VERIFICATION PROCEDURES

All claims filed with WellCare of North Carolina are subject to verification procedures. These include, but are not limited to, verification of the following:

- All required fields are completed on an original CMS 1500 Claim Form, CMS 1450 (UB-04) Claim Form, EDI electronic claim format, or the claim is submitted on our Secure Provider Portal, individually or in a batch.
- All claim submissions are subject to 5010 validation procedures based on CMS Industry Standards.
- Member ID and date of birth combination must exactly match a participating WellCare of North Carolina member.
- Claims must contain the CLIA number when CLIA is waived or CLIA certified services are provided. Paper claims must include the CLIA certification in Box 23 when CLIA is waived or CLIA certified services are billed.
- For EDI submitted claims, the CLIA certification number must be placed in:
    - X12N 837 (5010 HIPAA version) loop 2300 (single submission) REF segment with X4 qualifier; or
    - X12N 837 (5010 HIPAA version) loop 2400 REF segment with X4 qualifier, (both laboratory services for which CLIA certification is required and non-CLIA covered laboratory tests).
- Taxonomy codes are required. Please see further details in this Manual for taxonomy requirements.
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission codes are valid for:
    - Date of Service
    - Provider Type and/or provider specialty billing
    - Age and/or sex for the date of service billed.
    - Bill type
- All Diagnosis Codes are to their highest number of digits available.
- National Drug Code (NDC) is billed in the appropriate field on all claim forms when applicable. This includes the quantity and type. Type is limited to the list below:
    - F2 – International Unit
    - GR – Gram

  - ME – Milligram
  - ML – Milliliter
  - UN – Unit
- Principal diagnosis billed reflects an allowed principal diagnosis as defined in the volume of ICD-10-CM for the date of service billed.
  - For a CMS 1500 Claim Form, this criterion looks at all procedure codes billed and the diagnosis they are pointing to. If a procedure points to the diagnosis as primary, and that code is not valid as a primary diagnosis code, that service line will deny.
  - All inpatient facilities are required to submit a Present on Admission (POA) Indicator. Claims will be denied (or rejected) if the POA indicator is missing. Please reference the CMS Billing Guidelines regarding POA for more information and for excluded facility types. Valid 5010 POA codes are:
    - N – No
    - U – Unknown
    - W – Not Applicable
    - Y – Yes
- Member is eligible for services under WellCare of North Carolina during the time in which services were provided.
- Services are provided by a participating provider, or if provided by an "out of network" provider, authorization is received to provide services to the eligible member. (Excludes services by an "out of network" provider for an emergency medical condition; however, authorization requirements apply for post-stabilization services.)
- An authorization is given for services that require prior authorization by WellCare of North Carolina.
- Third party coverage is clearly identified, and appropriate COB information is included with the claim submission.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service.
- The service provided is a covered benefit under the member's contract on the date of service, and prior authorization processes are followed.
- Payment for services is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in the guide.

CLEAN CLAIM DEFINITION

A clean claim means a claim for payment of health care expenses that is submitted on a CMS 1500, or a CMS 1450 (UB04) claim form, in a format required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with all required fields completed in accordance with WellCare of North Carolina's published claim filing requirements.

NON-CLEAN CLAIM DEFINITION

A clean claim shall not include a claim:

- that contains invalid or missing data elements, a claim that has been suspended to get more information from the provider, or a claim that requires manual intervention/processing.
- For which WellCare of North Carolina requires additional information to resolve the claim.

UPFRONT REJECTIONS VS. DENIALS

Upfront Rejection

An upfront rejection is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located in Appendix IX of this manual. A list of common upfront rejections is in Appendix I of this manual. Upfront rejections do not enter our claims adjudication system, so there is no Explanation of Payment (EOP) for these claims. The provider receives a letter or a rejection report if the claim is submitted electronically. If a claim is rejected, the identified issue must be corrected, and the claim resubmitted as an original claim.

Denial

If all edits pass and the claim is accepted, it is entered into the system for processing**.** A **denial** is defined as a claim that passes edits and is entered into the system but is billed with invalid or inappropriate information causing the claim to deny. In this case, an EOP is sent that includes the denial reason. A list of common delays and denials is found with explanations in Appendix II.

TIMELY FILING

Initial Claims		**Reconsiderations or Claim Dispute/Appeals**		**Coordination of Benefits**	
Calendar Days		**Calendar Days**		**Calendar Days**	
Par	**Non-Par**	**Par**	**Non-Par**	**Par**	**Non-Par**
180 days	180 days	180 days	180 days	90 days from the primary payers EOP date to the date received.	90 days from the primary payers EOP date to the date received.

- **Initial Claims** - Days are calculated from the Date of Service (DOS) to the date received by WellCare of North Carolina or from the EOP date. For observation and inpatient stays, the date is calculated from the date of discharge.

- **Claims Dispute/Appeals** - Days are calculated from the date of the Explanation of Payment issued by WellCare of North Carolina to the date received.

- **Coordination of Benefits** - Days are calculated from the date of Explanation of Payment from the primary payers to the date received.

REFUNDS AND OVERPAYMENTS

WellCare of North Carolina routinely audits all claims for payment errors. Claims identified as underpaid or overpaid will be reprocessed appropriately. Providers are responsible for reporting overpayments or improper payments to WellCare of North Carolina. Providers have the option of requesting future offsets to payments or may mail refunds and overpayments, along with supporting documentation for medical and behavioral health claims (copy of the remittance advice along with affected claims identified) to:

WellCare of North Carolina
Attn: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

WHO CAN FILE CLAIMS?

All providers who have rendered services for WellCare of North Carolina members can file claims. It is important that providers ensure WellCare of North Carolina has accurate and complete information on file. Please confirm with the Provider Services department or your dedicated Provider Relations Representative that the following information is current in our files:

1. Provider Name (as noted on current W-9 form).
2. National Provider Identifier (NPI).
3. Group National Provider Identifier (NPI) (if applicable).
4. Tax Identification Number (TIN).
5. Taxonomy code (This is a REQUIRED field when submitting a claim).
6. Physical location address (as noted on current W-9 form); and
7. Billing name and address (as noted on current W-9 form).

We recommend that providers notify WellCare of North Carolina 30-60 days in advance of changes pertaining to billing information. If the billing information change affects the address to which the end of year 1099 IRS

form is mailed, a new W-9 form is required. Changes to a provider's TIN and/or address are NOT acceptable when conveyed via a claim form or a 277 electronic file.

Claims for billable services provided to WellCare of North Carolina members must be submitted by the provider who performed the services or by the provider's authorized billing vendor.

ELECTRONIC CLAIMS SUBMISSION

Providers are encouraged to participate in WellCare of North Carolina's Electronic Claims/Encounter Filing Program through Centene. WellCare of North Carolina (Centene) has the capability to receive an ANSI XS12N 837 professional, institutional, or encounter transaction. In addition, WellCare of North Carolina (Centene) has the capability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP).

For more information on electronic filing, contact:

WellCare of North Carolina c/o Centene EDI Department
1-800-225-2573, extension 6075525
Or by e-mail at EDIBA@centene.com

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers who bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

WellCare of North Carolina can receive coordination of benefits (COB or secondary) claims electronically. WellCare of North Carolina follows the 5010 X12 HIPAA Companion Guides for requirements on submission of COB data.

The WellCare of North Carolina Payer ID is 68069. For a list of the clearinghouses that we currently work with, please visit our website at marketplace.wellcarenc.com.

Specific Data Record Requirements

Claims transmitted electronically must contain all the required data of the X12 5010 Companion Guides. Please contact the clearinghouse you intend to use and ask if they have additional data record requirements.

Electronic Claim Flow Description & Important General Information

To send claims electronically to WellCare of North Carolina, all EDI claims first must be forwarded to one of WellCare of North Carolina's clearinghouses. Complete this via a direct submission to a clearinghouse or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and plan-specific requirements. Claims not meeting the requirements are immediately rejected

and sent back to the sender via a clearinghouse error report. It is very important to review this error report daily to identify any claims that were not transmitted to WellCare of North Carolina. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to WellCare of North Carolina, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to WellCare of North Carolina by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are upfront rejected and sent back daily to the clearinghouse. The clearinghouse in turn forwards the upfront rejection back to its trading partner (the intermediate EDI clearinghouse or provider). It is very important to review this report daily. The report shows rejected claims; these claims must be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily.

Since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to WellCare of North Carolina.

If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor Customer Service Department.

Rejected electronic claims may be resubmitted electronically once the error has been corrected. Be sure to submit the rejected claim as an original claim.

Invalid Electronic Claim Record Upfront Rejections/Denials

All claim records sent to WellCare of North Carolina first must pass the clearinghouse proprietary edits and plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by WellCare of North Carolina. In these cases, the claim must be corrected and re-submitted within the required filing deadline as previously mentioned in the Timely Filing section of this manual. It is important that you review the acceptance or claim status reports received from the clearinghouse to identify and re-submit these claims accurately.

Questions regarding electronically submitted claims should be directed to our EDI BA Support at 1-800-225-2573 Ext. 6075525, or via e-mail at EDIBA@Centene.com. If you are prompted to leave a voice mail, you will receive a return call within 24 business hours.

The full Companion Guides can be located on the Executive Office of Health and Human Services (EOHHS) on the state specific website.

Specific WellCare of North Carolina Electronic Edit Requirements – 5010 Information

- Institutional Claims – 837Iv5010 Edits

- Professional Claims – 837Pv5010 Edits

Please refer to the EDI HIPAA Version 5010 Implementation section on our website for detailed information.

Corrected EDI Claims

- CLM05-3 Required 7 or 8.
- IN 2300 Loop/REF segment is F8; Ref 02 must input original claim number assigned.

Failure to include the original claim number will result in upfront rejection of the adjustment (error code 76).

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
Submitting Claims Through a Clearinghouse: WellCare of North Carolina Payer ID number for all clearinghouses (Medical and Behavioral Health) is **68069.**	We use Availity as our primary clearinghouse, which provides us with an extensive network of connectivity. You are free to use whatever clearinghouse you currently do as Availity maintains active connections with many clearinghouses.
General EDI Questions:	Contact EDI Support at 1-800-225-2573 Ext. 6075525 or (314) 505-6525 or via e-mail at EDIBA@Centene.com.
Claims Transmission Report Questions:	Contact your clearinghouse technical support area.
Claim Transmission Questions (Has my claim been received or rejected?):	Contact EDI Support at 1-800-225-2573 Ext. 6075525 or via e-mail at EDIBA@Centene.com.
Remittance Advice Questions:	Contact WellCare of North Carolina Provider Services or the Secure Provider Portal.
Provider Payee, UPIN, Tax ID, Payment Address Changes:	Notify Provider Service in writing and include an updated W9.

Important Steps to a Successful Submission of EDI Claims:

1. Select a clearinghouse to utilize.
2. Contact the clearinghouse regarding what data records are required.
3. Verify with Provider Services at WellCare of North Carolina that the provider is set up in the WellCare of North Carolina system prior to submitting EDI claims.
4. You will receive two reports from the clearinghouse. Always review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to WellCare of North Carolina and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by WellCare of North Carolina. Always review the acceptance and claims stats report for rejected claims. If rejections are noted, correct, and resubmit.
5. Most importantly, all claims must be submitted with providers identifying the appropriate coding. See the CMS 1500 (02/12) and CMS 1450 (UB-04) Claims Forms instructions and claim form for details.

Online Claim Submission

For providers who have internet access and choose not to submit claims via EDI or paper, WellCare of North Carolina has made it easy and convenient to submit claims directly using the Secure Provider Portal at marketplace.wellcarenc.com.

You must request access to our secure site by registering for a username and password. If you have technical support questions, please contact Provider Services.

Once you have access to the secure portal, you may file first time claims individually or submit first time batch claims. You will also have the capability to find, view, and correct any previously processed claims. Detailed instructions for submitting via Secure Provider Portal are also stored on our website; you must login to the secure site for access to this manual.

Exclusions

The following inpatient and outpatient claim types are excluded from EDI submission options and must be filed on paper:

- Claim records requiring supportive documentation or attachments, e.g., consent forms. Note: COB claims can be filed electronically.
- Medical records to support billing miscellaneous codes.
- Claims for services that are reimbursed based on purchase price e.g., custom DME, prosthetics. Provider is required to submit the invoice with the claim.
- Claims for services requiring clinical review, e.g., complicated, or unusual procedure. Provider is required to submit medical records with the claim.
- Claim for services requiring documentation and a Certificate of Medical Necessity, e.g., oxygen, motorized wheelchairs.

PAPER CLAIM SUBMISSION

The mailing address for first time claims (Medical and Behavioral Health) corrected claims and requests for reconsideration:

WellCare of North Carolina
Attn: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

The mailing address for medical claim disputes/appeals:

WellCare of North Carolina

Attn: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

The mailing address for behavioral health medical necessity claims disputes/appeals:

WellCare of North Carolina
Attn: Appeals Department
12515-8 Research Blvd.
Suite 400
Austin, TX 78759

Fax: 1-866-714-7991

WellCare of North Carolina encourages all providers to submit claims electronically. The Companion Guides for electronic billing are available on our websites. Paper submissions are subject to the same edits as electronic and web submissions.

All paper claims sent to the claim's office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected. If a paper claim has been rejected, the provider should correct the error and resubmit the paper claim as an original claim. If the paper claim passes the specific edits and is denied after acceptance, the provider should submit the denial letter with the corrected claim.

Acceptable Forms

WellCare of North Carolina only accepts the CMS 1500 (02/12) and CMS 1450 (UB-04) paper claim forms. Other claim form types will be upfront rejected and returned to the provider.

Professional providers and medical suppliers complete the CMS 1500 (02/12) Claim Form and institutional providers complete the CMS 1450 (UB-04) Claim Form. WellCare of North Carolina does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms must be typed with either 10- or 12-point Times New Roman font and on the required original red and white version to ensure clean acceptance and processing. Black and white forms, handwritten forms and nonstandard will be upfront rejected and returned to provider. To reduce document handling time, do not use highlights, italics, bold text, or staples for multiple page submissions. If you have questions regarding what type of form to complete, contact Provider Services.

Important Steps to Successful Submission of Paper Claims

1. Providers must file claims using standard claims forms (CMS 1450 (UB-04) for hospitals and facilities; CMS 1500 for physicians or practitioners).
2. Complete all required fields on an original, red CMS 1500 (Version 02/12) or CMS 1450 (UB-04) Claim Form. NOTE: Non-red, nonstandard, and handwritten claim forms will be rejected back to the provider.

3. Enter the provider's NPI number in the "Rendering Provider ID#" section of the CMS 1500 form (see box 24J).
4. Providers must include their taxonomy code (e.g., 207Q00000X for Family Practice) and corresponding ID qualifier in this section for correct processing of claims.
5. Ensure all Diagnosis Codes, Procedure Codes, Modifier, Location (Place of Service); Type of Bill, Type of Admission, and Source of Admission Codes are valid for the date of service. Refer to WellCare of North Carolina Taxonomy (PDF) located on our website marketplace.wellcarenc.com.
6. Ensure all Diagnosis and Procedure Codes are appropriate for the age of sex of the member.
7. Ensure all Diagnosis Codes are coded to their highest number of digits available.
8. Ensure member is eligible for services during the time in which services were provided.
9. Ensure provider receives authorization to provide services to the eligible member, when appropriate.
10. Ensure an authorization is given for services that require prior authorization by WellCare of North Carolina.
11. A provider billing CLIA services on a CMS 1500 paper form must enter the CLIA number in Box 23 of the CMS 1500 form.
12. Ensure all paper claim forms are typed or printed with either 10- or 12-point Times New Roman font. Do not use highlights, italics, bold text, ink stamps, or staples for multiple page submissions.
13. Ensure print is properly aligned on the form. WellCare of North Carolina utilizes OCR software to convert paper forms to EDI transactions and improperly aligned information may not process correctly and result in a rejected claim.

Claims missing the necessary requirements are not considered "clean claims" and will be returned to providers with a written notice describing the reason for return.

CORRECTED CLAIMS, REQUESTS FOR RECONSIDERATION OR CLAIM DISPUTES

All requests for corrected claims, reconsiderations, or claim disputes must be received within 180 days from the date of the original explanation of payment or denial. Prior processing will be upheld for corrected claims or provider claims requests for reconsideration or disputes/appeals received outside of the 180-day timeframe, unless a qualifying circumstance is offered, and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

1. A catastrophic event that substantially interferes with normal business operation of the provider, or damage or destruction of the provider's business office or records by a natural disaster, mechanical, administrative delays, or errors by WellCare of North Carolina or the Federal and/or State regulatory body.

2. The member was eligible; however, the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all the following conditions are met:

    - The provider's records document that the member refused or was physically unable to provide their ID Card or information.
    - The provider can substantiate that they continually pursued reimbursement from the patient until eligibility was discovered; and
    - The provider has not filed a claim for this member prior to the filing of the claim under review.

Relevant Claim Definitions

- Corrected claim – A provider is *changing* the original claim.
- Request for reconsideration – A provider disagrees with the original claim outcome (payment amount, denial reason, etc.).
- Claim dispute/appeal – A provider disagrees with the outcome of the request for reconsideration.

Corrected Claims

Corrected claims must clearly indicate they are corrected in one of the following ways:

1. Submit a corrected claim via the Secure Provider Portal. Follow the instructions on the portal for submitting a correction.
2. Submit a corrected claim electronically via a clearinghouse.

Institutional Claims (UB): Field CLM05-3=7 and Ref*8 = **Original Claim Number**

Professional Claims (CMS): Field CLM05-3=7 and REF*8 = **Original Claim Number**

3. Submit a corrected paper claim to:

WellCare of North Carolina
Attn: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

Upon submission of a corrected paper claim, the original claim number must be **typed** in field 22 (CMS 1500) and in field 64 CMS 1450 (UB-04) with the corresponding frequency codes in field 22 of the CMS 1500 and in field 4 of the CMS 1450 (UB-04) form.

Corrected claims must be submitted on standard r WellCare of North Carolina

Request for Reconsideration

A request for reconsideration is a communication from the provider about a disagreement with the way a claim was processed. Generally, medical records are not required for a request for reconsideration. However, if the request for reconsideration is related to a code audit, code edit, or authorization denial, medical records **must accompany** the request for reconsideration. If the medical records are not received, the original denial will be upheld.

Reconsiderations may be submitted in the following ways:

1. Providers may elect to call to Provider Services. This method is for requests for reconsideration that do not require submission of supporting or additional information. An example of this is when a provider believes a particular service should be reimbursed at a particular rate, but the payment amount did not reflect that rate.
2. Providers may use the Request for Reconsideration form found on our website (preferred method).
3. Providers may send a written letter that includes a detailed description of the reason for the request. To ensure timely processing, the letter must include sufficient identifying information, which includes, at a minimum, the member's name, member ID number, date of service, total charges, provider name, original EOP, and/or the original claim number found in box 22 on a CMS 1500 form or field 64 on a CMS 1450 (UB-04 form). The corresponding frequency code should also be included with the original claim number (7 = replacement or corrected; 8 = voided or cancelled) in field 22 of the CMS 1500 and in field 4 of the CMS 1450 (UB-04) form.
4. It is not necessary to attach a copy of the submitted claim.

Written requests for reconsideration and any applicable attachments must be mailed to:

WellCare of North Carolina
Attn: Request for Reconsideration
P.O. Box 31370 Tampa, FL 33631-3370

When the request for reconsideration results in an overturn of the original decision, the provider will receive a revised EOP.

Claim Dispute

A claim dispute/claim appeal should be used only when a provider has received an unsatisfactory response to a request for reconsideration. If a dispute form is submitted and a reconsideration request is not located in our system, this will be considered a reconsideration and treated as outlined above.

A claim dispute/appeal must be submitted on a claim dispute/appeal form found on our website. The claim dispute form must be completed in its entirety. Mail completed claim dispute/appeal forms to:

WellCare of North Carolina

Attn: Claim Dispute
P.O. Box 31370 Tampa, FL 33631-3370

A claim dispute/appeal will be resolved within 30 calendar days. The provider will receive a written letter detailing the decision to overturn or uphold the original decision. If the original decision is upheld, the letter will include the rationale for upholding the decision. Disputed claims are resolved to a paid or denied status in accordance with state law and regulation.

ELECTRONIC FUNDS TRANSFERS (EFT) AND ELECTRONIC REMITTANCE ADVICES (ERA)

WellCare of North Carolina partners with specific vendors to provide an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers and allows online enrollment. Providers can enroll after they have received their completed contract or submitted a claim. Please visit our website for information about EFT and ERA or contact Provider Services.

Benefits include:

Elimination of paper checks - all deposits transmit via EFT to the designated bank account.

- Convenient payments & remittance information retrieval
- Electronic remittance advices presented online.
- HIPAA 835 electronic remittance files for download directly to a HIPAA-Compliant Practice Management for Patient Accounting System
- Reduced accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying.
- Improved cash flow – Electronic payments can mean faster payments, leading to improvements in cash flow.
- Maintain control over bank accounts - You keep total control over the destination of claim payment funds. Multiple practices and accounts are supported.
- Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily.
- Manage multiple Payers – Reuse enrollment information to connect with multiple payers and assign to different payers to different bank accounts as desired.

For more information, please visit our provider home page on our website at marketplace.wellcarenc.com. Please contact our Provider Services Department at 1-833-925-2861.

RISK ADJUSTMENT AND CORRECT CODING CLAIMS

Risk adjustment is a critical element of the Affordable Care Act (ACA) that will help ensure the long-term success of the Health Insurance Marketplace. Accurate risk adjustment calculation requires accuracy and specificity in diagnostic coding. Providers should, always, document and code according to CMS regulations and follow all applicable coding guidelines for ICD-10-CM, CPT, and HCPCs code sets. Providers should note the following guidelines:

- Code all diagnoses to the highest level of specificity, which means assigning the most precise ICD code that most fully explains the narrative description in the medical chart of the symptom or diagnosis.
- Ensure medical record documentation is clear, concise, consistent, complete, legible, and meets CMS signature guidelines (each encounter must stand alone);
- Submit claims and encounter information in a timely manner.
- Alert WellCare of North Carolina of any erroneous data submitted and follow WellCare of North Carolina's policies to correct errors in a timely manner.
- Provide medical records as requested in a timely manner; and
- Provide ongoing training to their staff regarding appropriate use of ICD coding for reporting diagnoses.

Accurate and thorough diagnosis coding is imperative to WellCare of North Carolina's ability to manage members, comply with Risk Adjustment Data Validation audit requirements, and effectively offer a Marketplace product. Claims submitted with inaccurate or incomplete data will often require retrospective chart review.

Coding of Claims/ Billing Codes

WellCare of North Carolina requires claims to be submitted using codes from the current version of ICD-10-CM, ASA, DRG, CPT, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. Below are some code related reasons a claim may reject or deny:

- Code billed is missing, invalid, or deleted at the time of services.
- Code is inappropriate for the age of the member.
- Diagnosis code is missing digits.
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary.
- Code billed is inappropriate for the location or specialty billed.
- Code billed is a part of a more comprehensive code billed on same date of service.

- Written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of WellCare of North Carolina.
- Newborn services provided in the hospital will be reimbursed separately from the mother's hospital stay. Submit separate claims for the mother and newborn(s).

Billing from independent provider-based Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) for covered RHC/FQHC services furnished to members should be made with specificity regarding diagnosis codes and procedure code/modifier combinations.

Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

For more information regarding billing codes, coding, and code auditing/editing, please contact WellCare of North Carolina Provider Services or visit marketplace.wellcarenc.com. The clinical and payment policies are located under the "Provider Resources" link.

Clinical Lab Improvement Act (CLIA) Billing Instructions

CLIA numbers are required for CMS 1500 claims where CLIA Certified or CLIA waived services are billed. If the CLIA number is not present, the claim will be upfront rejected. Below are billing instructions on how and/or where to provide the CLIA certification or waiver number on the following claim type submissions:

Paper Claims

If a particular claim has services requiring an authorization number and CLIA services, only the CLIA number must be provided in Box 23.

*Note
An independent clinical laboratory that elects to file a paper claim form shall file Form CMS 1500 for a referred laboratory service (as it would any laboratory service). The line-item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS 1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the reference laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS 1500 claim form to show where the service (test) was performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS 1500 claim form.

EDI

If a single claim is submitted for those laboratory services for which CLIA certification or waiver is required, report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4;

-Or-

If a claim is submitted with both laboratory services for which CLIA certification or waiver is required and non-CLIA covered laboratory test, in the 2400 loop for the appropriate line report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4.

*Note

The billing laboratory submits, on the same claim, tests referred to another (referral/rendered) laboratory, with modifier 90 reported on the line item and reports the referral laboratory's CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4.

Please refer to the 5010 implementation guides for the appropriate loops to enter the CLIA number. If a particular claim has services requiring an authorization number and CLIA services, only the CLIA number must be provided.

Web

Complete Box 23 with CLIA certification or waiver number as the prior authorization number for those laboratory services for which CLIA certification or waiver is required.

Taxonomy Code Billing Requirement

Taxonomy numbers are required for all WellCare of North Carolina claims. Claims submitted without taxonomy numbers will be upfront rejected with an EDI Reject Code of 91. If the claim was submitted on paper, a rejection letter will be returned indicating that the taxonomy code was missing.

The verbiage associated with Reject 91 is as follows: Invalid or Missing Taxonomy Code. Please contact Provider Services to resolve this issue.

Below are three scenarios involving the Taxonomy Code Billing Requirements:

Scenario One: Rendering NPI is different than the Billing NPI

CMS 1500 Form

Required Data	Paper CMS 1500	Electronic Submission	
		Loop ID	Segment/Data Element
Rendering NPI	Unshaded portion of box 24J	2310B 2420A	NM109 NM109
Taxonomy Qualifier ZZ	Shaded portion of box 24 I	2310B	PRV02 REF01

		2420A	PRV02 REF01
Rendering Provider Taxonomy Number	Shaded portion of box 24J	2310B	PRV03 REF02
		2420A	PRV03 REF02
Group NPI	Box 33a	2010AA	NM109
Billing Provider Group Taxonomy utilizing the ZZ Qualifier (for the 2000A PROV02 = qualifier "PXC") e.g., box 33b ZZ208D00000X EDI PRV*PE*PXC*208D00000X	Box 33b	2000A	PRV03
Billing Provider Group FTIN(EI)/SSN(SY)		2010AA	REF01 REF02

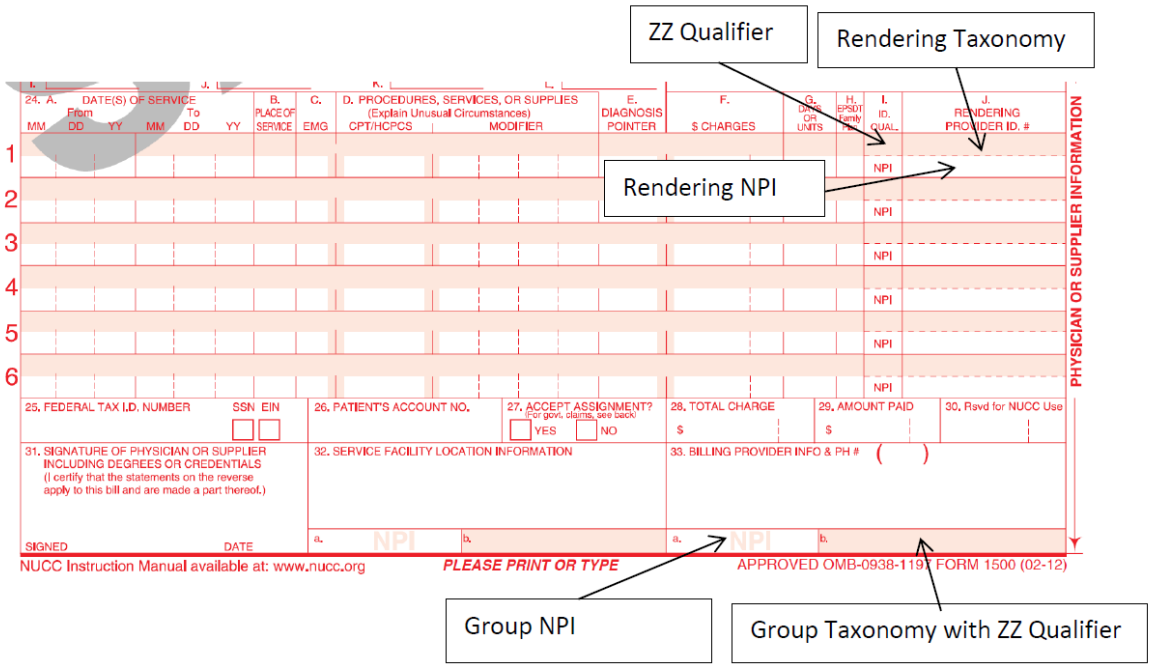
Scenario Two: Rendering NPI and Billing NPI are the same

CMS 1500 Form

It is NOT necessary to submit the Rendering NPI and Rendering Taxonomy in this Scenario; however, if box 24 I and 24 J are populated, then all data MUST be populated.

Required Data	Paper CMS 1500	Electronic Submission	
Applicable NPI	Box 33a	2010AA	NM109
Applicable Taxonomy utilizing the ZZ Qualifier (for the 2000A PROV02 = qualifier "PXC") Billing Provider Group FTIN(EI)/SSN(SY) e.g. **REF*EI*999999999**	Box 33b	2000A	PRV03
		2010AA	REF01 REF02

Below is an example of the fields relevant to Scenario One and Scenario Two above.

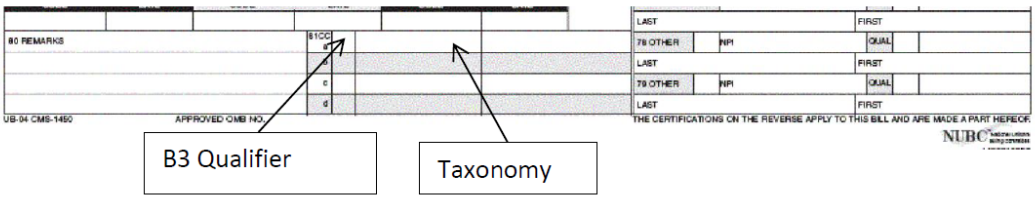


Scenario Three: Taxonomy Requirement for UB 04 Forms

Required Data	Paper UB 04	Electronic Submission
Taxonomy Code with B3 Qualifier	Box 81 CC	Billing Level 2000A Loop and PRVR segment

Below is an example of the UB 04 form:

Below is an example of the UB 04 form



Claim Reconsiderations Related to Code Editing and Editing

Claims reconsiderations resulting from claim-editing are handled per the provider claims dispute process outlined in this manual. When submitting claims reconsiderations, please submit medical records, invoices, and all related information to assist with the appeals review.

If you disagree with a code edit or edit and request claim reconsideration, you must submit medical documentation (medical records) related to the reconsideration. If medical documentation is not received, the original code edit(s) will be upheld.

CODE EDITING

WellCare of North Carolina uses HIPAA-compliant code auditing software to improve accuracy and efficiency in claims processing, payment, and reporting. The software detects and documents coding errors on provider claims prior to payment by analyzing CPT, HCPCS, ICD-10, modifier, and place of service codes against correct coding guidelines. While code auditing software is a useful tool to ensure provider compliance with correct coding, it will not wholly evaluate all clinical patient scenarios. Consequently, WellCare of North Carolina uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. WellCare of North Carolina may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

WellCare of North Carolina may request medical records or other documentation to verify that all procedures and/or services billed are properly supported in accordance with correct coding guidelines.

CPT AND HCPCS CODING

The Healthcare Common Procedure Coding System (HCPCS) is a set of health care procedure codes based on the American Medical Association's (AMA) Current Procedural Terminology (CPT). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding.

1. ***Level I HCPCS Codes (CPT):*** This code set is maintained by the AMA. CPT codes are a 5- digit, uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are updated (added, revised, and deleted) on an annual basis.

2. ***Level II HCPCS Codes*:** The Level II set of HCPCS codes is used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment, orthotics, and prosthetics, etc.). The Level II set is an alphanumeric coding system which is maintained by CMS. These codes are updated on an annual basis.

3. ***Miscellaneous/Unlisted Codes:*** These codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with miscellaneous or unlisted codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claim submission. If records are not received, the provider will receive a denial indicating that medical records are required. The medical documentation should clearly define the procedure performed including, but not limited to, office notes, operative report, and pathology report and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) to accurately describe the service or procedure rendered. Clinical validation also includes identifying and reviewing other procedures and services billed on the claim that may be related to the miscellaneous code. For example, if the miscellaneous code is determined to be the primary procedure, then other procedures and services that are

integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.

4. ***Temporary National Codes:*** These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are considered temporary and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H and T code ranges.

5. ***Modifiers:*** Modifiers are used to indicate additional information about the HCPCS, or CPT code billed. On occasion, certain procedures require more explanation because of special circumstances. For example, modifier -25 is appended to evaluation and management services to indicate that a patient was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

INTERNATIONAL CLASSIFICATION OF DISEASES (ICD-10)

ICD-10 is an alphanumeric system used by providers to classify diagnoses and symptoms. These codes consist of three to seven digits, which allows for a high level of specificity in coding a wide range of health problems.

REVENUE CODES

These 4-digit numeric codes are utilized by institutional providers to represent services, procedures, and/or supplies provided in a hospital or facility setting. Claims submitted with revenue codes should indicate a corresponding procedure code.

EDIT SOURCES

The claims editing software contains a comprehensive set of rules addressing coding inaccuracies such as: unbundling, frequency limitations, fragmentation, up coding, duplication, invalid codes, mutually exclusive procedures, and other coding inconsistencies. Each rule is linked to a generally accepted coding principle. Guidance surrounding the most likely clinical scenario is applied. This information is provided by clinical consultants, health plan medical directors, current research, etc.

- The following sources are utilized in determining correct coding guidelines for the software:

- Centers for Medicare & Medicaid Services (including National Correct Coding Initiative (NCCI) Policy Manual and Claims Processing Manual guidelines as well as current PTP and MUE tables)

- American Medical Association (CPT, HCPCS, and ICD-10 guidelines and publications including CPT manual, AMA website, CPT Assistant, CPT Insider's View, etc.)

- Public domain specialty provider associations (such as American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons, American College of Obstetricians and Gynecologists, etc.).

- State provider manuals, fee schedules, periodic provider updates (bulletins/transmittals)

- CMS coding resources such as National Physician Fee Schedule, Provider Benefit Manual, MLN Matters and Provider Transmittals
- Health Plan policies and provider contract considerations
- In addition to nationally recognized coding guidelines, the software has flexibility to allow business rules that are unique to the needs of individual product lines.

CODE EDITING AND THE CLAIMS ADJUDICATION CYCLE

Code editing is the final step in the claims adjudication process. Once a claim has completed all previous adjudication steps (such as benefits and member/provider eligibility review), the claim is ready for analysis.

As a claim progresses through the code editing cycle, each service line on the claim is processed through the code editing rules engine and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim as well as previously paid claims found in the member/provider history.

Depending upon the code edit applied, the software will make the following recommendations:

Deny: Code editing rule recommends the denial of a claim line. The appropriate explanation code is documented on the provider's explanation of payment along with reconsideration/appeal instructions.

Pend: Code editing recommends that the service line pend for clinical review and validation. This review may result in a pay or deny recommendation. The decision is documented on the provider's explanation of payment along with reconsideration/appeal instructions.

Replace and Pay: Code editing recommends denial of a service line, and a new line is added and paid. In this scenario, the original service line is left unchanged on the claim and a new line is added to reflect the software recommendations. For example, an incorrect CPT code is billed for the member's age. The software will deny the original service line billed by the provider and add a new service line with the correct CPT code, resulting in a paid service line. This action does not alter or change the provider's billing, as the original billing remains on the claim.

CODE EDITING PRINCIPLES

The below principles do not represent an all-inclusive list of code editing principles, but rather an area sampling of edits which are applied to physician and/or outpatient facility claims.

Unbundling Edits

PTP Practitioner and Hospital Edits

CMS has designated certain combinations of codes that are generally not separately reimbursable on the same date of service. These are known as Procedure-to-Procedure (PTP) and/or Column 1/Column II edits. Within the PTP edit category, there are Practitioner edits (applicable to claims submitted by physicians, non-physician

practitioners, and ambulatory surgical centers) and Hospital edits (applicable to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy, speech-language pathology, and comprehensive outpatient rehabilitation facilities).

The procedure code listed in column I is the most comprehensive code; reimbursement for the column II code is subsumed into the payment for the comprehensive code. The column II code is considered an integral component to the successful outcome of the column I code.

While these code pairs should not be billed together under most circumstances, there are circumstances when an NCCI-associated modifier may be appended to the column II code to indicate a significant and separately identifiable or distinct service. When these modifiers are used, prepay clinical validation will be performed to ensure that services are reported appropriately. For more information on the PTP edits, please visit www.cms.gov.

Medically Unlikely Edits (MUEs) for Practitioners, DME Providers and Facilities

An MUE is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. These edits are based on CPT/HCPCS code descriptions, anatomic specifications, nature of the service/procedure, nature of the analyte, equipment prescribing information and clinical judgment. Not all HCPCS/CPT codes have an MUE limit.

Code Bundling Rules Not Sourced To CMS

Many specialty medical organizations and health advisory committees have developed rules around how codes should be used in their area of expertise. These rules are published and are available for use by the public domain. Procedure code definitions and relative value units are considered when developing these code sets. Rules are specifically designed for professional and outpatient facility claims editing.

Procedure Code Unbundling

Two or more procedure codes are used to report a service when a single, more comprehensive code should have been used. The less comprehensive code will be denied.

Mutually Exclusive Editing

These are combinations of procedure codes that may differ in technique or approach but result in the same outcome. The procedures may be impossible to perform together anatomically. Procedure codes may also be considered mutually exclusive when an initial or subsequent service is billed on the same date of service. The procedure with the highest RVU is considered the reimbursable code.

Incidental Procedures

These are procedure code combinations that are considered clinically integral to the successful completion of the primary procedure and should not be billed separately.

Global Surgical Period Editing/Medical Visit Editing

CMS publishes rules surrounding payment of an evaluation and management service during the global surgical period of a procedure. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB).

Procedures are assigned a 0, 10 or 90-day global surgical period. Procedures assigned a 90-day global surgical period are designated as major procedures. Procedures assigned a 0- or 10-day global surgical period are designated as minor procedures.

Evaluation and Management services for a major procedure (90-day period) that are reported 1-day preoperatively, on the same date of service or during the 90-day post-operative period are not recommended for separate reimbursement.

Evaluation and Management services that are reported with minor surgical procedures on the same date of service or during the 10-day global surgical period are not recommended for separate reimbursement.

Evaluation and Management services for established patients that are reported with surgical procedures that have a 0-day global surgical period are not recommended for reimbursement on the same day of surgery because there is an inherent evaluation and management service included in all surgical procedures.

Global Maternity Editing

Procedures with "MMM"

Global periods for maternity services are classified as "MMM", Evaluation and management services billed during the antepartum period (270 days), on the same date of service or during the postpartum period (45 days) are not recommended for separate reimbursement if the procedure code includes antepartum and postpartum care.

Diagnostic Services Bundled to the Inpatient Admission (3-Day Payment Window)

Identifies outpatient diagnostic services that are provided to a member within three days prior to and including the date of an inpatient admission. When these services are billed by the same admitting facility or an entity wholly owned or operated by the admitting facility, they are considered bundled into the inpatient admission and therefore are not separately reimbursable.

Multiple Code Rebundling

Analyzes instances in which a provider billed two or more procedure codes when a single more comprehensive code should have been billed to represent all the services performed.

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the number of times a single code can be reported. Some codes are allowed a limited number of times on a single date of service, over a given period or during a member's

lifetime. State fee schedules also delineate the number of times a procedure can be billed over a given period or during a member's lifetime. A frequency edit is applied by code editing software when the procedure code is billed in excess of these guidelines.

Duplicate Edits

The code editing software evaluates prospective claims to determine if there is a previously paid claim for the same member and provider in history that is a duplicate to the prospective claim. The software also looks across different providers to determine if another provider was paid for the same procedure, for the same member on the same date of service. Finally, the software analyzes multiple services within the same range of services performed on the same day. For example, a nurse practitioner and physician billing for office visits for the same member on the same date of service.

National Coverage Determination Edits

CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services, or technologies can be paid under Medicare. These rules evaluate diagnosis to procedure code combinations.

Anesthesia Edits

Identifies anesthesia services that have been billed with a surgical procedure code instead of an anesthesia procedure code.

INVALID REVENUE TO PROCEDURE CODE EDITING

Identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

Evaluates claims billed with an assistant surgeon that normally do not require the attendance of an assistant surgeon. Modifiers are reviewed as part of the claims analysis.

Co-Surgeon/Team Surgeon Edits

Evaluates claims billed with a co-surgeon or team surgeon that normally do not require a co-surgeon/team surgeon. CMS guidelines define whether an assistant, co-surgeon or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co or team surgeon.

Add-on and Base Code Edits

Analyzes claims in which an add-on CPT code was billed without the primary service CPT code. Additionally, add-on codes are denied if the primary service code was denied. This rule also looks for circumstances where the primary code was billed in a quantity greater than one, when an add-on code should have been used to describe the additional services rendered.

Bilateral Edits

Analyzes claims in which the modifier -50 has been billed, but the same procedure code is submitted on a different service line on the same date of service without modifier -50. This rule is highly customized, as many health plans allow this type of billing.

Replacement Editing

Recommends that single service lines or multiple service lines are denied and replaced with a more appropriate code. For example, a provider bills more than one outpatient consultation code for the same member in the member's history. The software will deny the office consultation code and replace it with the appropriate evaluation and management service, established patient or subsequent hospital care code. Another example of the edit's function is when a provider has billed a new patient evaluation and management code within three years of a previous new patient visit. The edit will replace the second submission with the appropriate established patient visit. A crosswalk is used to determine the appropriate code to add.

Missing Modifier Edits

Analyzes service lines to determine if a modifier should have been reported but was omitted. For example, professional providers would not typically bill the global (technical and professional) component of a service when performed in a facility setting. The technical component is typically performed by the facility and not the physician.

INPATIENT FACILITY CLAIM EDITING

Potentially Preventable Readmissions Edit

Identifies readmissions within a specified time interval that may be clinically related to a previous admission. For example, a subsequent admission may be plausibly related to the care rendered during or immediately following a prior hospital admission in the case of readmission for a surgical wound infection or lack of postoperative follow up. Admissions to non-acute care facilities (such as skilled nursing facilities) are not considered readmissions and not considered for reimbursement. CMS determines the readmission time interval as 30 days; however, this rule is highly customizable by state rules and provider contracts.

ADMINISTRATIVE AND CONSISTENCY RULES

These rules are not based on clinical content and serve to validate code sets and other data billed on the claim. These types of rules do not interact with historically paid claims or other service lines on the prospective claim. Examples include, but are not limited to:

- ***Procedure code invalid:*** Evaluates claims for invalid procedure and revenue or diagnosis codes.
- ***Deleted Codes:*** Evaluates claims for procedure codes which have been deleted.

- ***Modifier to procedure code validation:*** Identifies invalid modifier to procedure code combinations. This rule analyzes modifiers affecting payment. As an example, modifiers such as -24, -25, -26, -57, -58 and -59.
- ***Age:*** Identifies procedures inconsistent with member's age
- ***Gender Procedure:*** Identifies procedures inconsistent with member's gender.
- ***Gender Diagnosis***: Identifies diagnosis codes inconsistent with member's gender.
- ***Incomplete/invalid diagnosis codes:*** Identifies incomplete or invalid diagnosis codes.

PREPAYMENT CLINICAL VALIDATION

Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. An example of WellCare of North Carolina's clinical validation services is the review of modifiers -25, -59, and X(EPSU). Within the CMS NCCI PTP edit tables, some code pairs allow an NCCI-associated modifier to be appended when the correct coding modifier indicator is "1". Furthermore, public-domain specialty organization edits may also be considered for override when billed with these modifiers. When these modifiers are billed, the provider's documentation should support a separately reimbursable service. Some examples of separately identifiable services include a different session, site or organ system, surgery, incision/excision, lesion, or separate injury. WellCare of North Carolina's clinical validation team uses the information on the prospective claim and claims history to determine whether it is likely that a modifier was used correctly based on the unique clinical scenario for a member on a given date of service.

The Centers for Medicare and Medicaid Services (CMS) supports this type of prepayment review. The clinical validation team uses nationally published guidelines from CPT and CMS to determine if a modifier was used correctly.

Modifiers -59 and X(EPSU)

The NCCI (National Correct Coding Initiative) states that the primary purpose of modifier -59 is to indicate that procedures or non-E/M services that are not usually reported together are appropriate for separate reimbursement under the circumstances. The CPT Manual defines modifier -59 as follows: "Modifier -59: Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, which are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

Some providers routinely assign modifier -59 or X(EPSU) when billing a combination of codes that will result in a denial due to unbundling. Modifier -59 is commonly misused as related to the portion of the definition that allows its use to describe "different procedure or surgery". NCCI guidelines state that providers should not use

modifier -59 solely because two different procedures/surgeries are performed or because the CPT codes are different procedures. Modifier -59 should only be used if the two procedures/surgeries are performed at separate anatomic sites, at separate patient encounters or by different practitioners on the same date of service. NCCI defines different anatomic sites to include different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ.

WellCare of North Carolina uses the following guidelines to determine if modifier -59 or X(EPSU) was used correctly:

- The diagnosis codes or clinical scenario on the claim indicate multiple conditions or sites were treated or are likely to be treated.
- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas which would result in procedures being performed on multiple body areas and sites.
- Claim history supports that each procedure was performed by a different practitioner or during different encounters or those unusual circumstances are present that support modifier 59 were used appropriately.

To avoid incorrect denials providers should assign to the claim all applicable diagnosis and procedure codes used, and all applicable anatomical modifiers designating which areas of the body were treated.

Modifier -25

Both CPT and CMS specify that by using a modifier -25 the provider is indicating that a “significant, separately identifiable evaluation and management service was provided by the same physician on the same day of the procedure or other service”. Additional CPT guidelines state that the evaluation and management service must be significant and separate from other services provided or above and beyond the usual pre-, intra-, and postoperative care associated with the procedure that was performed.

The NCCI policy manual states that “If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.) The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers and A/B MACs processing practitioner service claims have separate edits.

WellCare of North Carolina uses the following guidelines to determine whether modifier -25 was used appropriately. If any one of the following conditions is met, the clinical nurse reviewer will recommend reimbursement for the E/M service.

- The E/M service is the first time the provider has seen the patient or evaluated a major condition.
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed.
- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services.
- Other procedures or services performed for a member on or around the same date of the procedure support that an E/M service would have been required to determine the member's need for additional services.
- To avoid incorrect denials, providers should assign all applicable diagnosis codes that support additional E/M services.

CLAIM RECONSIDERATIONS RELATED TO CODE EDITING

Claims appeals resulting from claim editing are handled per the provider claims dispute process outlined in this manual. When submitting claims appeals, please submit medical records, invoices, and all related information to assist with the appeals review.

To request claim reconsideration, documentation (medical records) must be submitted related to the reconsideration. If medical documentation is not received, the original code edit will be upheld.

The reconsideration may include this type of information:

- Statement of why the service is medically necessary.
- Medical evidence which supports the proposed treatment
- How the proposed treatment will prevent illness or disability.
- How the proposed treatment will alleviate physical, mental, or developmental effects of the patient's illness.
- How the proposed treatment will assist the patient to maintain functional capacity.
- A review of previous treatments and results, including, based on your clinical judgment, why a new approach is necessary.
- How the recommended service has been successful in other patients.

VIEWING CLAIMS CODING EDITS

Code Auditing Tool

A web-based code editing reference tool designed to "mirror" how code editing products evaluate code and code combinations during the editing of claims. The tool is available for providers who are registered on the Secure Provider Portal. The tool can be accessed in the Claims Module by clicking "Claim Editing Tool" in the Secure Provider Portal.

This tool offers many benefits:

- Prospectively access the appropriate coding and supporting clinical edit clarifications for services *before* claims are submitted.
- Proactively determine the appropriate code/code combination representing the service to ensure accurate billing.

The tool reviews the codes entered to determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered.

The Code Editing Assistant is intended for use as a "what if" or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information which may be used to determine if an edit is appropriate.

The code editing assistant can be accessed from the Secure Provider Portal.

Disclaimer: This tool is used to apply coding logic *only*. It will not consider individual fee schedule reimbursement, authorization requirements, or other coverage considerations. Whether a code is reimbursable or covered is separate and outside of the intended use of this tool.

AUTOMATED CLINICAL PAYMENT POLICY EDITS

Clinical payment policy edits are developed to increase claims processing effectiveness, to decrease the administrative burden of prior authorization, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers. The purpose of these policies is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. These policies may be documented as a medical policy or pharmacy policy.

Clinical payment policies are implemented through prepayment claims edits applied within our claims adjudication system. Once adopted by the health plan, these policies are posted on the health plan's Secure Provider Portal.

Clinical medical policies can be identified by an alpha-numeric sequence such as CP.MP.xxx in the reference number of the policy. Clinical pharmacy policies can be identified by an alpha-numeric sequence such as CP.PHAR.xxx in the reference number of the policy.

Most clinical payment policy edits are applied when a procedure code (CPT/HCPCS) is billed with a diagnosis (es) that does not support medical necessity as defined by the policy. When this occurs, the following explanation (EX) code is applied to the service line billed with the disallowed procedure. This EX-code can be viewed on the provider's explanation of payment.

- xE: Procedure Code is disallowed with this Diagnosis Code(s) Per Plan Policy.

CLINICAL PAYMENT POLICY APPEALS

Clinical payment policy denials may be appealed based on medical necessity. Providers who disagree with a claim denial based on a clinical payment policy, and who believe that the service rendered was medically necessary and clinically appropriate, may submit a written reconsideration request for the claim denial using the provider claim reconsideration/appeal/dispute or other appropriate process as defined in the health plan's provider manual. The appeal should include information such as:

1. Statement of why the service is medically necessary.
2. Medical evidence which supports the proposed treatment.
3. How the proposed treatment will prevent illness or disability.

4. How the proposed treatment will alleviate physical, mental, or developmental effects of the patient's illness.
5. How the proposed treatment will assist the patient to maintain functional capacity.
6. A review of previous treatments and results, including, based on your clinical judgment, why a new approach is necessary.
7. How the recommended service has been successful in other patients.

THIRD PARTY LIABILITY

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the member.

If third party liability coverage is determined after services are rendered, WellCare of North Carolina will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

BILLING THE MEMBER

COVERED SERVICES

WellCare of North Carolina providers are prohibited from billing the member for any covered services except for copayments, coinsurance, and deductibles.

1. Copayments, coinsurance, and any unpaid portion of a deductible may be collected from the member at the time of service.
2. If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member the overpaid amount within 45 days.

For members who are in a suspended status and seeking services from providers:

1. Providers may advise the member that services may not be delivered because the member is in a suspended status. (Status must be verified through our Secure Provider Portal or by calling Provider Services. Providers should follow their internal policies and procedures regarding this situation.)
2. Should a provider make the decision to render services, the provider may collect from the member. Providers must submit a claim to WellCare of North Carolina.
3. If the member subsequently pays their premium and is removed from a suspended status, claims will be adjudicated by WellCare of North Carolina. The provider would then be responsible to reconcile the payment received from the member and the payment received from WellCare of North Carolina. The provider may then bill the member for an underpayment or return to the member any overpayment.
4. If the member does not pay their premium and is terminated from their WellCare of North Carolina plan, providers may bill the member for their full billed charges.
5. Non-participating providers may be limited by state or other regulations when balance billing members for amounts not considered to be copayments, coinsurance, or deductible.

NON-COVERED SERVICES

Contracted providers may only bill WellCare of North Carolina members for non-covered services if the member and provider both sign an agreement outlining the member's responsibility to pay prior to the services being rendered. The agreement must be specific to the services being rendered and clearly state:

1. The specific service(s) to be provided.
2. A statement that the service is not covered by WellCare of North Carolina
3. A statement that the member chooses to receive and pay for the specific service.

4. The member is not obligated to pay for the service if it is later found that service was covered by WellCare of North Carolina at the time it was provided, even if WellCare of North Carolina did not pay the provider for the service because the provider did not comply with WellCare of North Carolina requirements.

Billing for "No-Shows"

Providers may bill the member a reasonable and customary fee for missing an appointment when the member does fails to call in advance to cancel the appointment. The "no show" appointment must be documented in the medical record.

PREMIUM GRACE PERIOD FOR MEMBERS RECEIVING ADVANCED PREMIUM TAX CREDITS (APTCS)

For purposes of this discussion, please note the following:

1. Premiums are billed and paid at the subscriber level; therefore, the grace period is applied at the subscriber level.
2. All members associated with the subscriber will inherit the enrollment status of the subscriber.
3. After the initial premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium.
4. Coverage will remain in force during the grace period.
5. If payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period. The member shall be held liable for the cost of Covered Services received during the grace period, as well as any unpaid premium.
6. During months two and three of the grace period, claims will be pended. The EX-Code on the Explanation of Payment will state: "LZ – Pend: Non-Payment of Premium." During month one, claims may be submitted and paid.

FAILURE TO OBTAIN AUTHORIZATION

Providers may not bill members for services when the provider fails to obtain an authorization and the claim is denied by WellCare of North Carolina.

NO BALANCE BILLING

Payments made by WellCare of North Carolina to providers less any copays, coinsurance, or deductibles which are the financial responsibility of the member, will be considered payment in full. Providers may not seek payment from WellCare of North Carolina members for the difference between the billed charges and the contracted rate paid by WellCare of North Carolina.

INTERIM BILLING

It is the policy of WellCare Marketplace not to accept interim billing for estimated monies owed to participating and non-participating facilities. Claims processing will begin upon receipt of the final bill for services rendered for inpatient hospital stays and Skilled Nursing.

- WellCare Marketplace requires that participating and non-participating Providers submit final claim upon Members discharge from facility.
- To facilitate claims processing, it is recommended that Providers include an itemized statement and any supporting documentation with the claim submission.
- Interim billing will not be accepted. The claim will be denied until the final claim for the inpatient hospital stay or Skilled Nursing from the first date of admission through the date of final discharge is received.

GRIEVANCES AND APPPEALS

COMPLAINT/GRIEVANCE

A Complaint/Grievance is a verbal or written expression by a provider which indicates dissatisfaction or dispute with WellCare of North Carolina's policies, procedure, or any aspect of WellCare of North Carolina's functions. WellCare of North Carolina logs and tracks all Complaint/Grievance whether received verbally or in writing.

If the Complaint/Grievance is related to claim(s) payment, the provider must follow the process for claim reconsideration and claim dispute as noted in the Claims section of this Provider Manual prior to filing a Complaint/Grievance.

PROVIDER GRIEVANCE PROCESS

The provider can contact Provider Services if they have any questions or concerns. We will attempt to answer and address any issues during initial contact, as most Complaints can be resolved with a phone call. If we are unable to resolve their issue, the provider may elect to file a verbal Grievance with Provider Services or send us details of their Complaint/Grievance in writing.

The mailing address for non-claim related Provider Complaints/Grievances is:

WellCare of North Carolina
PO Box 10341
Van Nuys CA 91410

A provider has <ADD #> calendar days from the date of the incident, such as the original Explanation of Payment date, to file a Complaint/Grievance. After research and a full review of the Complaint/Grievance has been completed, WellCare of North Carolina shall provide a written notice to the provider within <ADD #> calendar days from the date we receive the provider's Complaint/Grievance.

MEMBER GRIEVANCE PROCESS

To ensure WellCare of North Carolina member's rights are protected, all WellCare of North Carolina members are entitled to a Complaint/Grievance and Appeals process. The procedures for filing a Complaint/Grievance are outlined in the WellCare of North Carolina member's Evidence of Coverage. Additionally, information regarding the Complaint/Grievance process can be found on our website at Marketplace.WellCareNC.com or by calling WellCare of North Carolina at 1-833-925-2861 (TTY 711).

If a member is displeased with any aspect of services rendered:

1. The member should contact our Member Services department at 1-833-925-2861 (TTY 711). The Member Services representative will assist the member.
2. If the member continues to be dissatisfied, they may file a formal complaint/grievance. Again, our Member Services department is available to assist with this process. Information regarding this process can be found at Marketplace.WellCareNC.com.
3. Depending on the nature of the complaint/grievance, the member will be offered the right to appeal our decision. At the conclusion of this formalized process, the member will receive written confirmation of the determination. WellCare of North Carolina will complete the appeal process in the timeframes as specified in rules and regulation.
4. The member has the right to appeal to an external independent review organization.
5. A member may designate in writing to WellCare of North Carolina that a provider is acting on behalf of the member regarding the complaint/grievance and appeal process.

- If and when a threshold number of members complain about a specific provider, WellCare of North Carolina may undertake a review of the provider including, but not limited to, a site review. Site reviews are performed at provider offices and facilities. A site review evaluates:
    - physical accessibility.
    - physical appearance.
    - adequacy of waiting and examining room space; and
    - adequacy of medical/treatment record keeping.

The mailing address for Member Complaints/Grievances is:

WellCare of North Carolina
Attn: Appeals and Grievances Department
PO Box 10341
Van Nuys, CA 91410-0341

Appeals

An Appeal is the mechanism by which members or providers contest actions or decisions made by WellCare of North Carolina including prior authorization denials, or if the member is aggrieved by any rule, policy, procedure, or other actions taken by WellCare of North Carolina.

Expedited appeals may be filed with WellCare of North Carolina if the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

Provider Claim Appeal Process

Claim Appeal requests must follow the claim reconsideration and claim dispute process. Please refer to instructions outlined under Request for Reconsideration and Claim Dispute sections of this Provider Manual. Providers can use the Request for Reconsideration form found on our website under Provider Resources to submit either request. If assistance accessing the form is required, a provider can contact Provider Services for support.

Claim reconsiderations and disputes should be mailed to:

WellCare of North Carolina
Attn: Request for Reconsideration
PO Box 5010
Farmington, MO 63640-5010

WellCare of North Carolina
Attn: Claim Disputes
PO Box 5010
Farmington, MO 63640-5010

Medical necessity and authorization denials are handled through the Member Appeal process below. The provider may file a medical necessity or authorization denial appeal on behalf of the member. (Written consent may be required.)

Member Appeals Process

A member has 180 calendar days from WellCare of North Carolina's notice of action to file the appeal. WellCare of North Carolina shall acknowledge receipt of each appeal within three business days after receiving an appeal. WellCare of North Carolina shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed 30 calendar days from the date WellCare of North Carolina receives the appeal. WellCare of North Carolina may extend the timeframe for resolution of the appeal up to 14 calendar days if the member requests the extension or WellCare of North Carolina demonstrates that there is need for additional information and how the delay is in the member's best interest. For any extension not requested by the member, WellCare of North Carolina shall provide written notice to the member for the delay.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding 72 hours from the initial receipt of the appeal or after the member provides any specified information required to complete the review. WellCare of North Carolina will afford a reasonable amount of time for the member to provide the information.

The procedures for filing an Appeal are outlined in the WellCare of North Carolina member's Evidence of Coverage. Additionally, information regarding the Appeal process can be found on our website at Marketplace.WellCareNC.com or by calling WellCare of North Carolina at 1-833-925-2861 (TTY 711).

For Physical Health related authorization appeals:

WellCare of North Carolina
Attn: Appeals and Grievances Department
PO Box 10341
Van Nuys, CA 91410-0341
Fax: 1-833-886-7956

For Behavioral Health related authorization appeals:

WellCare of North Carolina
Attn: BH Appeals Department
PO Box 10378
Van Nuys, CA 91410-0378
Fax: 1-866-714-7991

Providers may also invoke any remedies as determined in the Participating Provider Agreement.

FRAUD, WASTE AND ABUSE

WellCare of North Carolina takes the detection, investigation, and prosecution of fraud and abuse very seriously and has
a Fraud, Waste, and Abuse (FWA) program that complies with the federal and state laws. WellCare of North Carolina, in conjunction with its parent company, Centene, operates a Fraud, Waste, and Abuse unit. WellCare of North Carolina routinely conducts audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claim's payment process. To better understand this system, please review the billing and claims section of this manual. The Centene Special Investigation Unit (SIU) also performs retrospective audits, which, in some cases, may result in taking actions against providers who commit fraud, waste, and/or abuse. These actions include but are not limited to:

- Remedial education and training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Announced or unannounced onsite audit investigations
- Corrective action plan
- Any other remedies available to rectify

Some of the most common FWA practices include:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT.
- Diagnosis and/or procedure code not consistent with the member's age
- Use of exclusion codes
- Excessive use of units
- Misuse of benefits

- Claims for services not rendered

WellCare of North Carolina auditors consider state and federal laws and regulations, provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician of like specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report identifying all records reviewed during the audit. If the auditor determines that clinical documentation does not support the claims payment in some or all circumstances, WellCare of North Carolina will seek recovery of all overpayments. Depending on the number of services provided during the review period, WellCare of North Carolina may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998).

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential FWA hotline at 1-866-685-8664. WellCare of North Carolina takes all reports of potential fraud, waste, or abuse very seriously and investigates all reported issues.

FWA PROGRAM COMPLIANCE AUTHORITY AND RESPONSIBILITY

The Vice President of Compliance has overall responsibility and authority for carrying out the provisions of the compliance program. WellCare of North Carolina is committed to identifying, investigating, sanctioning, and prosecuting suspected fraud, waste, and abuse.

The WellCare of North Carolina provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process, including investigations.

POST-PROCESSING CLAIMS AUDIT

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. To start the audit, WellCare of North Carolina auditors request medical records for a defined review period. Providers have 30 days to respond to the request; if no response is received, a second and final request for medical records is forwarded to the provider. If the provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, WellCare of North Carolina will recover all amounts paid for the services in question.

WellCare of North Carolina auditors review cases for common FWA practices including:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT.
- Diagnosis and/or procedure code not consistent with the member's age/gender

- Use of exclusion codes
- Excessive use of units
- Misuse of benefits
- Claims for services not rendered.

WellCare of North Carolina auditors consider state and federal laws and regulations, provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician of like specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report identifying all records reviewed during the audit. If the auditor determines that clinical documentation does not support the claims payment in some or all circumstances, WellCare of North Carolina will seek recovery of all overpayments. Depending on the number of services provided during the review period, WellCare of North Carolina may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998).

FALSE CLAIMS ACT

The False Claims Act establishes liability when any person or entity improperly receives or avoids payment to the Federal government. The Act prohibits:

- Knowingly presenting or causing to be presented a false claim for payment or approval.
- Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim.
- Conspiring to commit any violation of the False Claims Act.
- Falsely certifying the type or amount of property to be used by the Government.
- Certifying receipt of property on a document without completely knowing that the information is true.
- Knowingly buying Government property from an unauthorized officer of the Government.
- Knowingly making, using, or causing to be made or used a false record to avoid or decrease an obligation to pay or transmit property to the Government.

For more information regarding the False Claims act, please visit www.cms.hhs.gov.

PHYSICIAN INCENTIVE PROGRAMS

On an annual basis and in accordance with federal regulations, WellCare of North Carolina must disclose to the Centers for Medicare and Medicaid Services, any Physician Incentive Programs that could potentially influence a physician's care decisions. The information that must be disclosed includes the following:

- Effective date of the Physician Incentive Program
- Type of Incentive Arrangement
- Amount and type of stop-loss protection
- Patient panel size
- Description of the pooling method, if applicable
- For capitation arrangements, provide the amount of the capitation payment that is broken down by percentage for primary care, referral, and other services
- The calculation of substantial financial risk (SFR)
- Whether WellCare of North Carolina does or does not have a Physician Incentive Program
- The name, address, and other contact information of the person at WellCare of North Carolina who may be contacted with questions regarding Physician Incentive Programs

Physician Incentive Programs may not include any direct or indirect payments to providers/provider groups that create inducements to limit or reduce the provision of necessary services. In addition, Physician Incentive Programs that place providers/provider groups at SFR may not operate unless there is adequate stop-loss protection, member satisfaction surveys, and satisfaction of disclosure requirements satisfying the Physician Incentive Program regulations.

Substantial financial risk occurs when the incentive arrangement places the provider/provider group at risk beyond the risk threshold, which is the maximum risk if the risk is based upon the use or cost of referral services. The risk threshold is set at 25% and does not include amounts based solely on factors other than a provider/provider group's referral levels. Bonuses, capitation, and referrals may be considered incentive arrangements that result in SFR.

If you have questions regarding the Physician Incentive Program regulations, please contact your Provider Partnership Manager.

MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS

Providers must comply with the rights of members as set forth below:

1. To participate with providers in making decisions about their healthcare. This includes working on any treatment plans and making care decisions. The member should know any possible risks, problems related to recovery, and the likelihood of success. The member shall not have any treatment without consent freely given by the member or the member's legally authorized surrogate decision-maker. The member must be informed of their care options.
2. To know who is approving and who is performing the procedures or treatment. All likely treatments and the nature of the problem should be explained clearly.
3. To receive the benefits for which the member has coverage.
4. To be treated with respect and dignity.
5. To privacy of their personal health information, consistent with state and federal laws, and WellCare of North Carolina policies.
6. To receive information or make recommendations, including changes, about WellCare of North Carolina 's organization and services, the WellCare of North Carolina network of providers, and member rights and responsibilities.
7. To candidly discuss with their providers appropriate and medically necessary care for their condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from the member's primary care provider about what might be wrong (to the level known), treatment, and any known likely results. The provider must tell the member about treatments that may or may not be covered by the plan, regardless of the cost. The member has a right to know about any costs they will need to pay. This should be told to the member in a way that the member can understand. When it is not appropriate to give the member information for medical reasons, the information can be given to a legally authorized person. The provider will ask for the member's approval for treatment unless there is an emergency and the member's life in danger.
8. To make recommendations regarding the WellCare of North Carolina member's rights, responsibilities, and policies.
9. To voice complaints or appeals about: WellCare of North Carolina, any benefit or coverage decisions WellCare of North Carolina makes, WellCare of North Carolina coverage, or the care provided.
10. To refuse treatment for any condition, illness, or disease without jeopardizing future treatment, and to be informed by the provider(s) of the medical consequences.
11. To see their medical records.
12. To be kept informed of covered and non-covered services, program changes, how to access services, primary care provider assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and other WellCare of North Carolina rules and guidelines. WellCare of North Carolina will notify members at least 60 days before the effective date of the modifications. Such notices shall include the following:

13. Any changes in clinical review criteria,
14. A statement of the effect of such changes on the personal liability of the member for the cost of any such changes.
15. To have access to a current list of network providers. Additionally, a member may access information on network providers' education, training, and practice.
16. To select a health plan or switch health plans, within the guidelines, without any threats or harassment.
17. To adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual orientation, national origin, or religion. Sex discrimination includes, but is not limited to, discrimination based on pregnancy, gender identity and sex stereotyping.
18. To access medically necessary urgent and emergency services 24 hours a day and seven days a week.
19. To receive information in a different format in compliance with the Americans with Disabilities Act if the member has a disability.
20. To refuse treatment to the extent the law allows. The member is responsible for their actions if treatment is refused or if the provider's instructions are not followed. The member should discuss all concerns about treatment with their primary care provider or other provider. The primary care provider or other provider must discuss different treatment plans with the member. The member must make the final decision.
21. To select a primary care provider within the network. The member has the right to change their primary care provider or request information on network providers close to their home or work.
22. To know the name and job title of people providing care to the member. The member also has the right to know which physician is their primary care provider.
23. To have access to an interpreter when the member does not speak or understand the language of the area.
24. To a second opinion by a network physician, at no cost to the member, if the member believes that the network provider is not authorizing the requested care, or if the member wants more information about their treatment.
25. To execute an advance directive for healthcare decisions. An advance directive will assist the primary care provider and other providers to understand the member's wishes about the member's healthcare. The advance directive will not take away the member's right to make their own decisions. Examples of advance directives include:

    a. Living Will

    b. Healthcare Power of Attorney

    c. "Do Not Resuscitate" Orders

    d. Members also have the right to refuse to make advance directives. Members may not be discriminated against for not having an advance directive.

MEMBER RESPONSIBILITIES

1. To read their WellCare of North Carolina contract in its entirety and understand to the best of their ability all materials concerning their health benefits or to ask for assistance if they need it.
2. To treat all health care professionals and staff with courtesy and respect.
3. To give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about their health. The member should make it known whether they clearly understand their care and what is expected of them. The member needs to ask questions of their provider, so they understand the care they are receiving.
4. To review and understand the information they receive about WellCare of North Carolina. The member needs to know the proper use of covered services.
5. To show their I.D. card and keep scheduled appointments with their provider and call the provider's office during office hours whenever possible if the member has a delay or cancellation.
6. To know the name of their assigned primary care provider. The member should establish a relationship with their primary care provider. The member may change their primary care provider verbally or in writing by contacting the WellCare of North Carolina Member Services Department.
7. To understand their health problems and participate, along with their health care providers in developing mutually agreed upon treatment goals to the degree possible.
8. To supply, to the extent possible, information that WellCare of North Carolina and/or their providers need to provide care.
9. To follow the treatment plans and instructions for care that they have agreed on with their health care providers.
10. To understand their health problems and tell their health care providers if they do not understand their treatment plan or what is expected of them. The member should work with their primary care provider to develop mutually agreed upon treatment goals. If the member does not follow the treatment plan, the member has the right to be advised of the likely results of their decision.
11. To follow all health benefit plan guidelines, provisions, policies, and procedures.
12. To use any emergency room only when they think they have a medical emergency. For all other care, the member should seek care at an Urgent Care Center or call their primary care provider.
13. To give all information about any other medical coverage they have at the time of enrollment. If, at any time, the member gains other medical coverage besides WellCare of North Carolina coverage, the member must provide this information to WellCare of North Carolina.
14. To pay their monthly premium, all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service.

PROVIDER RIGHTS AND RESPONSIBILITIES

PROVIDER RIGHTS

1. To be treated by their patients who are WellCare of North Carolina members and other healthcare workers with dignity and respect.

2. To receive accurate and complete information and medical histories for members' care.

3. To have their patients, who are WellCare of North Carolina members, act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.

4. To expect other network providers to act as partners in members' treatment plans.

5. To expect members to follow their health care instructions and directions, such as taking the right amount of medication at the right times.

6. To make a complaint or file an appeal against WellCare of North Carolina and/or a member.

7. To file a grievance on behalf of a member, with the member's consent.

8. To have access to information about WellCare of North Carolina quality improvement programs, including program goals, processes, and outcomes that relate to member care and services.

9. To contact Provider Services with any questions, comments, or problems.

10. To collaborate with other health care professionals who are involved in the care of members.

11. To not be excluded, penalized, or terminated from participating with WellCare of North Carolina for having developed or accumulated a substantial number of patients in WellCare of North Carolina with high-cost medical conditions.

12. To collect member copays, coinsurance, and deductibles at the time of the service.

PROVIDER RESPONSIBILITIES

Providers must comply with each of the items listed below.

1. To help or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
    a. Recommend new or experimental treatments,
    b. Provide information regarding the nature of treatment options,

2. Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered,
3. Be informed of risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options.
4. To treat members with fairness, dignity, and respect.
5. To not discriminate against members based on race, color, gender, national origin, limited language proficiency, religion, age, health status, existence of a pre-existing mental or physical disability/condition including pregnancy and/or hospitalization, the expectation for frequent or high-cost care.
6. To maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
7. To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice and scope of service.
8. To provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
9. To allow members to request restriction on the use and disclosure of their personal health information.
10. To provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.
11. To provide clear and complete information to members - in a language they can understand - about their health condition and treatment, regardless of cost or benefit coverage, and allow member participation in the decision-making process.
12. To tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.
13. To allow a member who refuses or requests to stop treatment the right to do so, if the member understands that by refusing or stopping treatment the condition may worsen or be fatal.
14. To respect members' advance directives and include these documents in their medical record.
15. To allow members to appoint a parent/guardian, family member, or other representative if they can't fully participate in their treatment decisions.
16. To allow members to obtain a second opinion, and answer members' questions about how to access health care services appropriately.
17. To follow all state and federal laws and regulations related to patient care and rights.
18. To participate in WellCare of North Carolina data collection initiatives, such as HEDIS® and other contractual or regulatory programs and allow use of provider performance data.
19. To review clinical practice guidelines distributed by WellCare of North Carolina.
20. To comply with the WellCare of North Carolina Medical Management program as outlined herein.
21. To disclose overpayments or improper payments to WellCare of North Carolina.
22. To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.

23. To obtain and report to WellCare of North Carolina information regarding other insurance coverage the member has or may have.
24. To give WellCare of North Carolina timely, written notice if provider is leaving/closing a practice.
25. To contact WellCare of North Carolina to verify member eligibility and benefits, if appropriate.
26. To invite member participation in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible.
27. To provide members with information regarding office location, hours of operation, accessibility, and translation services.
28. To object to providing relevant or medically necessary services based on the provider's moral or religious beliefs or other similar grounds.
29. To provide hours of operation to WellCare of North Carolina members which are no less than those offered to other commercial members.

CULTURAL COMPETENCY

WellCare of North Carolina views Cultural Competency as the measure of a person or organization's willingness and ability to learn about, understand, and provide excellent customer service across all segments of the population. It is the active implementation of a system-wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of health care delivery, Cultural Competency is the promotion of sensitivity to the needs of patients and incorporates cultural considerations that include, but are not limited to the following: race, ethnicity, primary language, age, geographic location, gender identity, sexual orientation, English proficiency, physical abilities/limitations, spiritual beliefs and practices, economic status, family roles, literacy, diverse populations. It accommodates the patient's culturally based attitudes, beliefs and needs within the framework of access to health care services and the development of diagnostic and treatment plans and communication methods to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions, and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

WellCare of North Carolina is committed to the development, strengthening, and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate care. Provider services should meet the unique needs of every enrollee regardless of race, ethnicity, culture, language proficiency, or disability. In all interactions, providers are expected to act in a manner that is sensitive to the ways in which the member experiences the world. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

As part of WellCare of North Carolina's Cultural Competency Program, providers must:

- Facilitate member access to Cultural and Linguistic Services, including Informing members of their right to access free, quality medical interpreters, and signers, accessible transportation, and TDD/TTY services. To support informing members of their right to access free language services, it is recommended that providers post nondiscrimination notices and language assistance taglines in lobbies and on websites. Language assistance taglines notify individuals of the availability of language assistance the top 15 languages utilized in the state as identified by the ACA 1557 and include at least one tagline in 18-point font.

- Provide medical care with consideration of the members' primary language, race ethnicity and culture

- Participate in cultural competency training annually and ensure that office staff routinely interacting with members have also been given the opportunity to participate in, and have participated in, cultural competency training

- Ensure that treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, gender identity, sexual orientation, and other characteristics that may influence the member's perspective on health care

- Ensure an appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public facility, or be subjected to discrimination by any such facility.

WellCare of North Carolina considers mainstreaming of members an important component of the delivery of care and expects providers to treat members without regard to race, color, creed, sex, gender identity, religion, age, national origin ancestry, marital status, sexual orientation, health status, income status, program membership, physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying covered service(s) to the member.

- Denying availability of a facility; and

- Providing an WellCare of North Carolina member a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay members (examples: separate waiting rooms, delayed appointment times).

For additional information regarding resources and trainings, visit:

- On the Office of Minority Health's website, you will find "A Physician's Practical Guide to Culturally Competent Care." By taking this course online, you can earn up to nine CME credits, or nine contact hours for free. The course may be found at: https://cccm.thinkculturalhealth.hhs.gov/

- Think Cultural Health's website includes classes, guides, and tools to assist you in providing culturally competent care. The website is: http://www.thinkculturalhealth.hhs.gov/

- The Health Care Literacy website which offers a toolkit as a way for primary care practices to assess their services for health literacy considerations, raise awareness of their entire staff, and work on specific areas. The toolkit can be found at http://www.ahrg.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-tookit/index.html

LANGUAGE SERVICES

In accordance with Title VI of the Civil Rights Act, Prohibition against national Origin Discriminations, the President's Executive Order 131166, section 1557 of the Patient Protection and Affordable care Act, The Health Plan and its providers must make language assistance available to persons with Limited English Proficiency

(LEP) at all points of contact during all hours of operation. Language services are available at no cost to WellCare of North Carolina members and providers without unreasonable delay at all medical points of contact. The member has the right to file a complaint or grievance if cultural and linguistic needs are not met.

Language services include:

- Telephonic interpretation
- Oral translation (reading of English material in a members preferred language)
- Face to Face non-English interpretation
- American Sign language
- Auxiliary aids including alternate formats such as large print and braille.
- Written translations for materials that are critical for obtaining health insurance coverage and access to health care services in non-English prevalent languages.

Information is deemed to be critical for obtaining health insurance coverage or access to health care services if the material is required by law or regulation to provide the document to an individual.

To obtain language services for a member, contact WellCare of North Carolina provider services. For Face to Face and American Sign Language requests, contact WellCare of North Carolina provider services as soon as possible, or at least 5 business days before the appointment. All providers (Medical, Behavioral, Pharmacy, etc.) can request language services by calling our Provider Customer Contact Center at: 1-833-925-2861 or TTY 711.

Restrictions Related to Interpretation or Facilitation of Communication

- Providers may not request or require an individual with limited English proficiency to provide their own interpreter.
- Providers may not rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency.
- Providers may not use an accompanying adult or minor child to interpreter or facilitate communication.

Exceptions to these expectations include:

- In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available.
- Accompanying adults (minors are excluded) where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances for minimal needs.

Providers are encouraged to document in the member's medical record any member denial of professional interpreters and the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.

Americans With Disabilities Act (ADA)

Title III of the ADA mandates that public accommodations, such as a Provider's office, be accessible to those with disabilities. The provisions of the ADA protect qualified individuals with a disability from:

- Exclusion from participation in the benefits of services, programs, or activities of a public entity.
- Denial of the benefits of services, programs, or activities of a public entity.
- Discrimination by any such entity. WellCare of North Carolina providers must provide physical access, accommodations, and accessible equipment for members with physical or mental disabilities as required by 42 CFR Section 438.206(c)(3).

Providers are required to comply with all federal and state disability access laws and regulations (including, but not limited to, the Medicaid/CHIP Managed Care final rule provisions noted above, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act). WellCare of North Carolina must inspect the office of any Provider who provides services on-site at the Provider's location and who seeks to participate in the Provider Network to determine whether the office is architecturally and programmatically accessible to persons with disabilities. Physical access," also referred to as "architectural access," refers to a person with a disability's ability to access buildings, structures, and the environment. "Programmatic access" refers to a person with a disability's ability to access goods, services, activities, and equipment.
If any disability access barriers are identified, the provider agrees, in writing, to remove the barrier to make the office, facility, or services accessible to persons with disabilities within one hundred eighty (180) days after WellCare of North Carolina has identified the barrier.

Providers are also required to:

- Provide Interpretation Services in all languages, including American and Mexican Sign Language, at all key points of contact through a variety of formats, including but not limited to an in-person interpreter upon a member's request; telephone, relay, or video remote interpreting 24 hours a day seven days a week; or through other formats, such as real-time captioning or augmentative & alternative communication devices, that ensure effective communication.
- Provide Member-Informing Materials (print documents, signage, and multimedia materials such as websites) translated into the currently identified threshold or concentration standard languages and provided through a variety of other means. This may include but not be limited to oral interpretation for other languages upon request; accessible formats (e.g., documents in Braille, large print, audio format, or websites with captioned videos and/or ASL versions) upon request; and easy-to-understand materials provided in a manner that takes into account different levels of health literacy.

- Provide Reasonable Accommodations that facilitate access for Members. This includes but is not limited to accessible: medical care facilities, diagnostic equipment, and examination tables & scales; and modification of policies, practices, and procedures (e.g., modify policies to permit the use of service animals or to minimize distractions and stimuli for Members with mental health or developmental disabilities).

- Inform Members of the availability of these cultural, linguistic, and disability access services at no cost to Members on brochures, newsletters, outreach and marketing materials, other materials that are routinely disseminated to Members, and at Member orientation sessions and sites where Members receive covered services.

    - WellCare of North Carolina and participating providers shall also facilitate access to these services and document a request and/or refusal of services in CRM or the provider's member data system.

- Call your Provider Relations Representative at 1-833-925-2861 (TDD/TTY: 711) for more information.

Important Points to Remember

Word Choice: Avoid words with negative connotations like "handicapped", "afflicted", "crippled", "victim", "sufferer", etc. Do not refer to individuals by their disability. A person is not a condition.

- Emphasize "person first" terminology:
    - Handicapped = A PERSON with a disability
    - Deaf = A PERSON who is deaf
    - Mute = A PERSON without speech
    - Confined/Wheelchair-Bound = A PERSON who uses a wheelchair
- If you happen to not have a disability currently in your life, that DOES NOT make you "normal" or "able-bodied". It makes you "non-disabled".

Call your Provider Relations Representative at 1-833-925-2861 for more information.

The term "disability" means, with respect to an individual -

Disability is any substantial limitation of one or more of a person's daily life activities and may be present from birth or may occur during a person's lifetime. Any individual meeting any of these conditions is an individual with a disability for purposes of coverage under the Americans with Disabilities Act.

Programmatic access to healthcare means that policies and practices that are part of the delivery of healthcare do not hinder the ability of members with disabilities to receive the same quality of care as other persons.

Common Methods to Ensure Equal Communication and Access to Information:

1. Provisions for intake forms to be completed by persons who are blind or with a low visual disability with the same confidentiality afforded other members.
    a. Use of large print forms, electronic or online web-based forms, or in-person staff assistance in a private location
2. Provision for a presence of sign language interpreters to enable full communication with deaf or hard of hearing members who use sign language.
3. Provision for making auditory information (e.g., automated messages) available via alternative means.
    a. Written communication or secure web-based methods may be used as possible substitutes.
4. Provision for communicating with deaf or hard of hearing members by telephone.
    a. Use of telephone relay services (TRS), video relay services (VRS), a TDD, or use of secure electronic means

Policies for Scheduling and Waiting for Appointments

1. Policies that allow scheduling additional time for the duration of appointments for members with disabilities who may require it.
2. Members may require more time than the standard because of multiple complexities. More time may be needed to conduct the examination or for communication through an interpreter as well as other communication issues.
3. Policies to enable members who may not be able to tolerate waiting in a reception area to be seen immediately upon arrival.
4. Members with cognitive, intellectual, or some psychiatric disability may be unable to wait in a crowded reception area without becoming agitated or anxious.
5. Policies to allow flexibility in appointment times for members who use paratransit.
6. Members may arrive late at appointments because of delays or other problems with paratransit scheduling or reliability.
7. Policies to enable compliance with federal law that guarantees access to provider offices for people with disabilities who use service animals.
8. Members with service animals expect the animal to accompany them into the waiting and examination rooms. This is protected under the Americans with Disabilities Act. This policy statement simply prepares staff to respond accordingly.

Policies for Conducting the Examination

1. Training of healthcare providers in operation of accessible equipment
2. Staff must know how to operate accessible equipment, such as adjustable height exam tables and scales so they can be regularly and easily utilized.

Policies for Follow-up or Referral

1. Current or potential members including people with disabilities should only be referred to another provider for established medical reasons or specialized expertise.
2. Referrals result in a delay of treatment and subject members to additional time, expenses, and reduce the member's choice of providers.
3. Knowledge and/or attention to the accessibility of laboratories, testing facilities, specialists, or other healthcare delivery venues to which members are referred.
4. Members may be unable to comply with medical referrals if referred location is not accessible and/or not prepared to provide the recommended service.

GENERAL PROHIBITIONS AGAINST DISCRIMINATION

Except as may be otherwise provided by applicable law, the following prohibitions against discrimination binding upon public entities also apply to Providers:

- No qualified individual with a disability shall, based on disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.

- A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, based on disability.

- Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service.

- Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others.

- Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others.

- Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others.

- Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates because of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program.

- Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards.

- Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, WellCare of North Carolina, or opportunity enjoyed by others receiving the aid, benefit, or service.

- A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.

- A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:

- That have the effect of subjecting qualified individuals with disabilities to discrimination because of disability.
- That have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or
- That perpetuate the discrimination of another public entity if both public entities are subject to common administrative control and are agencies of the same State.

- A public entity may not, in determining the site or location of a facility, make selections:
  - That have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or
  - That have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, program, or activity with respect to individuals with disabilities.
- A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination because of disability.
- A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination because of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination because of disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.
- A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination because of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.
- A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.
- Nothing in this part prohibits a public entity from providing benefits, services, or advantages to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.
- A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

- Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such individual chooses not to accept.

- Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.

- A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, which are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.

- A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

- Providers must ensure their websites meet compliance with Section 508 Accessibility Standards. Section 508 is a federal law that requires agencies to provide people with disabilities equal access to electronic information and data comparable to those who do not have disabilities.

PROVIDER ACCESSIBILITY INITIATIVE

WellCare of North Carolina is committed to providing equal access to quality health care and services that are physically and programmatically accessible for our members with disabilities. In May of 2017, our parent company, Centene, launched a Provider Accessibility Initiative (PAI) to increase the percentage of Centene's providers that meet minimum federal and state disability access standards. One of the goals of the PAI is to improve the accuracy, completeness, and transparency of provider self-reported disability access data in Provider Directories so that members with disabilities have the most accurate, accessible, and up-to-date information possible related to a provider's disability access. To accomplish this, providers are asked to complete a self-report of disability access that will be verified by WellCare of North Carolina through an onsite Accessibility Site Review (ASR).

WellCare of North Carolina's expectation, as communicated through the provider contract, is full compliance with all federal and state disability access laws and regulations (including, but not limited to, the Medicaid/CHIP Managed Care final rule provisions, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act). "Minimum accessibility," as defined in the ASR Tool, is not to be confused with, nor is intended to replace, the obligation of full compliance with all federal and state disability access laws and regulations, which remains the legal responsibility of WellCare of North Carolina providers.

988 SUICIDE & CRISIS LIFELINE

In 2020, Congress designated the new 988 dialing code to operate through the existing National Suicide Prevention Lifeline. The Substance Abuse and Mental Health Services Administration (SAMHSA) is the lead federal agency, in partnership with the Federal Communications Commission and the Department of Veterans Affairs, working to make the promise of 988 a reality for America. Moving to a 3-digit dialing code is a once-in-a-lifetime opportunity to strengthen and expand the existing National Suicide Prevention Lifeline (the Lifeline). Of course, 988 is more than just an easy-to-remember number. It is a direct connection to compassionate, accessible care and support for anyone experiencing mental health related distress – whether that is thoughts of suicide, mental health or substance use crisis, or any other kind of emotional distress. SAMHSA is first focused on strengthening and expanding the existing Lifeline network, providing life-saving service to all who call, text or chat via 988. Longer term, SAMHSA recognizes that linking those in crisis to community-based providers—who can deliver a full range of crisis care services— requires a bold vision for a crisis care system that provides direct, life-saving services to all in need. SAMHSA sees 988 as a first step towards a transformed crisis care system in much the same way as emergency medical services have expanded in the US.

FREQUENTLY ASKED QUESTIONS

What is the Lifeline and will 988 replace it?

The Lifeline is a national network of over two hundred local, independent, and state-funded crisis centers equipped to help people in emotional distress or experiencing a suicidal crisis. Moving to 988 will not replace the Lifeline, rather it will be an easier way to access a strengthened and expanded network of crisis call centers. People can access the Lifeline via 988 or by the 10-digit number (which will not go away).

When will 988 go live nationally?

The 988 dialing codes were available nationwide for call (multiple languages), text or chat (English only) on July 16, 2022. Those experiencing a mental health or suicide-related crisis, or those helping a loved one through crisis, can continue to reach the Lifeline at its current number, 1-800-273-8255.

How is 988 different from 911?

988 was established to improve access to crisis services in a way that meets our country's growing suicide and mental health related crisis care needs. 988 will provide easier access to the Lifeline network and related crisis resources, which are distinct from 911 (where the focus is on dispatching Emergency Medical Services, fire and police as needed).

How is 988 being funded?

Congress has provided the Department of Health and Human Services workforce funding through the American Rescue Plan, some of which will support the 988 workforce. At the state level, in addition to existing public/private sector funding streams, the National Suicide Hotline Designation Act of 2020 allows states to enact new state telecommunication fees to help support 988 operations.

Is 988 available for substance use crisis?

The Lifeline accepts calls from anyone who needs support for a suicidal, mental health and/or substance use crisis.

QUALITY IMPROVEMENT PLAN

OVERVIEW

WellCare of North Carolina's culture, systems, and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality improvement initiatives applying reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of healthcare provided to all members, including those with special needs. This system provides a continuous cycle for assessing the level of care and service among health plan initiatives, including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions. WellCare of North Carolina requires all practitioners and providers to cooperate with all quality improvement activities and allow WellCare of North Carolina to use practitioner and/or provider performance data to ensure success of the QAPI Program.

WellCare of North Carolina is accredited by the National Committee for Quality Assurance (NCQA), an independent, nonprofit organization dedicated to improving health care quality. The NCQA seal is a widely recognized symbol of quality. NCQA Health Plan Accreditation surveys include rigorous on-site and off-site evaluation of standards, with a national oversight committee of physicians who analyze the survey team's findings and assign an accreditation level based on the performance level of each health plan as evaluated against NCQA's standards. This recognition is the result of WellCare of North Carolina's long-standing dedication to provide quality health care service and programs to our members.

WellCare of North Carolina promotes the delivery of appropriate care with the primary goal to improve the health status of its members. Where the member's condition is not amenable to improvement, WellCare of North Carolina implements measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This includes the identification of members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions. Whenever possible, the WellCare of North Carolina QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

QAPI Program Structure

The WellCare of North Carolina Board of Directors has the ultimate oversight for the care and service provided to members. The Board of Directors oversees the QAPI Program and has established various committees and ad-hoc committees to monitor and support the QAPI Program.

The Quality Improvement Committee (QIC) is a senior management committee with physician representation that is directly accountable to the Board of Directors. The primary purpose of the QIC is:

- to enhance and improve quality of care.

- to provide oversight and direction regarding policies, procedures, and protocols for member care and services; and

- to offer guidelines based on recommendations for appropriateness of care and services.

This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process issues; the identification of opportunities to improve member outcomes; and the education of members, providers, and staff regarding the Quality Improvement, Utilization Management, Pharmacy and Credentialing Programs.

The following standard sub-committees report directly to the QIC:

- Credentialing Committee

- Utilization Management Committee

- Performance Improvement Team

- HEDIS® Steering Committee

- Pharmacy and Therapeutics Committee

- Delegate Vendor Oversight/Joint Operations Committee

- Peer Review Committee (ad hoc)

- Subcommittees may also include a Grievance and Appeals Committee, Cultural Competence Committee, Member Advisory Committee, Physician Advisory Committee, Hospital Advisory Committee, and the Community Advisory Committee, based on health plan needs and state requirements.

Practitioner Involvement

WellCare of North Carolina recognizes the integral role practitioner plays in the success of the QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through network provider representation. WellCare of North Carolina encourages primary care, behavioral health, specialty, and OB/GYN representation on key quality committees such as, but not limited to, the QIC, Credentialing Committee, and select ad-hoc committees.

Network practitioners and providers are contractually required to cooperate with all quality improvement activities to improve the quality of care and services and member experience. This includes the collection and evaluation of performance data and participation in WellCare of North Carolina's QI programs and use of performance data for quality improvement activities.

Quality Assessment and Performance Improvement Program Scope and Goals

The scope of the QAPI Program is comprehensive and addresses both the level of clinical care and the level of service provided to WellCare of North Carolina members. The WellCare of North Carolina QAPI Program incorporates all demographic groups and ages, benefit packages, care settings, providers, and services in quality improvement activities. This includes services for the following: preventive care, primary care, specialty care, acute care, short-term care, long-term care, ancillary services, and operations, among others.

To that end, the WellCare of North Carolina QAPI Program scope encompasses the following:

- Acute and chronic care management
- Behavioral health care
- Compliance with member confidentiality laws and regulation
- Compliance with preventive health guidelines and clinical practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency
- Marketing practices
- Member enrollment and disenrollment
- Member grievance system
- Member experience
- Patient safety
- Primary care provider changes
- Pharmacy
- Provider and plan after-hours telephone accessibility

- Provider appointment availability
- Provider Complaint System
- Provider network adequacy and capacity
- Provider experience
- Selection and retention of providers (credentialing and recredentialing)
- Utilization of services, including under-and over-utilization

WellCare of North Carolina's primary quality improvement goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

Quality improvement **goals** include but are not limited to the following:

- A high level of health status and quality of life will be experienced by WellCare of North Carolina members.
- Network quality of care and service will meet industry-accepted standards of performance.
- WellCare of North Carolina services will meet industry-accepted standards of performance.
- Fragmentation and/or duplications of services will be minimized through integration of quality improvement activities across plan functional areas.
- Member satisfaction will meet the plan's established performance targets.
- Preventive and clinical practice guideline compliance will meet established performance targets. This includes, but is not limited to, compliance with immunizations, prenatal care, diabetes, asthma, early detection of chronic kidney disease and well child visits.
- Compliance with all applicable regulatory requirements and accreditation standards will be maintained.

WellCare of North Carolina's QAPI Program **objectives** include, but are not limited to, the following:

- To establish and maintain a health system that promotes continuous quality improvement.
- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice
- To select areas of study based on demonstration of need and relevance to the population served.
- To develop standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time.

- To utilize management information systems in data collection, integration, tracking, analysis, and reporting of data that reflects performance on standardized measures of health outcomes.
- To allocate personnel and resources necessary to:
    - support the QAPI Program, including data analysis and reporting.
    - meet the educational needs of members, providers, and staff relevant to quality improvement efforts.
- To seek input and work with members, providers, and community resources to improve quality of care
- To oversee peer review procedures that will address deviations in medical management and health care practices, and devise action plans to improve services.
- To establish a system to provide frequent, periodic quality improvement information to participating providers to support them in their efforts to provide high quality health care.
- To recommend and institute "focused" quality studies in clinical and non-clinical areas, where appropriate
- To conduct and report annual QHP/CAHPS surveys and certified HEDIS® results for WellCare of North Carolina members.
- To achieve and maintain NCQA accreditation.
- To monitor for ongoing compliance with regulatory and NCQA requirements

Practice Guidelines

Evidence based preventive health and clinical practice guidelines are provided to assist providers in making decisions regarding health care in specific clinical situations. Guidelines are adopted from national recognized sources, in consultation with network providers (including behavioral health as indicated) and based on the health needs and opportunities for improvement identified as part of the QAPI Program, valid and reliable clinical evidence, or a consensus of health care professionals in the field and needs of the members.

Preventive health and clinical practice guidelines are reviewed annually and updated upon significant new scientific evidence or change in national standards or at least every two years. WellCare of North Carolina distributes updated guidelines to all affected providers and makes all current preventive health and clinical practice guidelines available online via the WellCare of North Carolina website and/or secure provider portal.

A complete listing of approved preventive health and clinical practice guidelines is available at marketplace.wellcarenc.com.

Patient Safety and Quality of Care

Patient safety is a key focus of the WellCare of North Carolina QAPI Program. Monitoring and promoting patient safety is integrated throughout activities across the health plan, primarily through identification of potential

and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care, or that signals a potential sentinel event, up to and including death of a member. WellCare of North Carolina employees (including medical management staff, member services staff, provider services, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors, or the Board of Directors may advise the QI Department of potential quality of care issues. Adverse events may also be identified through claims-based reporting and analyses. A potential quality of care issue requires investigation of the factors surrounding the event to decide of the severity and need for corrective action up to and including review by an WellCare of North Carolina Medical Director or the Peer Review Committee, as indicated. Potential quality of care issues are tracked and monitored for trends in occurrences, regardless of their outcome or severity level.

Performance Improvement Process

The WellCare of North Carolina QIC reviews and adopts an annual QAPI Program Description and Work Plan based on managed care appropriate industry and accreditation standards. The QIC adopts traditional quality/risk/utilization management approaches to identify problems, issues, and trends with the objective of developing and implementing improvement opportunities. Initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving health outcomes or service standards.

Performance improvement projects, focus studies, and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and level of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow WellCare of North Carolina to monitor improvement over time.

Annually, WellCare of North Carolina completes an evaluation of the QAPI Program and develops a QAPI Work Plan for the upcoming year based on the evaluation. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The Work Plan integrates QIC activities, reporting, and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

WellCare of North Carolina providers may request additional information on the health plan programs, including a description of the QAPI Program and a report on WellCare of North Carolina's progress in meeting QAPI Program goals, by contacting the QI Department.

QUALITY RATING SYSTEM

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS® is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows comparison across health plans. HEDIS® gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences.

As Federal and State governments move toward a health care industry that is driven by quality, HEDIS® rates are becoming more and more important, not only to the health plan, but to the individual provider. Purchasers of health care may use the aggregated HEDIS® rates to evaluate the effectiveness of a health insurance company's ability to demonstrate the clinical management of its members. Physician-specific scores are being used as evidence of preventive care from primary care office practices.

HEDIS® Rate Calculations

HEDIS® rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include annual mammogram, annual chlamydia screening, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and behavioral health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT, ICD-10,and HCPCS codes can reduce the necessity of medical record reviews (see the marketplace.wellcarenc.com and HEDIS® brochure (posted on marketplace.wellcarenc.com) for more information on reducing HEDIS® medical record reviews)**.** HEDIS® measures typically requiring medical record review include childhood immunizations, well child visits, diabetic HbA1c values, LDL, eye exam and nephropathy, controlling high-blood pressure, cervical cancer screening, and prenatal care and postpartum care.

Who Conducts Medical Record Reviews (MRR) for HEDIS®?

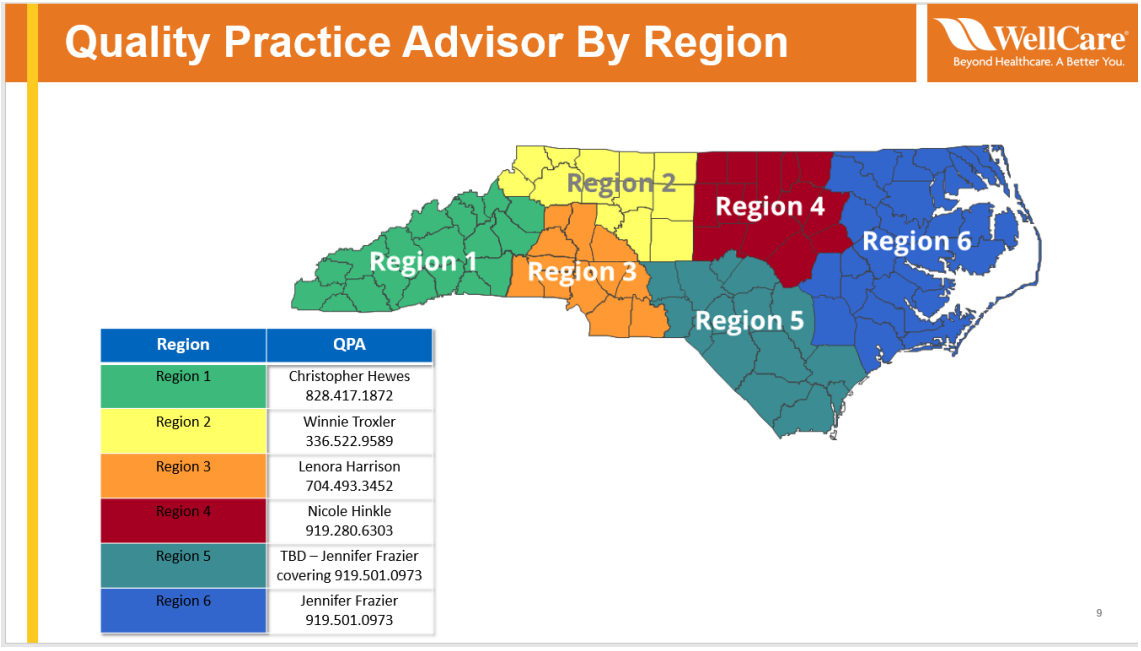
WellCare of North Carolina may contract with an independent national MRR vendor to conduct the HEDIS® MRR on its behalf. Medical record review audits for HEDIS® are conducted on an ongoing basis with a particular focus from January through May each year. At that time, a sample of your patient's medical records may be selected for review; you will receive a call and/or a letter from a medical record review representative. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, sharing of protected health information (PHI) that is used or disclosed for purposes of treatment, payment, or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with WellCare of North Carolina, which allows them to collect PHI on our behalf.

How can providers improve their HEDIS® scores?

- ***Understand the specifications*** established for each HEDIS® measure.
- ***Submit claims and encounter data for each and every service rendered.*** All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with WellCare of North Carolina. Claims and encounter data is the most clean and efficient way to report HEDIS®.
- ***Submit claims and encounter data correctly, accurately, and on time.*** If services rendered are not filed or billed accurately, then they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS® rate calculation.
- ***Ensure chart documentation reflects all services provided.*** Keep accurate chart/medical record documentation of each member service, and document conversation/services.
- ***Submit claims and encounter data using CPT codes related to HEDIS®*** measures such as diabetes, eye exam, and blood pressure, where appropriate.

If you have any questions, comments, or concerns related to the annual HEDIS® project or medical record reviews, please contact the Quality Improvement Department by phone number(s) pictured below:



PROVIDER SATISFACTION SURVEY

WellCare of North Carolina conducts an annual provider satisfaction survey, which includes questions to evaluate the provider experience our services such as claims, communications, utilization management, and provider services. Behavioral health providers receive a provider survey specific to the provision of behavioral health services in the WellCare of North Carolina network. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by WellCare of North Carolina. If selected by the vendor, we encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related quality improvement initiatives.

QUALIFIED HEALTH PLAN (QHP) ENROLLEE SURVEY

The QHP Enrollee survey is a tool that measures the member experience and is integral to support CMS's ongoing administration of the Health Insurance Marketplace as well as a requirement for NCQA accreditation. It is a standardized survey administered annually to members by an NCQA-certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services. It gives a general indication of how well the plan is meeting the members' expectations. Member responses to the QHP survey are used in various aspects of the quality program, including, but not limited to, monitoring member perception of practitioner access and availability and care coordination. This survey is similar to the NCQA survey tool CAHPS (Consumer Assessment of Healthcare Provider Systems) used for other lines of business. Members receiving behavioral health services have the opportunity to respond to the Experience of Care Health Outcomes (ECHO) survey to provide feedback and input into the quality oversight of the behavioral health program.

PROVIDER PERFORMANCE MONITORING AND INCENTIVE PROGRAMS

It is nationally recognized that pay-for-performance (P4P) programs, which include provider profiling, are a promising strategy to improve the level and cost-effectiveness of care. WellCare of North Carolina will manage a provider performance monitoring program to capture data relating to healthcare access, costs, and level of care that WellCare of North Carolina members receive.

The WellCare of North Carolina Provider Profiling Program is designed to analyze utilization data to identify provider utilization and care issues. WellCare of North Carolina will use provider profiling data to identify opportunities to improve communications to providers regarding preventive health and clinical practice guidelines. Provider profiling is a highly effective tool that compares individual provider practices to normative data, so that providers can improve their practice patterns, processes, and level of care in alignment with evidence-based clinical practice guidelines. The WellCare of North Carolina Program and Provider Overview Reports will increase provider awareness of performance, identify opportunities for improvement, and facilitate plan-provider collaboration in the development of clinical improvement initiatives. WellCare of North Carolina's Profiling Program incorporates the latest advances in this evolving area.

Process For Submitting Medical Records

WellCare of North Carolina requires members' medical record data for a wide variety of operational and analytical processes that help to improve quality, reduce risk, and lower costs of care for the members being served. These processes include but are not limited to quality (e.g., HEDIS®) and risk adjustment data tracking, clinical and population health stratification and prioritization, investigation of potential quality of care concerns, and continuity of care and care planning purposes. In addition, WellCare of North Carolina requires medical record data relating to its members for purposes of complying with a wide array of regulatory and statutory data reporting requirements. Making these data available to WellCare of North Carolina in the form of Electronic Medical Record (EMR) data reduces costs for both the provider and WellCare of North Carolina.

At WellCare of North Carolina's request, Provider will make commercially reasonable efforts to make EMR data relating to WellCare of North Carolina's members available and accessible to WellCare of North Carolina within a reasonable time frame requested by WellCare of North Carolina via: 1) electronic access to APIs (Application Programming Interfaces), 2) use of HL7 and FHIR data transfer protocols, and/or 3) data-formatted content delivered via Continuity of Care Document (CCD) data specifications. Alternatively, at WellCare of North Carolina's request or authorization, Provider may provide EMR data to WellCare of North Carolina by other means, including but not limited to text file, image, or PDF, which may be transferred through SFTP (Secured File Transfer Protocol) or available for download via a secure web portal.

WellCare of North Carolina reserves the right to assess a penalty of up to $30.00 per unmet medical record request on providers that fail to provide medical records as reasonably requested by Health Plan.

REGULATORY MATTERS

MEDICAL RECORDS

WellCare of North Carolina providers must keep accurate and complete patient medical records which are consistent with 45 CFR 156, financial, and other records pertinent to WellCare of North Carolina members. Such records enable providers to render the most appropriate level of health care service to members. They will also enable WellCare of North Carolina to review the level and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. WellCare of North Carolina requires providers to maintain all records for members for at least 10 years after the final date of service, unless a longer period is required by applicable state law.

Required Information

To be considered a complete and comprehensive medical record, the member's medical record (file) should include, at a minimum: provider notes regarding examinations, office visits, referrals made, tests ordered, and results of diagnostic tests ordered (i.e., x-rays, laboratory tests). Medical records should be accessible at the site of the member's participating primary care provider. All medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, should be documented, and prepared in accordance with all applicable state rules and regulations and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the standards set forth below:

- Member's name, and/or medical record number must be on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance must be included.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.

- An up-to-date immunization record is established for pediatric members, or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with WellCare of North Carolina practice guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed, including instructions to the member.
- Documentation of prenatal risk assessment for pregnant members or infant risk assessment for newborns.
- Signed and dated required consent forms are included.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate are documented.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review.
- Referrals to specialists and ancillary providers are documented, including follow up of outcomes and summaries of treatment rendered elsewhere, including family planning services, preventive services, and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- For members 10 years and over, appropriate notations concerning use of tobacco, alcohol, and substance use (for members seen three or more times substance abuse history should be queried).

- Documentation of failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months, or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of member information and records are protected.
- Evidence that an advance directive has been offered to adults 18 years of age and older.

Access to Records and Audits by WellCare of North Carolina

Subject only to applicable state and federal confidentiality or privacy laws, the provider shall permit WellCare of North Carolina or its designated representative access to provider's records, at provider's place of business in this state during normal business hours, or remote access of such records, to audit, inspect, review, perform chart reviews, and duplicate such records. If performed on site, access to records for the purpose of an audit shall be scheduled at mutually agreed upon times, upon at least 30 business days prior written notice by WellCare of North Carolina or its designated representative, but not more than 60 days following such written notice.

EMR Access

Providers will grant WellCare of North Carolina access to the provider's Electronic Medical Record (EMR) system to effectively case manage members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to the WellCare of North Carolina for this access.

Medical Records Release

All member medical records are confidential and must not be released without the written authorization of the member or their parent/legal guardian, in accordance with state and federal law and regulation. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

All release of specific clinical or medical records for substance use disorders must meet federal guidelines at 42 CFR Part 2 and any applicable state laws.

Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned WellCare of North Carolina members. If the member or member's parent/legal guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, then this should also be noted in the medical record.

The release of certain information is governed by a myriad of federal and/or state laws.

These laws often place restrictions on how specific types of information may be disclosed, including, but not limited to, behavioral health, alcohol /substance abuse treatment, and communicable disease records.

For example, HIPAA requires that covered entities, such as health plans and providers, release protected health information only when permitted under the law, such as for treatment, payment, and operations activities, including care management and coordination.

However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance abuse treatment records (42 CFR Part 2 or "Part 2"). These records generally may not be released without consent from the individual whose information is subject to the release.

Still other laws at the state level place further restrictions on the release of certain information, such as behavioral health, communicable disease, etc.

For more information about any of these laws, refer to the following:

- HIPAA - please visit the Centers for Medicare & Medicaid Services (CMS) website at: www.cms.hhs.gov, and then select "Regulations and Guidance" and "HIPAA – General Information;"
- 42 CFR Part 2 regulations - please visit the Substance Abuse and Mental Health Services Administration (within the U.S. Department of Health and Human Services) at: www.samhsa.gov;
- State laws - consult applicable statutes to determine how they may impact the release of information on patients whose care you provide.

Contracted providers within the WellCare of North Carolina network are independently obligated to know, understand, and comply with these laws.

WellCare of North Carolina takes privacy and confidentiality seriously. We have established processes, policies,
and procedures to comply with HIPAA and other applicable federal and/or State confidentiality and privacy laws.

Please contact the WellCare of North Carolina Compliance Officer by phone at 1-866-678-8355 or in writing (refer to address below) with any questions about our privacy practices.

WellCare of North Carolina
P.O. Box 25408
Little Rock, AR 72221

NON-DISCRIMINATION NOTICE

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination because of race, color, national origin, sex, age, or disability in certain health programs or activities. Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in:

- Any health program or activity any part of which received funding from HHS.
- Any health program or activity that HHS itself administers.
- Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces.

For more information, please visit www.hhs.gov/civil-rights/for-individuals/section-1557/index.html.

APPENDIX

APPENDIX I: COMMON CAUSES FOR UPFRONT REJECTIONS

Common causes for upfront rejections include but are not limited to:

- Unreadable Information - The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), the font is too small.
- Member Date of Birth is missing.
- Member Name or Identification Number is missing.
- Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) Number is missing.
- Attending Provider information missing from Loop 2310A on Institutional claims when CLM05-1 (Bill Type) is 11, 12, 21, 22, or 72 or missing from box 48 on the paper UB claim form.
- Date of Service is not prior to the received date of the claim (future date of service).
- Date of Service or Date Span is missing from required fields. Example: "Statement From" or “Service From" dates.
- Type of Bill is invalid.
- Diagnosis Code is missing, invalid, or incomplete.
- Service Line Detail is missing.
- Date of Service is prior to member’s effective date.
- Admission Type is missing (Inpatient Facility Claims – CMS 1450 (UB-04), field 14).
- Patient Status is missing (Inpatient Facility Claims – CMS 1450 (UB-04), field 17).
- Occurrence Code/Date is missing or invalid.
- Revenue Code is missing or invalid.
- CPT/Procedure Code is missing or invalid.
- A missing CLIA Number in Box 23 or a CMS 1500 for CLIA or CLIA waived service.

- Incorrect Form Type used.
- A missing taxonomy code and qualifier in box 24 I, 24 J, or Box 33b on the CMS 1500 form or Box 81 CC on the CMS 1450 (UB04) form (see further requirements in this Manual).

APPENDIX II: COMMON CAUSE OF CLAIMS PROCESSING DELAYS AND DENIALS

- Procedure or Modifier Codes entered are invalid or missing including GN, GO, or BP modifier for therapy services.
- Diagnosis Code is missing the 4th or 5th digit.
- DRG code is missing or invalid.
- Explanation of Benefits (EOB) from the primary insurer is missing or incomplete.
- Third Party Liability (TPL) information is missing or incomplete.
- Member ID is invalid.
- Place of Service Code is invalid.
- Provider TIN and NPI do not match.
- Revenue Code is invalid.
- Dates of Service span do not match the listed days/units.
- Tax Identification Number (TIN) is invalid.

APPENDIX III: COMMON EOP DENIAL CODES AND DESCRIPTIONS

See the bottom of your paper EOP for the updated and complete description of all explanation codes associated with your claims. Electronic Explanations of Payment will use standard HIPAA denial codes.

EX Code	Description
18	DENY: DUPLICATE CLAIM SERVICE
28	DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED
29	DENY: THE TIME LIMIT FOR FILING HAS EXPIRED
46	DENY: THIS SERVICE IS NOT COVERED
OB	ADJUST: CLAIM TO BE RE-PROCESSED CORRECTED UNDER NEW CLAIM NUMBER
A1	DENY: NO AUTHORIZATION ON FILE THAT MATCHES SERVICE(S) BILLED

AB	ACE LINE-ITEM REJECTION
AQ	ACE CLAIM LEVEL RETURN TO PROV. MUST CALL PROV SERVICES FOR MORE DETAIL
AT	ACE CLAIM LEVEL REJECTION
fq	DENY: RESUBMIT CLAIM UNDER FQHC RHC CLINIC NPI NUMBER
IM	DENY: MODIFIER MISSING OR INVALID
M3	DENY: NO ASSOCIATED FACILITY CLAIM RECEIVED
w1	Co-surgeon/team surgeon disallowed per CMS surgical billing guidelines
w2	Assistant & primary surgeon procedure codes must match per CMS
w3	Assistant, co-surgeon, or team surgeons not typically required per CMS
w4	Inappropriate level of E/M service billed per AMA guidelines
w5	Primary service is denied; therefore, add-on service is denied per AMA
w6	State-Specific Guideline: Procedure code to Revenue code mismatch
x3	PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE
x8	MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED
x9	PROCEDURE CODE PAIRS INCIDENTAL, MUTUALLY EXCLUSIVE OR UNBUNDLED
xE	Procedure code is disallowed with this diagnosis code(s) per plan policy
xf	MAXIMUM ALLOWANCE EXCEEDED
y1	DENY: SERVICE RENDERED BY NON-AUTHORIZED NON PLAN PROVIDER
ya	DENIED AFTER REVIEW OF PATIENT'S CLAIM HISTORY
yf	HCI partially approved units; Claim needs manual pricing
yq	Duplicate claims or multiple providers billing same/similar code(s)
yr	Incorrect procedure code for diagnosis per NCD/CMS
ys	Reimbursement included in another code per CMS/AMA/Medical Guidelines
yt	Incorrect Procedure code for member age or gender per CMS/AMA/Plan
yu	Incorrect CPT/HCPCS/REV/Modifier or unlisted code based on CPT/CMS guidelines
yv	Outpatient services included in inpatient admit per CMS/Plan Guidelines
yw	Not covered or eligible service per CMS or Plan Guidelines
yx	Included in global surgical or maternity package per CMS or ACOG
yy	Reimbursement reduction based on CPT and/or CMS
yz	Incorrect use of modifier -26 or -TC based on CMS
Za	DENY - PROVIDER BILLING ERROR
ZW	After review, previous decision upheld; See provider handbook for appeal process

APPENDIX IV: INSTRUCTIONS FOR SUPPLEMENTAL INFORMATION

CMS 1500 (02/12) FORM, SHADED FIELD 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (02/12) Claim Form field 24-A-G:

- National Drug Code (NDC)
- Narrative description of unspecified/miscellaneous/unlisted codes
- Contract Rate

The following qualifiers are to be used when reporting these services:

- ZZ Narrative description of unspecified/miscellaneous/unlisted codes
- N4 National Drug Code (NDC)
- CTR Contract Rate

If required to report other supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

More than one supplemental item can be reported in the shaded lines of item number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

For reporting dollar amounts in the shaded area, always enter the dollar amount, a decimal point, and the cents. Use 00 for cents if the amount is a whole number. Do not use commas. Do not enter dollars signs (ex. 1000.00; 123.45).

Additional Information for Reporting NDC:

When adding supplemental information for NDC, enter the information in the following order:

- Qualifier
- NDC Code
- One space

- Unit/basis of measurement qualifier

- F2- International Unit
- ME – Milligram
- UN – Unit
- GR – Gram

- ML - Milliliter
- Quantity
- The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal (ex. 99999999.999).
- When entering a whole number, do not use a decimal.
- Do not use commas.

Unspecified/Miscellaneous/Unlisted Codes

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZLaparoscopic Ventral Hernia Repair Op Note Attached															
														NPI	

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZKaye Walker													N	G2	12345678901
10	01	05	10	01	05	11		E1399		12	165 00	1	N	NPI	0123456789

NDC Codes

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N459148001665 UN1													N	G2	12345678901
10	01	05	10	01	05	11		J0400		1	250 00	40	N	NPI	0123456789

APPENDIX V: COMMON BUSINESS EDI REJECTION CODES

The codes on the following page are the Standard National Rejection Codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted.

Error ID	Error Description
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Prv
07	Invalid Mbr DOB & Prv
08	Invalid Mbr & Prv
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Prv not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17	Invalid Diag
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS; Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS
23	Invalid Prv; Invalid Diag
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag
25	Invalid Mbr; Invalid Prv; Invalid Diag
26	Mbr not valid at DOS; Invalid Diag
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag
29	Prv not valid at DOS; Invalid Diag
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag
32	Mbr not valid at DOS; Prv not valid; Invalid Diag
33	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid; Invalid Diag
34	Invalid Proc
35	Invalid DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
37	Invalid or future date
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Prv; Invalid Proc; Invalid Mbr DOB
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc

44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc

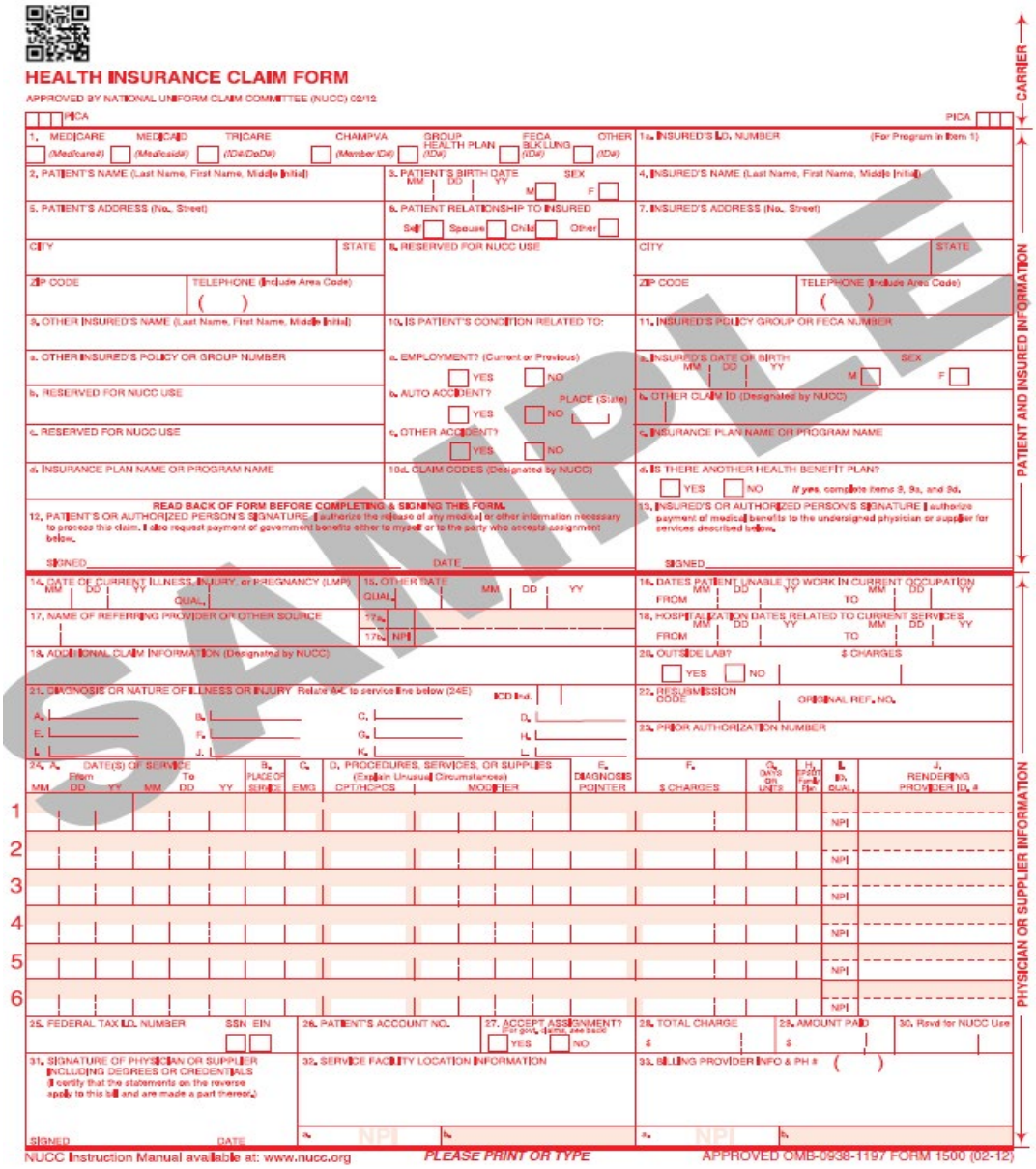
Error ID	Error Description
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS, Invalid Proc
49	Invalid Proc; Invalid Prv; Mbr not valid at DOS
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc
55	Mbr not valid at DOS; Prv not valid at DOS, Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS; Invalid Diag; Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
74	Reject. DOS prior to 6/1/2006; OR Invalid DOS
75	Invalid Unit
76	Original claim number required
77	INVALID CLAIM TYPE
81	Invalid Unit; Invalid Prv
83	Invalid Unit; Invalid Mbr & Prv
89	Invalid Prv; Mbr not valid at DOS; Invalid DOS
91	Missing or Invalid Taxonomy Code
A2	DIAGNOSIS POINTER INVALID
A3	CLAIM EXCEEDED THE MAXIMUM 97 SERVICE LINE LIMIT
B1	Rendering and Billing NPI are not tied on state file
B2	Not enrolled with MHS and/or State with rendering NPI/TIN on DOS. Enroll with MHS and resubmit claim
B5	Missing/incomplete/invalid CLIA certification number
H1	ICD9 is mandated for this date of service.
H2	Incorrect use of the ICD9/ICD10 codes.
HP	ICD10 is mandated for this date of service.
ZZ	Claim not processed

APPENDIX VI: CLAIM FORM INSTRUCTIONS

CLAIM FORMS

Claim forms are the standardized medical billing forms for professional and facility medical billing of health insurance claims in the United States. There are two types of claim forms: CMS 1500 (HCFA) and CMS 1450 (UB 04).

CMS 1500 (HCFA)


HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1											NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Overview

The CMS-1500 is a standard claim form used by healthcare professionals and suppliers including:

- All professional services (including specialists)
- Individual practitioners
- Non-hospital outpatient clinics
- Transportation providers
- Ancillary services (laboratory tests, radiology, genetic
- Testing, diagnostic imaging)
- Durable Medical Equipment
- Professional charges
- Technical components of hospital-based physicians
- Certified Nurse Anesthetists (CRNAs).

CMS-1500 Fields

The CMS1500 contains two sections: member information and provider of services or supplier information.

Field #	Field Description	Instruction or Comments	Required or Conditional
1	Insurance Program ID	Type of Health Coverage applicable to the claim.	Not Required
1a*	Insured I.D. Number	10-digit Medicaid id number on the member's health plan I.D. card	Required
2*	Patient's Name	Patients last name, first name, and middle initial	Required
3*	Patient's Birth date/Sex	Patients 8-digit birth date (MM/DD/YYYY) and patient's gender	Required

Field #	Field Description	Instruction or Comments	Required or Conditional
4	Insured's Name	Patient's name as it appears on their health plan I.D.	Required
5	Patient's Address	Patients complete address	Required
6	Patient's Relation to Insured	Indicates patient's relationship	Conditional
7	Insured's Address	Insured's complete address	Not Required
8	Patient Status		Not Required
9	Other Insured's Name	Refers to someone other than the patient (required if patient is covered by another insurance)	Conditional
9a	Other Insured's Policy or Group Number	Refers to someone other than the patient (required if patient is covered by another insurance)	Conditional
9b	Other insured's birth date/sex	Required if field 9 is completed	Conditional
9c	Employer's or School Name	Employer's or School name	Conditional
9d*	Insurance Plan Name	Other insured's insurance plan or program name	Conditional

Field #	Field Description	Instruction or Comments	Required or Conditional
10d	Reserved for Local Use		Not Required
11	Insured's Policy Group or FECA number		Required
11a	Insured's Date of Birth/Sex		Conditional
11b	Employer's Name or School Name		Conditional
11c*	Insurance Plan Name or Program Name		Required
11d*	Is there Another Health Benefit Plan		Required
12	Patient's or Authorized Person's Signature		Required

Field #	Field Description	Instruction or Comments	Required or Conditional
13	Patient's or Authorized Person's Signature		Not Required
14	Date of current illness, first symptom, or pregnancy		Conditional
15	First date of same or similar illness		Not Required
16	Date patient unable to work in current occupation		Not Required
17	Name of referring provider		Not Required
17a	ID Number of referring physician		Conditional
17b	NPI of referring physician		Conditional
18	Hospitalization dates related to current services		Not Required
19	Reserved for local use		Not Required
20	Outside lab/charges		Not Required
21	Diagnosis or nature of illness	ICD-10 codes related to pointers in 24E	Required
22	Medicaid resubmission code / original Ref No.		Conditional
23	Prior Authorization Number		Not Required

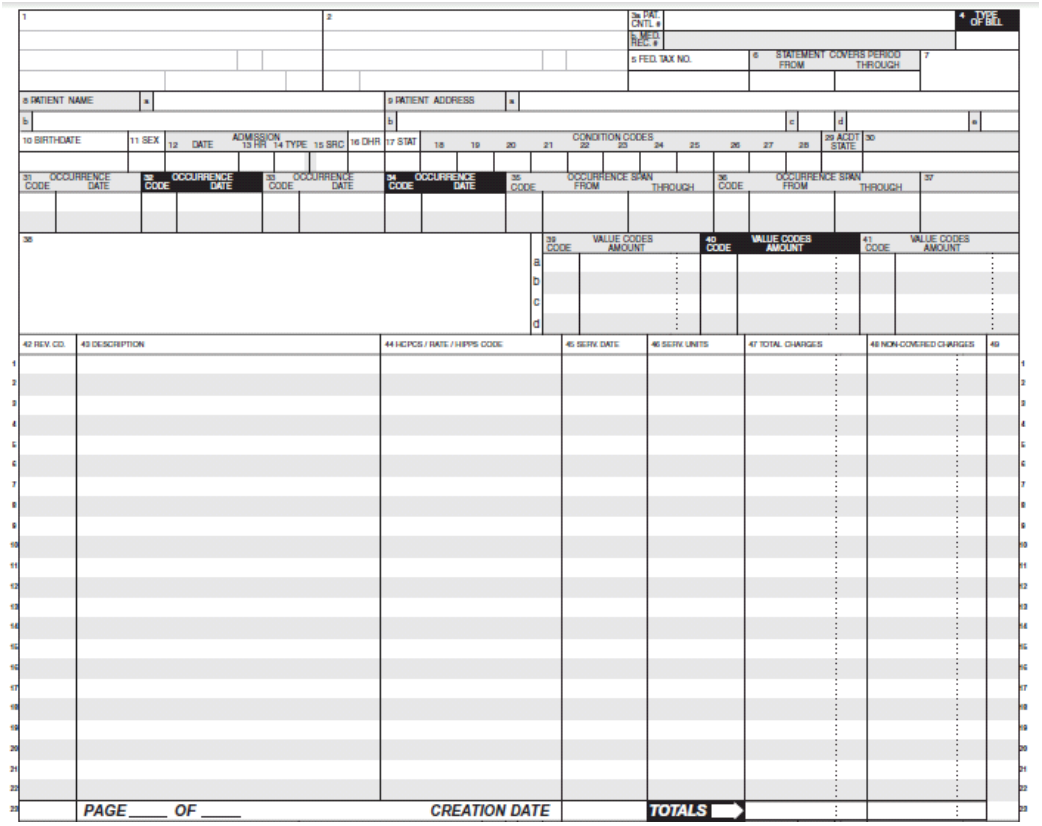
Field #	Field Description	Instruction or Comments	Required or Conditional
24A-J	Box 24 contains 6 claim service lines. Each line is split horizontally and has 10 individual fields labeled A – J.		
24A	Date of Service (From and To dates)		Required
24B	Place of Service or Location		Required
24C	EMG (Emergency)		Required
24D	CPT/HCPCS and Modifiers		Required

Field #	Field Description	Instruction or Comments	Required or Conditional
24E	Diagnosis Code (pointer)		Required
24F	Charges	Charge amount for service line	Required
24G	Days or Units		Required
24H	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)		Conditional
24I	ID qualifier		Conditional
24J Shaded	Non-NPI Provider		Required
24J Un-shaded	NPI Provider ID		Required
25	Federal Tax I.D. Number	9-digit TIN	Required
26	Patient's Account Number	Provider's billing account number	Not Required
27	Accept Assignment		Required
28	Total Charges	Total billed charges	Required
29	Amount Paid		Conditional
30	Balance Due		Conditional
31	Signature of Physician or supplier		Required
32	Service Facility Location Information		Conditional

Field #	Field Description	Instruction or Comments	Required or Conditional
32a	NPI Services – Services Rendered		Conditional
32b	Other Provider ID		Conditional
33	Billing provider Information and phone number		Required

Field #	Field Description	Instruction or Comments	Required or Conditional
33a	Group Billing NPI		Required
33b	Group Billing Other Id		Required

CMS 1450 (UB 04)



Overview

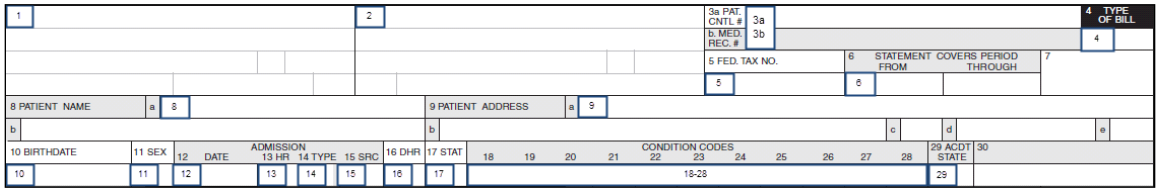
The CMS 1450 (UB-04) is the only acceptable claim form for submitting inpatient or outpatient hospital claim charges for reimbursement. The following Providers are required to bill to the CMS 1450 (UB-04):

- Inpatient/Outpatient hospital charges
- Nursing home services
- Home health
- Inpatient Hospice

- Ambulatory surgery center
- Dialysis services

The CMS 1450 contains multiple sections: Provider/Member information, Occurrence and Value codes, Service lines, Other Insurance Carrier Indicators, Diagnosis codes.

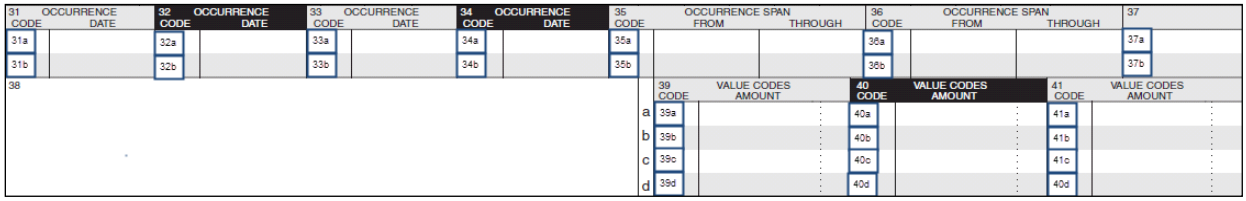
UB-04 Fields



Field #	Field Description	Instruction or Comments	Required or Conditional
1	Provider's Name	Provider's name, address, and telephone number	Required
2	Facility (Pay to) Address	Facility name, address, and telephone number	Billed But Not Required
3a	Patient Account or Control Number	Patient account number from doctor/hospital	Billed But Not Required
3b	Medical Record Number	Medical record or health record number	Required
4	Type of Bill	3-digit type of bill code indicating the type of facility, type of care, and billing sequence	Required
5	Federal Tax Number	9-digit federal tax id number (TIN) assigned by the federal government for tax reporting purposes.	Required

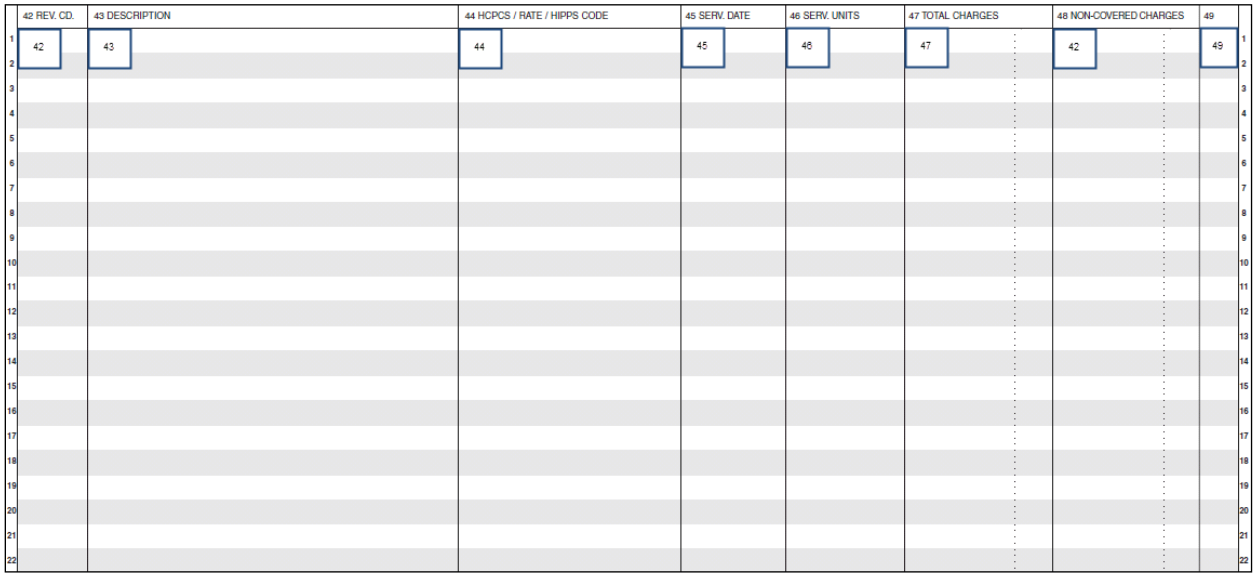
Field #	Field Description	Instruction or Comments	Required or Conditional
6	Statement Covers Period From/Through	Begin and end or admission and discharge dates for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a data span;	Required

Field #	Field Description	Instruction or Comments	Required or Conditional
		however, all other outpatient services must be billed using the actual date of service (MMDDYY).	
8a-b	Patient Name	Patient's last name, first name, and middle initial.	Required
9a-e	Patient Address	Patient's complete address.	Required
10	Birthdate	Patient's date of birth (MMDDYYYY).	Required
11	Sex	Patient's gender	Required
12	Admission Date	Date of admission for inpatient claims and date of service for outpatient claims	Required
13	Admission Hour	2-digit military time (00-23) for inpatient admission or time of treatment for outpatient services.	Required
14	Admission Type	1-digit code indicating the priority of the admission. Required for inpatient claims with a type of bill 11X, 118X, 21X, and 41X.	Conditional
15	Admission Source	1-digit code indicating the source of admission or outpatient service.	Conditional
16	Discharge Hour	2-digit military time (00-23) for time of inpatient or outpatient discharge.	Conditional
17	Patient Status	2-digit disposition or status of the patient as of the "through" date for the billing period listed in field 6. Required for inpatient claims.	Conditional
18-28	Condition Codes	2-digit condition code relating to the bill that may affect payer processing.	Conditional
29	Accident State		Not Required



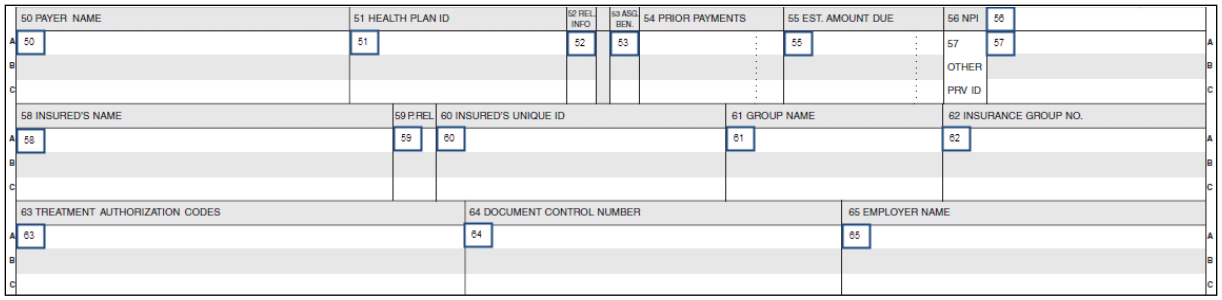
Field #	Field Description	Instruction or Comments	Required or Conditional

31-34 (a-b)	Occurrence Code and Date	Occurrence codes identify relating events that may affect payer processing. It is a 2-character code in alphanumeric sequence. The occurrence dates are a date for the associated occurrence code in a MMDDYYYY format.	Conditional
35-36 (a-b)	Occurrence Span Code and Date	Occurrence span codes identify relating events that may affect payer processing. It is a 2-character code in alphanumeric sequence. The occurrence dates are a date for the associated occurrence code in a MMDDYYYY format.	Conditional
38	Responsible Party	name and address of responsible party	Conditional
39-41 (a-d)	Value Codes and Amounts	Value codes are used identify events relating events relating to the bill that may affect payer processing. Up to 12 codes can be entered. All a fields must be entered before using b fields and so on. Entry is a 2-character code.	Conditional



Field #	Field Description	Instruction or Comments	Required or Conditional
The UB-04 consists of 22 service lines for claim detail information. Fields 42, 43, 45, 47, and 48 include conditional instructions for completions of lines 1-22 and line 23.			
42	Revenue Code	4-digit revenue code itemizing accommodations, services, and items furnished to the patient.	Required

43	Description	Description corresponding to the revenue code entered in field 42.	Required
44	HCPCS/RATES	Required for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. Only one CPT/HCPCS and up to two modifiers are accepted	Conditional
45	Service Date	Required on all outpatient claims. Date of service for each line billed (MMDDYYYY).	Conditional
46	Service Units	Number of units, days, or visits for the same service. A value of at least 1 must be entered.	Required
47 Line 23	Total Charges	Total charges for each service line.	Required
48	Non-covered Charges	Non-covered charges included in field 47 for the revenue code listed in field 42 of the service line.	Conditional

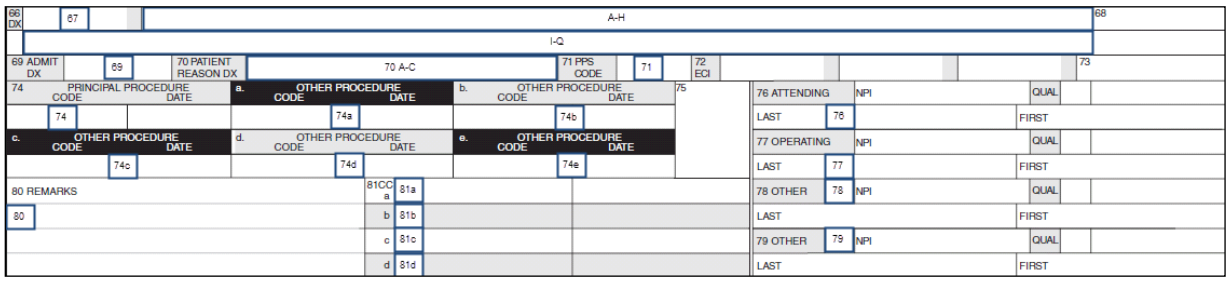


Field #	Field Description	Instruction or Comments	Required or Conditional
50 (A-C)	Payer	4-digit revenue code itemizing accommodations, services, and items furnished to the patient.	Required
51 (A-C)	Health Plan ID Number		Not Required
52 (A-C)	Release Info	Release information certification indicator in which providers are expected to have necessary information on file. Marked with Y or N.	Required

Field #	Field Description	Instruction or Comments	Required or Conditional
53	Asg. Ben	Indicates a signed form is on file authorizing payment of the payer directly to the provider for services. Marked with a Y or N.	Required
54	Prior Payments	Amount received from the primary on the appropriate line when Medicaid/Superior Health Plan is listed as secondary or tertiary.	Conditional
55	Est. Amount Due		Not Required
56	NPI or Provider ID	Provider's 10-digit NPI identification number.	Required

Field #	Field Description	Instruction or Comments	Required or Conditional
57	TPI Number	TPI number (non NPI number) of the billing provider.	Not Required
58 (A-C)	Insured's Name	required for each line completed in field 50, this field contains the names of the person who carries the insurance for the patient	Conditional
59	Patient Relationship	Relationship to the insured	Not Required
60	Insured's Unique ID	patient's insurance/Medicaid identification number exactly as it appears on the patient's ID card	Required
61	Group Name		Not Required
62	Insurance Group Number		Not Required
63	Treatment Authorization Codes		Not Required
64	Document Control Number	12-digit document control number of the paid health claim when submitting a replacement or void on a corresponding A, B, C line reflecting Superior Health plan from field 50.	Conditional

Field #	Field Description	Instruction or Comments	Required or Conditional
65	Employer Name		Not Required

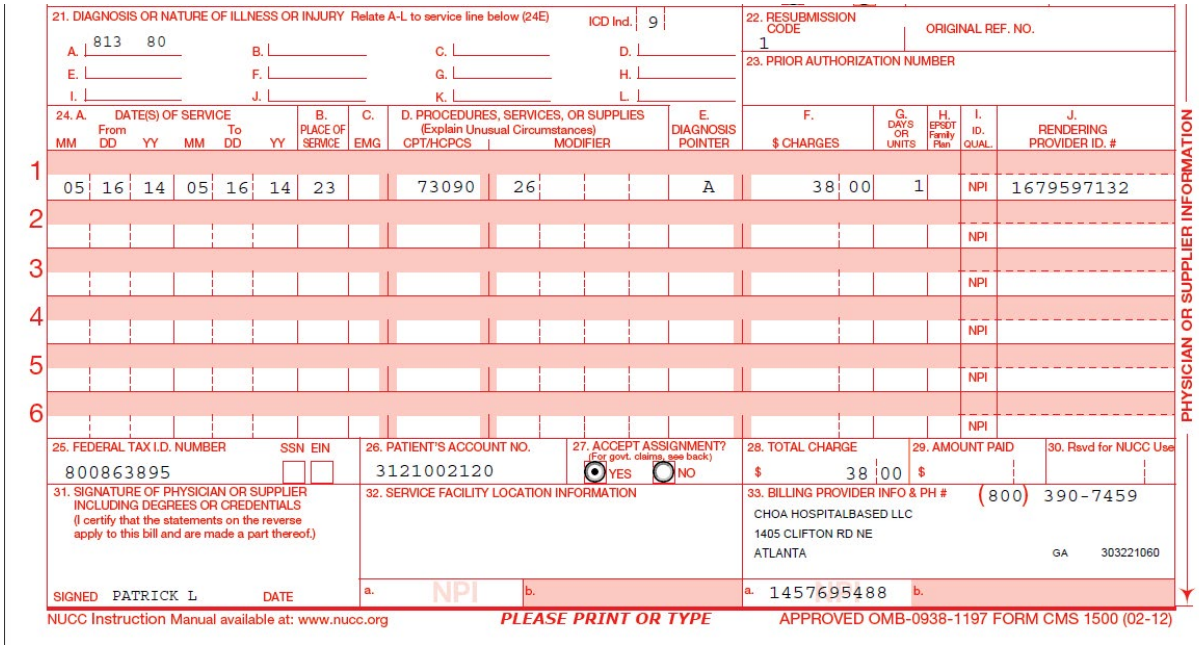


Field #	Field Description	Instruction or Comments	Required or Conditional
66	Primary Diagnosis	Principle or primary diagnosis (ICD-10) or condition	Required
67 (A - Q)	Additional Diagnosis	Additional diagnosis (ICD-10) or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received	Required
69	Admitting Diagnosis	Admitting diagnosis or condition provided at the time of admission as stated by the physician	Required
70 (a – c)	Patients Reason Diagnosis	Required code that reflects he patient's reason for visit at time of outpatient registration	Required
71	PPS of DRG Code		Not Required
74 (a – e)	ICD-10 Procedure Code	Identifies significant procedures performed other than the principal or primary procedure.	Required on Inpatient claims when a procedure performed during the date span of the bill
76	Attending Physician	10 digit NPI and name of attending physician in charge of patient care	Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
77	Operating Physician	NPI, type of qualifier, and name of operating physician	Required when surgical procedure is performed
78 -79	Other Physician	Provider type qualifier, NPI and name of other physician in charge of the patient's care	Not Required
80	Remarks		Not Required
81	Taxonomy	Taxonomy of billing provider, using the ZZ Qualifier	Not Required

EDI Health Claims

EDI stands for Electronic Data Interchange. EDI refers to the transfer of electronic data. Sending healthcare claims via EDI has many advantages. Since EDI claims are sent electronically from one computer to another, there is no costly paperwork involved. By the time we receive a paper claim through the mail, we would have already received an electronic claim and processed for payment/denial. Reducing printing and mailing costs along with improved accuracy and speed of claim payments makes sending electronic claims extremely cost-effective. The claims are viewed the same way as a paper claim through the AWD system. Below is an example of an EDI claim.



Completing a CMS 1450 (UB-04) Claim Form

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient hospital claim charges for reimbursement by Wellcare of North Carolina. In addition, a UB-04 is required for Comprehensive Outpatient

Rehabilitation Facilities (CORF), Home Health Agencies, nursing home admissions, inpatient hospice services, and dialysis services. Incomplete or inaccurate information will result in the claim/encounter being rejected for correction.

Attachment Samples

Claims may have attachments such as medical records, health records, medical charts, transportation records, explanation of benefits (EOB), explanation of payment (EOP), etc. The following section provides some examples of different types of attachments.

Medical Records

A medical record, health record, or medical chart is documentation of patient medical history and care. It is a written transcript of information obtained from a patient, guardian, or medical professional concerning a patient's health history, diagnostic test, diagnosis, treatment, and prognosis.

Patient: MICHELLE Unit#:K000369323
Date: 05/04/14 Acct#:K01013299734

A: Intractable abdominal pain s/p colostomy reversal
P: Pain control with Dilaudid PCA and transition to oral regimen
Date of admission:
Date of admission: 05/02/14

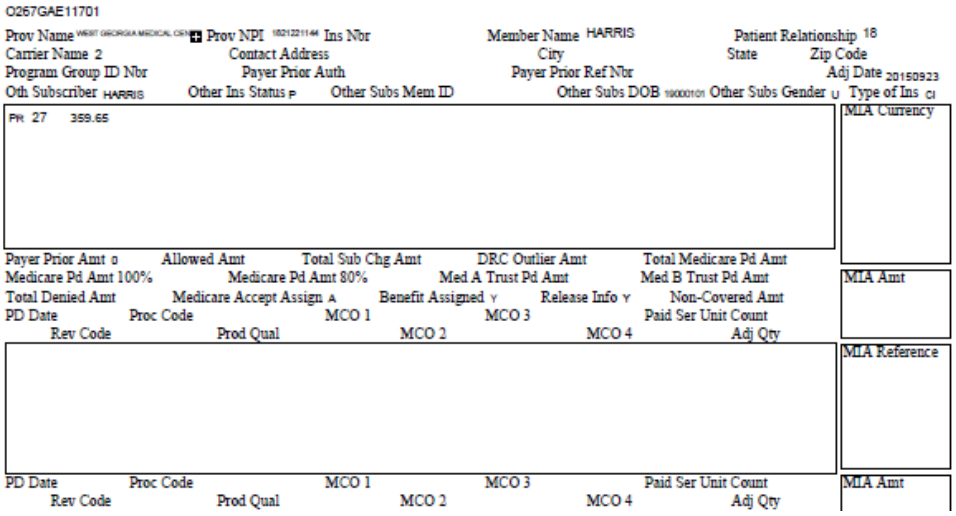
Date of discharge: 05/04/14
Admission diagnosis:
Intractable abdominal pain
Discharge diagnosis:
Intractable abdominal pain
Hospital course:
Admitted for intractable, chronic abdominal pain, now recently s/p colostomy reversal on 4/10/14 by me. She was treated with Dilaudid PCA transitioned to oral regimen eventually. No surgical complication at all on clinical exam, on labs, and on CT A/P.

Current Hospital Medications:
Ondansetron HCl 4 MG Q4H PRN PRN IV
Famotidine 20 MG ONCE PO (DC)
Lactated Ringer's 1,000 ML PACU CI (DC)
Lactated Ringer's 1,000 ML ASDIR IV (DC)
Naloxone HCl 0.08 MG PACU PRN IV
Acetaminophen 500 MG Q6H PRN PRN PO
Docusate Sodium 100 MG BID PO
Hydromorphone HCl 4 MG Q4HR PO
Hydroxocobalamin 100 MCG DAILY PO
Multivitamins/Minerals Therapeutic 1 TAB DAILY PO
Cyclobenzaprine HCl 10 MG TID PO

EOB

An explanation of benefits (EOB) is a statement listing services provided, amount billed, and payment amount. The statement also includes the name of the provider, date of service (DOS), and amount allowed. An EOB is

required if a patient has other insurance coverage (OIC), and the provider is required to bill the primary insurance company first and attach a copy of the primary's EOB for benefit coordination.



O267GAE11701

Prov Name [redacted] Prov NPI [redacted] Ins Nbr | Member Name HARRIS | Patient Relationship 18
Carrier Name 2 | Contact Address | City | State | Zip Code
Program Group ID Nbr | Payer Prior Auth | Payer Prior Ref Nbr | Adj Date 20150923
Oth Subscriber HARRIS | Other Ins Status P | Other Subs Mem ID | Other Subs DOB 19000101 | Other Subs Gender U | Type of Ins CI

PW 27 359.65

MIA Currency

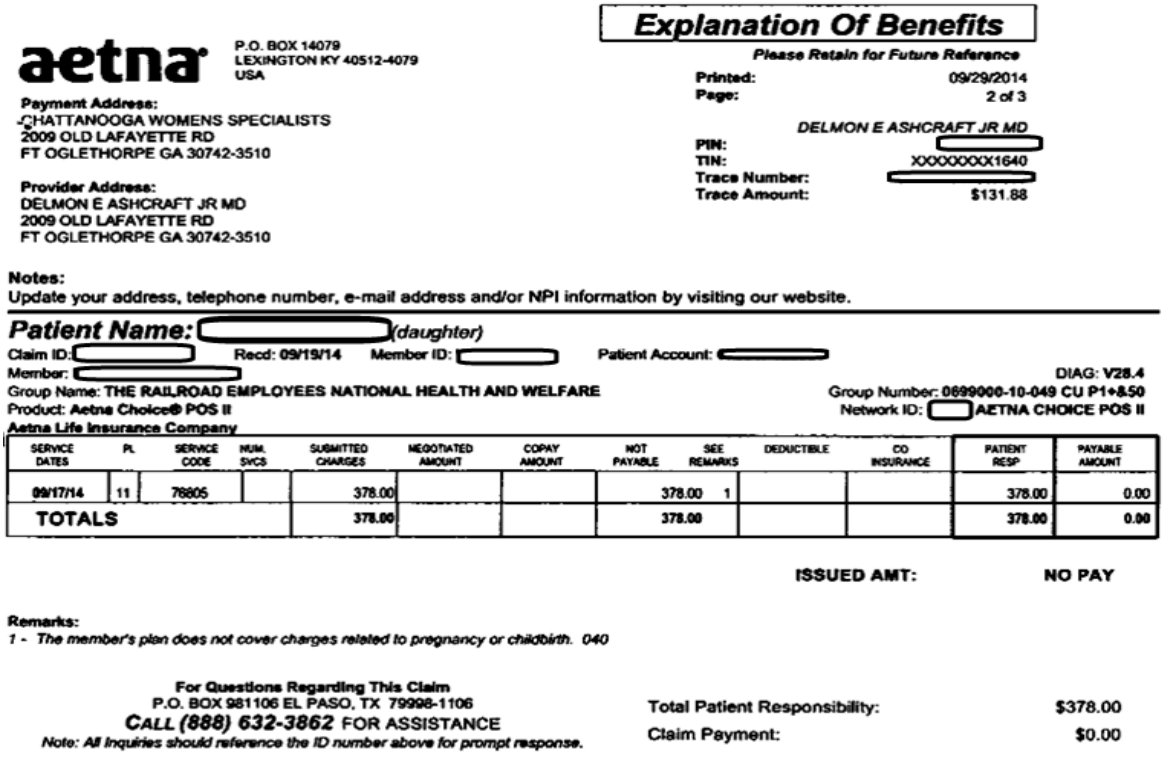
Payer Prior Amt 0 | Allowed Amt | Total Sub Chg Amt | DRC Outlier Amt | Total Medicare Pd Amt
Medicare Pd Amt 100% | Medicare Pd Amt 80% | Med A Trust Pd Amt | Med B Trust Pd Amt
Total Denied Amt | Medicare Accept Assign A | Benefit Assigned Y | Release Info Y | Non-Covered Amt
PD Date | Proc Code | MCO 1 | MCO 3 | Paid Ser Unit Count
Rev Code | Prod Qual | MCO 2 | MCO 4 | Adj Qty

MIA Amt

MIA Reference

PD Date | Proc Code | MCO 1 | MCO 3 | Paid Ser Unit Count
Rev Code | Prod Qual | MCO 2 | MCO 4 | Adj Qty

MIA Amt



aetna

P.O. BOX 14079
LEXINGTON KY 40512-4079
USA

Payment Address:
CHATTANOOGA WOMENS SPECIALISTS
2009 OLD LAFAYETTE RD
FT OGLETHORPE GA 30742-3510

Provider Address:
DELMON E ASHCRAFT JR MD
2009 OLD LAFAYETTE RD
FT OGLETHORPE GA 30742-3510

Explanation Of Benefits

Please Retain for Future Reference

Printed: 09/29/2014
Page: 2 of 3

DELMON E ASHCRAFT JR MD
PIN: [redacted]
TIN: XXXXXXXX1640
Trace Number: [redacted]
Trace Amount: $131.88

Notes:
Update your address, telephone number, e-mail address and/or NPI information by visiting our website.

Patient Name: [redacted] *(daughter)*
Claim ID: [redacted] Recd: 09/19/14 Member ID: [redacted] Patient Account: [redacted]
Member: [redacted]
DIAG: V28.4
Group Name: THE RAILROAD EMPLOYEES NATIONAL HEALTH AND WELFARE
Group Number: 0699000-10-049 CU P1+&50
Product: Aetna Choice® POS II
Network ID: [redacted] AETNA CHOICE POS II
Aetna Life Insurance Company

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
09/17/14	11	76805		378.00			378.00	1			378.00	0.00
TOTALS				378.00			378.00				378.00	0.00

ISSUED AMT: **NO PAY**

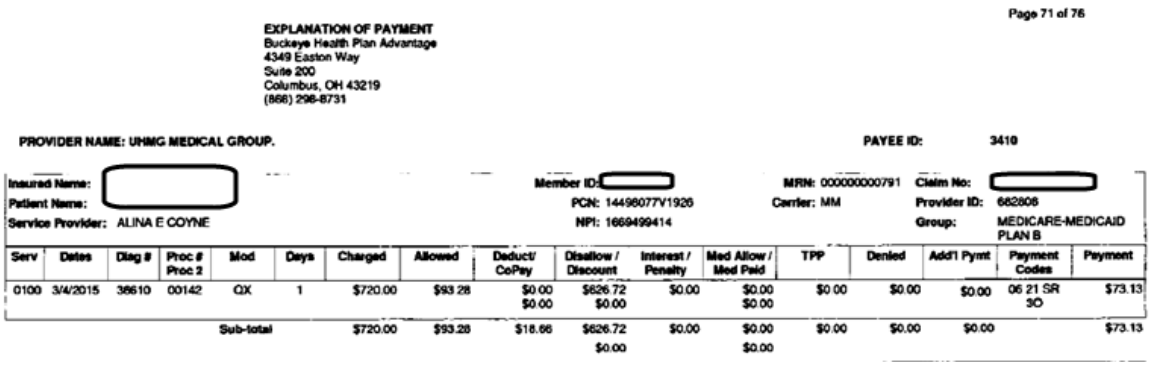
Remarks:
1 - The member's plan does not cover charges related to pregnancy or childbirth. 040

For Questions Regarding This Claim
P.O. BOX 981106 EL PASO, TX 79998-1106
CALL (888) 632-3862 FOR ASSISTANCE
Note: All inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: $378.00
Claim Payment: $0.00

EOP

An explanation of payment (EOP) is a remittance statement sent to the rendering provider explaining the payment or denial by DOS, amount charged, amount allowed, and amount paid. If a provider disagrees with the payment or denial of a claim, an adjustment may be submitted with a copy of the original EOP attached.



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EXPLANATION OF PAYMENT
Buckeye Health Plan Advantage
4349 Easton Way
Suite 200
Columbus, OH 43219
(866) 298-8731

PROVIDER NAME: UHMG MEDICAL GROUP. PAYEE ID: 3410

Insured Name: [redacted] Member ID: [redacted] MRN: 000000000791 Claim No: [redacted]
Patient Name:
Service Provider: ALINA E COYNE PCN: 14498077V1926 Carrier: MM Provider ID: 662806
NPI: 1669499414 Group: MEDICARE-MEDICAID PLAN B

Serv	Dates	Diag #	Proc # Proc 2	Mod	Days	Charged	Allowed	Deduct/ CoPay	Disallow / Discount	Interest / Penalty	Med Allow / Med Paid	TPP	Denied	Add'l Pymt	Payment Codes	Payment
0100	3/4/2015	36610	00142	QX	1	$720.00	$93.28	$0.00 $0.00	$626.72 $0.00	$0.00	$0.00 $0.00	$0.00	$0.00	$0.00	06 21 SR 3O	$73.13
				Sub-total		$720.00	$93.28	$18.66	$626.72 $0.00	$0.00	$0.00 $0.00	$0.00	$0.00	$0.00		$73.13

Claim Type Hints

Professional billing is responsible for the billing of claims generated for work performed by physicians, suppliers, and other non-institutional providers for both outpatient and inpatient services.

Forms Used: Professional charges are billed on a CMS-1500 form. The CMS-1500 is the red-ink on white paper standard claim form used by physicians and suppliers for claim billing.

While some claims are currently billed on paper, Medicare, Medicaid, and most other insurance companies accept electronic claims as the primary billing method. The electronic version of the CMS-1500 is called the 837-P, the P standing for the professional format.

Institutional billing is responsible for the billing of claims generated for work performed by hospitals, skilled nursing facilities, and other institutions for outpatient and inpatient services, including the use of equipment and supplies, laboratory services, radiology services, and other charges.

Forms Used: Institutional charges are billed on a UB-04. The UB-04 is the red ink on white paper standard claim form used by institutional providers for claim billing. The electronic version of the UB-04 is called the 837-I, the I standing for the institutional format.

Medicaid is always the payer of last resort. This simply means that Medicaid always pays last where other health insurance plans are present. Recipients are required to keep Medicaid informed of any health insurance information.

Providers are also responsible for notifying Medicaid of third-party insurance they find out about as well as informing Medicaid of any third-party payments they receive on behalf of the recipient.

Medicaid is state regulated; therefore, each state has its own billing requirements. Billers must contact the Medicaid program in their own state to find out specific billing information.

The Difference Between A UB 04 and A HCFA 1500

Full Answer

The UB-92 form was replaced by the UB-04 Form per the ruling of the National Uniform Billing Committee in 2005. The UB form is maintained by the NUBC, which is a voluntary committee that procures and develops data for claims and related transactions.

The primary difference between the UB and the HCFA-1500 forms is that the UB form is required for facility billing purposes. The form is filed by an assortment of institutions, including acute care facilities, stand-alone clinics, surgery centers, sub-acute facilities, home healthcare agencies, hospice organizations, and psychiatric, drug and alcohol treatment centers. The UB is a claim for Medicare Part A reimbursement of both inpatient and outpatient services to Medicare MAC's and FI's. The UB form is not used to file charges of physicians or individual medical providers. These charges are billed on the HCFA-1500 claim form.

The HCFA-1500 is the standard paper claim form used by medical suppliers and professionals to bill Medicare providers and Durable Medical Equipment Medicare Administrative Contractors. The HCFA-1500 must be submitted within one year from the date of service, and beneficiaries cannot be charged for filing or completing this claim.

Examples of types of bill codes and what they mean.

- Type of Bill 111 represents a Hospital Inpatient Claim indicating that the claim period covers admit through the patient's discharge.
- Type of Bill 117 represents a Hospital Inpatient Replacement or Corrected claim to a previously submitted hospital inpatient claim that has paid in order for the payer to reprocess the claim.
- Type of Bill 138 represents a Hospital Outpatient Void or Cancel of a Prior claim to a previously submitted hospital outpatient claim that has paid in order for the payer to recoup the payment made.
- Type of Bill 831 represents a Hospital Outpatient Surgery performed in an Ambulatory Surgical Center. For an outpatient surgery performed in a Hospital, the type of bill would be 131 instead of 831.

First Digit of the Bill Type Code - Facility Type

The first digit refers to the type of facility.
1 - Hospital
2 - Skilled Nursing
3 - Home Health
4 - Religious Nonmedical Healthcare Facility (Hospital)
5 - Religious Nonmedical Healthcare Facility (Extended Care)
7 - Clinic
8 - Specialty Facility, Hospital ASC Surgery

Second Digit of the Bill Type Code
What the second digit signifies depends on the first digit is. It has a different set of meanings for clinics and special facilities.

The second digit refers to the bill classification except for clinics and special facilities.

If the first digit is 1-5, then the second digit is:
1 - Inpatient (Medicare Part A)
2 - Inpatient (Medicare Part B)
3 - Outpatient
4 - Other (Medicare Part B)
5 - Level I Intermediate Care
6 - Level II Intermediate Care
7 - Subacute Inpatient (for use with Revenue Code 019X)
8 - Swing Bed

For Clinics only:

If the first digit is 7, then the second digit is:
1 - Rural Health Clinic
2 - Hospital Based or Independent Renal Dialysis Facility
3 - Federally Qualified Health Center (FQHC), Free Standing Provider-Based
4 - Other Rehabilitation Facility (ORF)
5 - Comprehensive Outpatient Rehabilitation Facility (CORF)
6 - Community Mental Health Center (CMHC)

For Special Facilities Only:

If the first digit is 8, then the second digit is:
1 - Nonhospital Based Hospice
2 - Hospital Based Hospice
3 - Ambulatory Surgical Center Services to Hospital Patients
4 - Other Rehabilitation Facility (ORF)
5 - Comprehensive Outpatient Rehabilitation Facility (CORF)
6 - Community Mental Health Center (CMHC)

Third Digit of the Bill Type Code - Frequency
The third digit refers to the frequency:

0 - Nonpayment or Zero Claims
1 - Admit Through Discharge Claim
2 - Interim (First Claim)
3 - Interim (Continuing Claims)
4 - Interim (Last Claim)
5 - Late Charge Only
7 - Replacement of Prior Claim or Corrected Claim

8 - Void or Cancel of a Prior Claim
9 - Final Claim for a Home Health PPS Episode

Types of Facilities Using the UB-04

- Community Mental Health Center
- Comprehensive Outpatient Rehabilitation Facility
- Critical Access Hospital
- End-Stage Renal Disease Facility
- Federally Qualified Health Center
- Histocompatibility Laboratory
- Home Health Agency
- Hospice
- Hospital
- Indian Health Services Facility
- Organ Procurement Organization
- Outpatient Physical Therapy Services
- Occupational Therapy Services
- Speech Pathology Services
- Religious Non-Medical Healthcare Institution
- Rural Health Clinic
- Skilled Nursing Facility

Type of Bill (TOB) Codes

Bill Code	Bill Code Description	Part A or B
011X	Hospital Inpatient	Part A
012X	Hospital Inpatient	Part B
013X	Hospital Outpatient	N/A
014X	Hospital Other	Part B
018X	Hospital Swing Bed	N/A
021X	SNF Inpatient	N/A
022X	SNF Inpatient	Part B
023X	SNF Outpatient	N/A
028X	SNF Swing Bed	N/A
032X	Home Health	N/A
033X	Home Health	N/A
034X	Home Health	Part B Only
041X	Religious Nonmedical Health Care Institutions	N/A
071X	Clinical Rural Health	N/A
072X	Clinic ESRD	N/A
073X	Federally Qualified Health Centers	N/A
074X	Clinic OPT	N/A
074X	Clinic CORF	N/A
076X	Community Mental Health Centers	N/A
081X	Nonhospital based hospice	N/A
082X	Hospital based hospice	N/A
083X	Hospital Outpatient (ASC)	N/A
085X	Critical Access Hospital	N/A

For more information, visit www.cms.gov/Regulations-and-Guidance.

Appendix VII: Billing Tips and Reminders

Adult Day Health Care

- Must be billed on a CMS 1500 Claim Form.
- Must be billed in location 99.

Ambulance

Can be billed on either a CMS 1500 or CMS 1450 Claim Form.

Appropriate modifiers must be billed with the Transportation Codes.

Ambulance Claims

Hospital owned Ambulance must bill under Hospital and use CMS 1450 form. Check rules on Value Code A0 and Zip code to show patient pick up location.

Independent Ambulance must bill under their own NPI and Tax ID Number with a CMS 1500 form.

Ambulatory Surgery Center (ASC)

- Ambulatory surgery centers can submit charges using either the CMS 1500 or CMS 1450 Claim Form.
- Must be billed in place of service 24
- Must be billed using the appropriate revenue code, HCPCS codes.
- Invoice must be billed with Corneal Transplants.
- Most surgical extractions are billable only under the ASC.

Anesthesia

Bill total number of minutes in field 24G of the CMS 1500 Claim Form and must be submitted with the appropriate modifier.

Failure to bill total number of minutes may result in incorrect reimbursement or claim denial.

Appropriate modifiers must be utilized.

Anesthesia claims may not be billed that contain both: modifier QK-medical direction by a physician AND modifier QX-qualified non-physician anesthetist with medical direction by a physician.

APC Billing Rules

Bill type for APC claims is limited to 13x-14x range.

Acute General Hospitals must bill with bill type 13x.

Independent labs owned/billed under Hospital will use bill type 14x.

- Late charge claims are not allowed, only replacement claims. Claims with late charges will be denied to be resubmitted.

Submit bill type xxx7 with completed claims.

Bill type xxx5 is not accepted.

Claims spanning two calendar years will be required to be submitted by the provider as one claim.

CMS Maximum Unit Edits (MUEs) will be applied per line, per claim.

Claim lines exceeding the MUE value will be denied.

Observation: Providers are required to bill HCPCS G0378 along with the revenue code. The Observation G code will allow the case rate. CMS is proposing significant changes to observation rules and payment level for 2014, and this will be updated accordingly.

Follow CMS billing guidelines on requirements around Revenue codes and HCPCs codes for APC claims. Most Revenue codes require Procedure codes per CMS billing guidelines.

Comprehensive Day Rehab

Must be billed on a CMS 1500 Claim Form.

Must be billed in location 99.

Acceptable modifiers.

Critical Access Hospitals

Bill type must be 85x.

Must provide Fiscal Intermediary (FI) letter.

DME/Supplies/Prosthetics and Orthotics

Must be billed with an appropriate modifier.

Purchase only services must be billed with modifier NU.

Rental services must be billed with modifier RR.

Hearing Aids

Must be billed with the appropriate modifier LT or RT.

Home Health

Must be billed on CMS-1450.

Bill type must be 32X or 34X.

Must be billed in location 12.

Both Rev and CPT codes are required.

Each visit must be billed individually on a separate service line.

Therapy services must be billed with the appropriate modifier(s).

Nursing services must be billed with the appropriate modifier(s).

Current Medicare requires to episodic billing requirements.

Long Term Acute Care Facilities (LTACs)

Long Term Acute Care Facilities (LTACs) must submit Functional Status Indicators on claim submissions.

Maternity Deliveries

Use appropriate value codes as well as birth weight when billing for delivery services.

Maternity Services

- Providers must utilize correct coding for Maternity Services.
- Services provided to members prior to their WellCare of North Carolina effective date should be correctly coded and submitted to the payer responsible.
- Services provided to the member on or after their WellCare of North Carolina effective date should be correctly coded and submitted to WellCare of North Carolina.

Modifiers

Appropriate uses of 25, 26, 96, 97 TC, 50, CO, CQ, GN, GO, GP, TD, TE:

- 25 Modifier - should be used when a significant and separately identifiable E&M service is performed by the same physician on the same day as another procedure (e.g., 99381 and 99211-25). Modifier 25 is subject to code editing and audit process. Appending modifier 25 is not a guarantee of automatic payment and may require the submission of medical records.

  Well-Child and sick visit performed on the same day by the same physician.
  *NOTE: 25 modifiers are not appended to non-E&M procedure codes, e.g., lab.

- 26 Modifier – should never be appended to an office visit CPT code.
  - Use 26 modifier to indicate that the professional component of a test or study is performed using the 70000 (radiology) or 80000 (pathology) series of CPT codes.
  - Inappropriate use may result in a claim denial/rejection.
- 96 Modifier – used for all habilitative services.
- 97 Modifier – used for all rehabilitative services.
- TC Modifier – used to indicate the technical component of a test or study is performed.
  Inappropriate use may result in a claim denial/rejection
- 50 Modifier – indicates a procedure performed on a bilateral anatomical site.
  - Procedure must be billed on a single claim line with the 50 modifier and quantity of one.
  - RT and LT modifiers or quantities greater than one should not be billed when using modifier 50
- CO Modifier – required when occupational therapy is performed by an Occupational Therapist Assistant
- CQ Modifier – required when physical therapy is performed by a Physical Therapist Assistant
- GN, GO, GP Modifiers – rehabilitative therapy modifiers required for speech, occupational, and physical therapy.
- TD and TE Modifiers - nursing modifiers required for nursing services.

Present on Admission (POA)

The Present on Admission (POA) Indicator is required on all inpatient facility claims.

Failure to include the POA may result in a claim denial/rejection.

Rehabilitation Services – Inpatient Services

Functional status indicators must be submitted for inpatient Rehabilitation Services.

Reproductive Health Services

Beginning March 1, 2024, the billing requirements are changing for Reproductive Health Services in the State of North Carolina. Claims will adjudicate in accordance with state and federal laws. The below information offers further detail on specifics that are required to review and adjudicate the claim appropriately.

The following procedure codes are impacted by these changes:

Reproductive Health Procedure Codes

59414	59812	59820	59821	59840
59841	59850	59851	59852	59855
59856	59857	59866	59870	59830
S0190	S0199	S2260	S2265	S2266
S2267				

Claims for these services must be presented with a condition code:

Hyde Procedures[4]	
Condition Code	**Description**
AA	Rape
AB	Incest
AD	Life Endangerment
AF	Due to Emotional/Physical Health of Mother
Non-Hyde Futile Pregnancy Procedures	
AC	Due to serious fetal genetic defect, deformity, abnormality

Claims for these services must be presented with a modifier code (Hyde Procedures Only):

Modifier	Description
G7	Pregnancy resulted from rape or incest, or pregnancy certified by physician as life-threatening.

- *For procedures completed between 13-20 weeks can only be performed in locations 19, 21, 22 or 23.*
- *Procedures that are elective in nature will not be covered.*

Supplies

Physicians may bill for supplies and materials in addition to an office visit if these supplies are over and above those usually included with the office visit.

Supplies such as gowns, drapes, gloves, specula, pelvic supplies, urine cups, swabs, jelly, etc., are included in the office visit and may not be billed separately. Providers may not bill for any reusable supplies.

Telehealth Services

For telehealth services billed with a place of service 02 or 10, providers will be reimbursed per state guidelines, such as in person services.

Telemedicine

Physicians at the distant site may bill for telemedicine services and MUST utilize the appropriate modifier to identify the service was provided via telemedicine.

E&M CPT plus the appropriate modifier.

Via interactive audio and video telecommunication systems.

[4] *Hyde Procedures are cases involving rape, incest, or when the continuation of the pregnancy would endanger the mother's life.*

Appendix VIII: Reimbursement Policies

As a general rule, WellCare of North Carolina follows Medicare reimbursement policies. Instances that vary from Medicare include:

Admissions for Same or Related Diagnoses

Inpatient admissions for the same or a related diagnoses occurring within 30 days following a discharge in connection with a previous admission shall be considered part of the previous admission and are not separately reimbursable.

Calculating Anesthesia

Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service.

Total anesthesia time is calculated in 15- minute increments, rounding up to the next 15 minutes. Anesthesia is calculated using the following computation: Base units + Time Units+ Physical Status X Conversation factor,

Certified Nurse Midwife (CNM) Rules

Payment for CNM services is made at 100% of the contracted rate.

EKG Payment

EKG Interpretation is separately billable and payable from the actual test. However, the first provider to bill receives payment for services.

Diagnostic Testing Of Implants

Charges and payments for diagnostic testing of implants following surgery is not included in the global fee for surgery and is reimbursable if the testing is outside the global timeframe. If it is inside the global timeframe, it is not reimbursable.

Hospital-Acquired Conditions and Provider Preventable Conditions

Payment to a contracted Provider under the compensation schedule shall comply with state and federal laws requiring reduction of payment or non-payment to a contracted provider for “hospital-acquired conditions” and for “provider preventable conditions” as such terms (or the reasonable equivalents thereof) are defined under applicable state and federal laws.

Incomplete Colonoscopy Rule

Incomplete colonoscopies should be billed with CPT 45378 and modifier 53. This will pay 25% of the fee schedule rate for the incomplete procedures. The rest of the claim pays according to the fee schedule.

Injection Services

Injection service codes must pay separately if no other physician service is paid and when not billed with office visit. If an office visit is billed, then no injection is payable because it is covered in the office charge.

Lesser Of Language

Pay Provider lesser of the Providers allowable charges or the contracted rate.

Multiple Procedure Rules for Surgery and Endoscopic

Where multiple outpatient surgical or scope procedures are performed on a member during a single occasion of surgery, reimbursement, will be as follows:

- The procedure for which the allowed amount is greatest will be reimbursed at 100%.
- The procedures with second and third greatest allowed amounts will each be reimbursed at 50%.
- Any additional procedures will not be eligible for reimbursement.

Multiple Procedure Rules for Radiology

Multiple procedure radiology codes follow Multiple Procedure discount rules: 100%/50%/50%, max three radiology codes.

Payment for Capped Rental Items during Period of Continuous Use

When no purchase options have been exercised, rental payments may not exceed a period of continuous use of longer than 13 months. For the month of death or discontinuance of use, contractors pay the full month rental. After 13 months of rental have been paid, the supplier must continue to provide the item without any charge, other than for the maintenance and servicing fees until medical necessity ends or WellCare of North Carolina coverage ceases. For this purpose, unless there is a break in need for at least 60 days, medical necessity is presumed to continue. Any lapse greater than 60 days triggers new medical necessity.

If the beneficiary changes suppliers during or after the 13-month rental period, this does not result in a new rental episode. The supplier that provides the item in the 13th month of the rental period is responsible for supplying the equipment and for maintenance and servicing after the 13-month period. If the supplier changes after the 10th month, there is no purchase option.

Percutaneous Electrical Nerve Stimulator (PENS) Rent Status While Hospitalized

An entire month's rent may not be paid when a patient is hospitalized during the month. The rent will be prorated to allow for the time not hospitalized.

Physician Assistant (PA) Payment Rules

Physician assistant services are paid at 85% of what a physician is paid under the WellCare of North Carolina Physician Fee Schedule.

- PA services furnished during a global surgical period shall be paid 85% of what a physician is paid under the WellCare of North Carolina Physician Fee Schedule.
- PA assistant-at-surgery services at 85%of what a physician is paid under the Medicare Physician Fee Schedule. Since physicians are paid at 16% of the surgical payment amount under the Medicare Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that PAs receive for assistant-at-surgery services is 13.6% of the amount paid to physicians. The AS modifier must be used.

Physician Site of Service

Physicians will be paid at Physician rate only at the following Sites of Service: Office, Home, Assisted Living Facility, Mobile unit, walk in retail health clinic, urgent care facility, birthing center, nursing facility, SNFs, independent clinic, FQHC, Intermediate HC Facility, Resident Substance Abuse Facility, Nonresident Substance Abuse Facility, Comprehensive OP Rehab facility, ESRD Facility, State or Local Health Clinic, RHC, Indy lab, Other POS.

Provider-Based Billing

Provider-based billing will not be reimbursed as they are included as part of the compensation for professional fees. Neither the payor nor the member shall be responsible for such provider-based billing. Provider-based billing are amounts charged by a clinic or facility as a technical component, or for overhead, in connection with professional services rendered in a clinic or facility and include but are not limited services billed using revenue codes 510-519.

Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) Payment Rules

In general, NPs and CNSs are paid for covered services at 85% of what a physician is paid under the WellCare of North Carolina Physician Fee Schedule.

NP or CNS assistant-at-surgery services at 85% of what a physician is paid under the WellCare of North Carolina Physician Fee Schedule. Since physicians are paid at 16% of the surgical payment amount under the WellCare of North Carolina Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that PAs receive for assistant-at-surgery services is 13.6% of the amount paid to physicians. The AS modifier must be used.

Reimbursement Service Grouping

If either payor or provider determines in good faith that a change made by payor to a reimbursement service grouping has (or is reasonably expected to have) an adverse financial impact that is more than an immaterial effect (e.g., an increase or decrease in provider's overall reimbursement of three percent or more), such party may notify the other party of such determination within the 365-day period following the date on which such change is made. Following the timely giving of such notice, payor will evaluate the effect of such change and, notwithstanding anything to the contrary contained elsewhere in the provider agreement (or schedule or attachment), Payor will implement appropriate adjustments, if any, to the reimbursement amounts with the intention of making the change in the reimbursement service groupings cost neutral and to offset for the adverse financial impact. Payor will notify provider, in writing, of the adjustments made.

Surgical Physician Payment Rules

For surgeries billed with either modifiers 54, 55, 56, or 78 pay the appropriate percentage of the fee schedule payment as identified by the modifier and procedure code used.

Rental or Purchase Decisions

Rental or purchase decisions are made at the discretion of Medical Management.

Transcutaneous Electrical Nerve Stimulator (TENS)

In order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, contractors pay 10 percent of the purchase price of the item for each of two months. The purchase price and payment for maintenance and servicing are determined under the same rules as any other frequently purchased item. There is a reduction in the allowed amount for purchase due to the two months rental.

Unpriced Codes

In the event that the CMS/Medicare does not contain a published fee amount, an alternate "gap fill" source is utilized to determine the fee amount. Unlisted codes are subject to the code edit and audit process and will require the submission of medical records.

Appendix IX: EDI Companion Guide Overview

The Companion Guide provides WellCare of North Carolina trading partners with guidelines for submitting the ASC X12N/005010x222 Health Care Claim: Professional (837P); and ASC X12N/005010x223 Health Care Claim: Institutional (837I). The WellCare of North Carolina Companion Guide documents any assumptions, conventions, or data issues that may be specific to WellCare of North Carolina business processes when implementing the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3). As such, this Companion Guide is unique to WellCare of North Carolina and its affiliates.

This document does NOT replace the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) for electronic transactions, nor does it attempt to amend any of the rules therein or impose any mandates on any trading partners of WellCare of North Carolina. This document provides information on WellCare of North Carolina-specific code handling and situation handling that is within the parameters of the HIPAA administrative Simplification rules. Readers of this Companion Guide should be acquainted with the HIPAA Technical Reports Type 3, their structure and content. Information contained within the HIPAA TR3s is not repeated here, although the TR3s have been referenced when necessary. The HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) can be purchased at http://store.x12.org.

The Companion Guide provides supplemental information to the Trading Partner Agreement (TPA) that exists between WellCare of North Carolina and its trading partners. Refer to the TPA for guidelines pertaining to WellCare of North Carolina legal conditions surrounding the implementations of EDI transactions and code sets. Refer to the Companion Guide for information on WellCare of North Carolina business rules or technical requirements regarding the implementation of HIPAA-compliant EDI transactions and code sets.

Nothing contained in this guide is intended to amend, revoke, contradict, or otherwise alter the terms and conditions of the Trading Partner Agreement.

If there is an inconsistency with the terms of this guide and the terms of the Trading Partner Agreement, the terms of the Trading Partner Agreement shall govern.

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277CA Health Care Claim Acknowledgement

The X12N005010X214 Health Care Claim Acknowledgment (277CA) provides a more detailed explanation of the transaction set. WellCare of North Carolina also provides the Pre-Adjudication rejection reason of the claim within the STC12 segment of the 2220D loop. **NOTE: The STC03 – Action Code will only be a "U" if the claim failed on HIPAA validation errors, NOT Pre-Adjudication errors.**

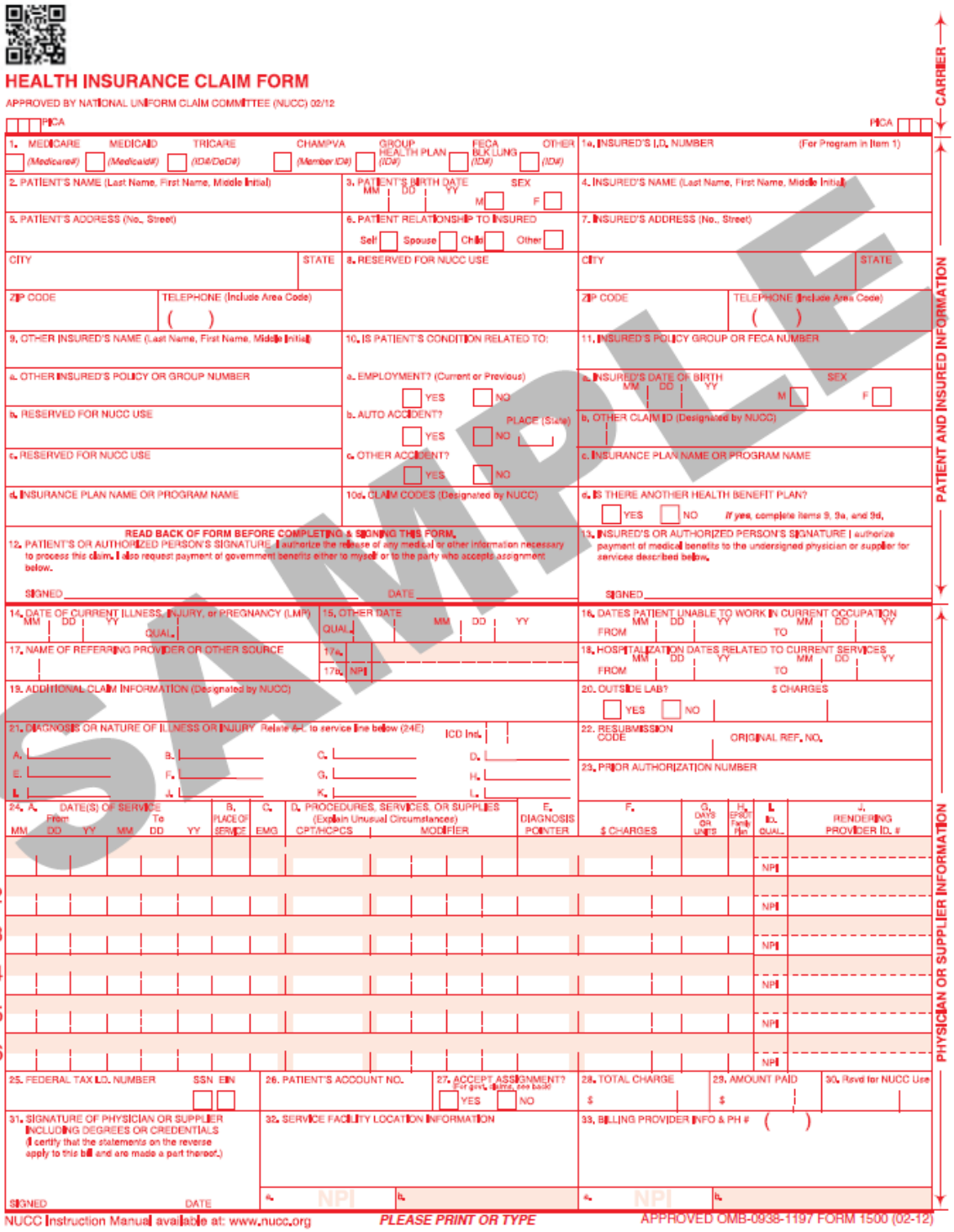
277CA/Audit Report Rejection Codes

Error Code	Rejection Reason
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Provider
07	Invalid Mbr DOB & Provider
08	Invalid Mbr & Provider
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Provider not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17	Invalid Diag Code
18	Invalid Mbr DOB; Invalid Diag

Error Code	Rejection Reason
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS; Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS
23	Invalid Prv; Invalid Diagnosis Code
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag Code
25	Invalid Mbr; Invalid Prv; Invalid Diag Code
26	Mbr not valid at DOS; Invalid Diag Code
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag Code
29	Provider not valid at DOS; Invalid Diag Code
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag
32	Mbr not valid at DOS; Prv not valid; Invalid Diag
33	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag
34	Invalid Proc
35	Invalid Mbr DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
37	Invalid Future Service Date
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Mbr DOB, Invalid Prv; Invalid Proc
42	Invalid Mbr; Invalid Prv; Invalid Proc

Error Code	Rejection Reason
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS; Invalid Proc
49	Mbr not valid at DOS; Invalid Prv; Invalid Proc
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc
55	Mbr not valid at DOS; Prv not valid at DOS; Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS; Invalid Diag; Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
74	Services performed prior to Contract Effective Date

Error Code	Rejection Reason
75	Invalid units of service
76	Original Claim Number Required
77	Invalid Claim Type
78	Diagnosis Pointer- Not in sequence or incorrect length
81	Invalid units of service, Invalid Prv
83	Invalid units of service, Invalid Prv, Invalid Mbr
89	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
91	Invalid Missing Taxonomy or NPI/Invalid Prov
92	Invalid Referring/Ordering NPI
93	Mbr not valid at DOS; Invalid Proc
96	GA OPR NPI Registration-State
A2	Diagnosis Pointer Invalid
A3	Service Lines- Greater than 97 Service lines submitted- Invalid
B1	Rendering and Billing NPI are not tied on State File- IN rejection
B2	Not enrolled with MHS IN and/or State with rendering NPI/TIN on DOS. Enroll with MHS and Resubmit claim
B5	Invalid CLIA
C7	NPI Registration- State GA OPR
C9	Invalid/Missing Attending NPI
HP/H1/H2	ICD9 after end date/ICD10 sent before Eff Date/Mixed ICD versions



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI
2										NPI
3										NPI
4										NPI
5										NPI
6										NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Field #	Field Description	Instruction or Comments	Required or Conditional
1	INSURANCE PROGRAM IDENTIFICATION	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed.	R
1a	INSURED'S I.D. NUMBER	The 11-digit identification number on the member's WellCare of North Carolina I.D. Card	R
2	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's WellCare of North Carolina I.D. card. Do not use nicknames.	R
3	PATIENT'S BIRTH DATE/SEX	Enter the patient's 8-digit date of birth (MM/DD/YYYY) and mark the appropriate box to indicate the patient's sex/gender. M= Male F= Female	R
4	INSURED'S NAME	Enter the patient's name as it appears on the member's WellCare of North Carolina I.D. Card	C
5	PATIENT'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	C
6	PATIENT'S RELATION TO INSURED	If patient is self, always mark to indicate self.	C
7	INSURED'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state.	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	
8	RESERVED FOR NUCC USE		Not Required
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.	C
9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if field 9 is completed. Enter the policy or group number of the other insurance plan.	C
9b	RESERVED FOR NUCC USE		Not Required
9c	RESERVED FOR NUCC USE		Not Required
9d	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.	C
10a, b, c	IS PATIENT'S CONDITION RELATED TO	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.	R
10d	CLAIM CODES (Designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code.	C
11	INSURED POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If Item Number 10abc is marked Y, this field should be populated.	C
11a	INSURED'S DATE OF BIRTH / SEX	Enter the 8-digit date of birth (MM | DD | YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.	C

Field #	Field Description	Instruction or Comments	Required or Conditional
11b	OTHER CLAIM ID (Designated by NUCC)	The following qualifier and accompanying identifier have been designated for use: Y4 Property Casualty Claim Number **FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY:** Required if known. Enter the claim number assigned by the payer.	C
11c	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance health plan or program.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If yes, complete field's 9a-d and 11c.	R
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	C
13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Obtain signature if appropriate.	Not Required
14	DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)	Enter the 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	C
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS GIVE FIRST DATE	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) format.	C
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		C
17	NAME OF REFERRINGPHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials).	C

Field #	Field Description	Instruction or Comments	Required or Conditional
17a	ID NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. Use ZZ qualifier for Taxonomy Code.	C
17b	NPI NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Required for inpatient stay. Enter R for inpatient. Enter C for all other.	R/C
19	RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL CLAIM INFORMATION		C
20	OUTSIDE LAB / CHARGES		C
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS A-L to ITEM 24E BY LINE). NEW FORM ALLOWS UP TO 12 DIAGNOSES, AND ICD INDICATOR	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-10-CM Diagnosis Codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. **Note:** Claims missing or with invalid Diagnosis Codes will be rejected or denied for payment.	R
22	RESUBMISSION CODE / ORIGINAL REF.NO.	For re-submissions or adjustments, enter the original claim number of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim	C
23	PRIOR AUTHORIZATION NUMBER or CLIA NUMBER	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services.	If auth = C If CLIA = R (If both, always submit the CLIA number)
24A-J General Information	Box 24 contains six claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line, there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are four individual fields labeled 24A-24G, 24H, 24J, and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields. The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Number.		

Field #	Field Description	Instruction or Comments	Required or Conditional
	Shaded boxes 24 A-G is for line-item supplemental information and provides a continuous line that accepts up to 61 characters. Refer to the instructions listed below for information on how to complete. The un-shaded area of a claim line is for the entry of claim line-item detail.		
24 A-G Shaded	SUPPLEMENTAL INFORMATION	The shaded top portion of each service claim line is used to report supplemental information for: • NDC • Narrative description of unspecified codes • Contract Rate • For detailed instructions and qualifiers refer to Appendix IV of this guide.	C
24A Unshaded	DATE(S) OF SERVICE	Enter the date the service listed in field 24D was performed (MM | DD | YYYY). If there is only one date, enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. If identical services (identical CPT/HCPC Code(s)) were performed, each date must be entered on a separate line.	R
24B Unshaded	PLACE OF SERVICE	Enter the appropriate 2-digit CMS Standard Place of Service (POS) Code. A list of current POS Codes may be found on the CMS website.	R
24C Unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	Not Required
24D Unshaded	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Enter the 5-digit CPT or HCPC Code and 2-character modifier, if applicable. Only one CPT or HCPC and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the Procedure Code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.	R
24 E Unshaded	DIAGNOSIS CODE	In 24E, enter the Diagnosis Code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-10-CM Diagnosis Codes must be entered in Item Number 21 only. Do not enter them in	R

Field #	Field Description	Instruction or Comments	Required or Conditional
		24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-10 Codes for the date of service, or the claim will be rejected/denied.	
24 F Unshaded	CHARGES	Enter the charge amount for the claim line-item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (e.g., 10.00), enter 00 in the area to the right of the vertical line.	R
24 G Unshaded	DAYS OR UNITS	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one (1).	R
24 H Shaded	EPSDT (Family Planning)	Leave blank or enter "Y" if the services were performed because of an EPSDT referral.	C
24 H Unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit.	C
24 I Shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy. Use 1D qualifier for ID if an Atypical Provider.	R
24 J Shaded	NON-NPI PROVIDER ID#	Typical Providers: Enter the Provider Taxonomy Code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code. Atypical Providers: Enter the Provider ID number.	R
24 J Unshaded	NPI PROVIDER ID	Typical providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g., DME, Independent Lab, Home Health, RHC/FQHC General Medical Exam, etc.).	R
25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number, and mark the box labeled EIN	R
26	PATIENT'S ACCOUNT NO.	Enter the provider's billing account number.	C

Field #	Field Description	Instruction or Comments	Required or Conditional
27	ACCEPT ASSIGNMENT?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to an WellCare of North Carolina recipient using state funds indicates the provider accepts assignment. Refer to the back of the CMS 1500 (02-12) claim form for the section pertaining to Payments.	C
28	TOTAL CHARGES	Enter the total charges for all claim line items billed on claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (e.g., 10.00), enter 00 in the area to the right of the vertical line.	R
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing WellCare of North Carolina. WellCare of North Carolina programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (e.g., 10.00), enter 00 in the area to the right of the vertical line.	C
30	BALANCE DUE	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (e.g., 10.00), enter 00 in the area to the right of the vertical line.	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid, the claim will be returned unprocessed. **Note:** Does not exist in the electronic 837P.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
32	SERVICE FACILITY LOCATION INFORMATION	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box numbers are not acceptable here.) First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen.	C
32a	NPI – SERVICES RENDERED	Typical providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	c
32b	OTHER PROVIDER ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical Providers: Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces). Atypical Providers: Enter the 2-character qualifier 1D (no spaces).	C
33	BILLING PROVIDER INFO & PH#	Enter the billing provider's complete name, address (include the zip + 4 code), and phone number. First line -Enter the business/facility/practice name. Second line -Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line -In the designated block, enter the city and state. Fourth line- Enter the zip code and phone number. When entering a 9-digit zip code (zip+ 4 code), include the hyphen.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
		Do not use a hyphen or space as a separator within the telephone number (e.g., (555)555-5555). NOTE: The 9-digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission.	
33a	GROUP BILLING NPI	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID.	R
33b	GROUP BILLING OTHERS ID	Enter as designated below the Billing Group Taxonomy Code. Typical Providers: Enter the Provider Taxonomy Code. Use ZZ qualifier. Atypical Providers: Enter the Provider ID number.	R

999 Functional Acknowledgement

The 999 Functional Acknowledgement reports on all Implementation Guide edits from the Functional Group and transaction Sets.

Batch Matching

Senders of batch transmissions should note that transactions are unbundled during processing, and rebundled so that the original bundle is not replicated. Trace numbers or patient account numbers should be used for batch matching or batch balancing.

Claims Processing

Acknowledgements

Senders receive four types of acknowledgement transactions: the TA1 transaction to acknowledge the Interchange Control Envelope (ISA/IEA) of a transaction; the 999 transaction to acknowledge the Functional

Group (GS/GE) and Transaction Set (ST/SE); the 277CA transaction to acknowledge health care claims; and the WellCare of North Carolina Audit Report. At the claim level of a transaction, the only acknowledgement of receipt is the return of the Claim Audit Report and/or a 277CA.

Coordination of Benefits (COB) Processing

To ensure the proper processing of claims requiring coordination of benefits, WellCare of North Carolina recommends that providers validate the patient's Membership Number and supplementary or primary carrier information for every claim.

Code Sets

Only standard codes, valid at the time of the date(s) of service, should be used.

Corrections and Reversals

The 837 defines what values submitters must use to signal payers that the Inbound 837 contains a reversal or correction to a claim that has previously been submitted for processing. For both Professional and Institutional 837 claims, 2300 CLM05-3 (Claim Frequency Code) must contain a value for the National UB Data Element Specification Type List Type of Bill Position 3.

Data Format/Content

WellCare of North Carolina accepts all compliant data elements on the 837 Professional Claim. The following points outline consistent data format and content issues that should be followed for submission.

Dates

The following statements apply to any dates within an 837 transaction:

All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD.

The only values acceptable for "CC" (century) within birthdates are 18, 19, or 20.

Dates that include hours should use the following format: CCYYMMDDHHMM.

Use Military format, or numbers from 0 to 23, to indicate hours. For example, an admission date of 201006262115 defines the date and time of June 26, 2010, at 9:15 PM.

No spaces or character delimiters should be used in presenting dates or times.

Dates that are logically invalid (e.g., 20011301) are rejected.

Dates must be valid within the context of the transaction. For example, a patient's birth date cannot be after the patient's service date.

Decimals

All percentages should be presented in decimal format. For example, a 12.5% value should be presented as .125.

Dollar amounts should be presented with decimals to indicate portions of a dollar; however, no more than two positions should follow the decimal point. Dollar amounts containing more than two positions after the decimal point are rejected.

Monetary and Unit Amount Values

WellCare of North Carolina accepts all compliant data elements on the 837 Professional Claim; however, monetary or unit amount values that are in negative numbers are rejected.

Delimiters

Delimiters are characters used to separate data elements within a data string. Delimiters suggested for use by WellCare of North Carolina are specified in the Interchange Header segment (the ISA level) of a transmission; these include the tilde (~) for segment separation, the asterisk (*) for element separation, and the colon (:) for component separation.

Phone Numbers

Phone numbers should be presented as contiguous number strings, without dashes or parenthesis markers. For example, the phone number (336) 555-1212 should be presented as 3365551212. Area codes should always be included. WellCare of North Carolina requires the phone number to be AAABBBCCCC where AAA is the Area code, BBB is the telephone number prefix, and CCCC is the telephone number.

Additional Items

- WellCare of North Carolina will not accept more than 97 service lines per CMS 1450 (UB-04) claim.
- WellCare of North Carolina will not accept more than 50 service lines per CMS 1500 claim.
- WellCare of North Carolina will only accept single digit diagnosis pointers in the SV107 of the 837P.
- The Value-Added Network Trace Number (2300-REF02) is limited to 30 characters.

Connectivity Media for Batch Transactions

Encryption

WellCare of North Carolina offers the following methods of encryption SSH/SFTP, FTPS (Auth TLS), FTP w/PGP, HTTPS (Note this method only applies with connecting to WellCare of North Carolina's Secure FTP. WellCare of North Carolina does not support retrieval of files automatically via HTTPS from an external source currently.) If PGP or SSH keys are used, they will be shared with the trading partner. These are not required for connecting via SFTP or HTTPS.

Direct Submission

WellCare of North Carolina also offers posting an 837-batch file directly on the Secure Provider Portal website for processing.

Edits and Reports

Incoming claims are reviewed first for HIPAA compliance and then for WellCare of North Carolina business rules requirements. The business rules that define these requirements are identified in the 837 Professional

Data Element Table below and are also available as a comprehensive list in the 837 Professional Claims – WellCare of North Carolina Business Edits Table. HIPAA TR3 implementation guide errors may be returned on either the TA1 or 999 while WellCare of North Carolina business edit errors are returned on the WellCare of North Carolina Claims Audit Report.

Reporting

The following table indicates which transaction or report to review for problem data found within the 837 Professional Claim Transaction.

Transaction Structure Level	Type of Error or Problem	Transaction or Report Returned
ISA/IEA Interchange Control		TA1
GS/GE Functional Group ST/SE Segment Detail Segments	HIPAA Implementation Guide violations	999 WellCare of North Carolina Claims Audit Report (a proprietary confirmation and error report)
Detail Segments	WellCare of North Carolina Business Edits (See audit report rejection reason codes and explanation.)	WellCare of North Carolina Claims Audit Report (a proprietary confirmation and error report)
Detail Segments	HIPAA Implementation Guide violations and WellCare of North Carolina Business Edits	277CA

Duplicate Batch Check

To ensure that duplicate transmissions have not been sent, WellCare of North Carolina checks five values within the ISA for redundancy:

ISA06, ISA08, ISA09, ISA10, ISA13

Collectively, these numbers should be unique for each transmission. A duplicate ISA/IEA receives a TA1 response of “025” (Duplicate Interchange Control Number).

To ensure that Transaction Sets (ST/SE) have not been duplicated within a transmission, WellCare of North Carolina checks the ST02 value (Transaction Set Control Number), which should be a unique ST02 within the Functional Group transmitted.

Note: ISA08 & GS03 could also be the Single Payer ID

Identification Codes and Numbers

General Identifiers

Sender Identifier

The Sender Identifier is presented at the Interchange Control (ISA06) of a transmission. WellCare of North Carolina expects to see the sender's Federal Tax Identifier (ISA05, qualifier 30) for this value. In special circumstances, WellCare of North Carolina will accept a "Mutually Defined" (ZZ) value. Senders wishing to submit a ZZ value must confirm this identifier with WellCare of North Carolina EDI.

Provider Identifiers

National Provider Identifiers (NPI)

HIPAA regulation mandates that providers use their NPI for electronic claims submission. The NPI is used at the record level of HIPAA transactions; for 837 claims, it is placed in the 2010AA loop. See the 837 Professional Data Element table for specific instructions about where to place the NPI within the 837 Professional file. The table also clarifies what other elements must be submitted when the NPI is used.

Billing Provider

The Billing Provider Primary Identifier should be the group/organization ID of the billing entity, filed only at 2010AA. This will be a Type 2 (Group) NPI unless the Billing provider is a sole proprietor and processes all claims and remittances with a Type 1 (Individual) NPI.

Rendering Provider

When providers perform services for a subscriber/patient, the service will need to be reported in the Rendering Provider Loop (2310B or 2420A) You should only use 2420A when it is different than Loop 2310B/NM1*82.

Referring Provider

WellCare of North Carolina has no specific requirements for Referring Provider information.

Atypical Provider

Atypical Providers are not always assigned an NPI number, however, if an Atypical Provider has been assigned an NPI, then they need to follow the same requirements as a medical provider. An Atypical Provider which provides non-medical services is not required to have an NPI number (i.e., carpenters, transportation, etc.). Existing Atypical Providers need only send the Provider Tax ID in the REF segment of the Billing Provider loop. *NOTE: If an NPI is billed in any part of the claim, it will not follow the Atypical Provider Logic.*

Subscriber Identifiers

Submitters must use the entire identification code as it appears on the subscriber's card in the 2010BA element.

Claim Identifiers

WellCare of North Carolina issues a claim identification number upon receipt of any submitted claim. The ASC X12 Technical Reports (Type 3) may refer to this number as the Internal Control Number (ICN), Document Control Number (DCN), or the Claim Control Number (CCN). It is provided to senders in the Claim Audit Report and in the CLP segment of an 835 transaction. WellCare of North Carolina returns the submitter's Patient Account Number (2300, CLM01) on the Claims Audit Report and the 835 Claim Payment/Advice (CLP01).

New Trading Partners

New trading partners should access https://sites.edifecs.com/index.jsp?WellCare of North Carolina, register for access, and perform the steps in the WellCare of North Carolina trading partner program. The EDI Support Desk (EDIBA@WellCare of North Carolina.com) will contact you with additional steps necessary upon completing your registration.

Rules of Exchange

The Rules of Exchange section details the responsibilities of trading partners in submitting or receiving electronic transactions with WellCare of North Carolina.

Transmission Confirmation

Transmission confirmation may be received through one of two possible transactions: the ASC X12C/005010X231 Implementation Acknowledgment for Health Care Insurance (TA1, 999). A TA1 Acknowledgement is used at the ISA level of the transmission envelope structure, to confirm a positive transmission or indicate an error at the ISA level of the transmission. The 999 Acknowledgement may be used to verify a successful transmission or to indicate various types of errors.

Confirmations of transmissions, in the form of TA1 or 999 transactions, should be received within 24 hours of batch submissions, and usually sooner. Senders of transmissions should check for confirmations within this time frame.

TA1 Interchange Acknowledgement

The TA1 Interchange Acknowledgement provides senders a positive or negative confirmation of the transmission of the ISA/IEA Interchange Control.

STATE MANDATED REGULATORY REQUIREMENTS

NORTH CAROLINA

STATE REGULATORY REQUIREMENTS

This section sets forth the provisions that are required by State law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product are or will be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, or a Participation Provider is subject to the law cited in the parenthetical at the end of a provision in this section, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person or Participating Provider, as applicable.
The Parties shall comply with the State requirements set forth below.

NC-1 Entire Agreement. The Agreement and any attached or incorporated amendments, exhibits, or appendices constitute the entire contract between the parties in accordance with this Section NC-1 and the "Entire Agreement" provision of the Agreement. (11 N.C. ADMIN. CODE 20.0202(1)).

NC-2 Definitions. Except as set forth in this Section NC-2, the definitions of technical insurance or managed care terms used in the Agreement are generally set forth in the "Definitions" Article of the Agreement. To the extent applicable, such definitions contain references to certain other documents distributed to providers (e.g., the Provider Manual), and are consistent with the definitions included in the evidence of coverage issued in connection with the Coverage Agreements. (11 N.C. ADMIN. CODE 20.0202(2)).

When appearing in this Product Attachment or the Agreement, the following quoted and bolded terms (and the plural thereof, when appropriate) have the meaning set forth below with respect to the Individual Market Product.

a. "***Emergency Medical Condition***" and "***Emergency Services***" or "***Emergency Care***" have the meaning set forth in N.C. GEN. STAT. § 58-3-190(g), which as of the Effective Date, "Emergence Services" (sometimes referred to herein as Emergency Care) means those health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department, and "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge
of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following: (a) placing the health of an individual, or with respect to a pregnant member, the

health of the member or their unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

b. "***Medical Necessity***" or "***Medically Necessary***" or "***Medically Necessary Services or Supplies***" has the definition set forth at N.C. GEN STAT. § 58-3-200(b), which, as of the Effective Date, is as follows: those Covered Services (or supplies) that are: (1) provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease, and, except as allowed under N.C. GEN. STAT. § 58-3-255 (regarding coverage of clinical trials), not for experimental, investigational, or cosmetic purposes; (2) necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms; (3) within generally accepted standards of medical care in the community; and (4) not solely for the convenience of the insured (i.e., the Covered Person), the insured's family, or the provider.

For Medically Necessary services, nothing herein precludes a Payor from comparing the cost effectiveness of alternative services or supplies when determining which of the services or supplies will constitute Covered Services.

c. "***Intermediary***" has the definition set forth at 11 N.C. ADMIN. CODE 20.0101(b)(4), which, as of the Effective Date, is as follows: an entity that employs or contract with health care providers for the provision of health care services, and that also contracts with a network plan carrier, including the Company or a Payor, or its intermediary.

d. ***"Utilization Review"*** or ***"utilization review"*** means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities. These techniques may include: (a) ambulatory review - utilization review of services performed or provided in an outpatient setting; (b) case management - a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions; (c) certification - a determination by an insurer or its designated utilization review organization that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies the insurer's requirements for medically necessary services and supplies, appropriateness, health care setting, level of care, and effectiveness; (d) concurrent review - utilization review conducted during a patient's hospital stay or course of treatment; (e) discharge planning - the formal process for determining, before discharge from a provider facility, the coordination and management of the care that a patient receives after discharge from a provider facility; (f) prospective review - utilization review conducted before an admission or a course of treatment including any required preauthorization or precertification; (g) retrospective review - utilization review of medically necessary services and supplies that is conducted after services have been provided to a patient, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment. Retrospective review includes the review of claims for emergency services to determine whether the prudent layperson standard in N.C. GEN. STAT. §

58-3-190 has been met; (h) second opinion - an opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service.

NC-3 Term. The term of the Agreement is set forth in the "Term" provision of the Agreement, and the term of this Product Attachment is set forth in Section 6 of this Product Attachment. (11 N.C. ADMIN. CODE 20.0202(3)).

NC-4 Written Notice of Termination; Grounds for Termination. The requirements for written notice of termination and each Party's grounds for termination are generally set forth in the "Term and Termination" Article of the Agreement. (11 N.C. ADMIN. CODE 20.0202(4)).

NC-5 Continuity of Care. Each Participating Provider shall continue to provide services to Covered Persons after termination of the Agreement or in the event of a Payor's or Intermediary's insolvency in accordance with the "Effect of Termination" provision of the Agreement and this Section NC-5, including, but not limited to, when inpatient care of a Covered Person is ongoing until patient is ready for discharge. In addition, in the event of a Payor's or Intermediary's insolvency, each Participating Provider shall continue to provide services to Covered Persons during the period for which premium has been paid. Each Participating Provider will cooperate with Company regarding the transition of administrative duties and records. To the extent that services are provided or arranged for on prepaid basis, each Participating Provider shall continue to provide inpatient care until the Covered Person is ready for discharge. (11 N.C. ADMIN. CODE 20.0202(5); N.C. GEN. STAT. § 58-67-120).

NC-6 Credentials. Each Participating Provider shall maintain licensure, accreditation, and credentials sufficient to meet Company's and/or Payor's credential verification program requirements, which are set forth in the Policies. Each Participating Provider shall notify Company of subsequent changes in status of any information relating to the Participating Provider's professional credentials in accordance with this Section NC-6 and the "Notice of Certain Events" provision of the Agreement. (11 N.C. ADMIN. CODE 20.0202(6)).

NC-7 Insurance. Each Participating Provider shall maintain professional liability insurance coverage in an amount acceptable to Health Plan and will inform Health Plan of subsequent changes in status of professional liability insurance on a timely basis in accordance with this Section NC-7 and the "Insurance" provision of the Agreement. (11 N.C. ADMIN. CODE 20.0202(7)).

NC-8 Hold Harmless.

a. No Participating Provider shall bill a Covered Person for Covered Services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a Participating Provider and a Covered Person from agreeing to continue non-

Covered Services at the Covered Person's own expense if the Participating Provider has notified the Covered Person in advance that the Payor may not cover or continue to cover specific services and the Covered Person chooses to receive the service. This Section NC-8 survives termination of the Agreement for any reason, including Plan insolvency. Each Participating Provider is responsible for collecting any applicable deductibles, copayments, coinsurance, and fees for non-Covered Services from Covered Persons. (11 N.C. ADMIN. CODE 20.0202(8)).

b. In the event Payor fails to pay for Covered Services as set forth in the Agreement, the Covered Person shall not be liable to the Participating Provider for any sums owed by the Payor. No other provisions of the Agreement will, under any circumstances, change the effect of the foregoing. No Participating Provider, or agent, trustee, or assignee thereof, may maintain any action at law against a Covered Person to collect sums owed by the Payor. (N.C. GEN. STAT. § 58-67-115(a))

NC-9 Call Coverage. Each Participating Provider shall arrange for call coverage or other backup to provide service in accordance with the Payor's standards for provider accessibility, which are set forth in the Agreement, the Provider Manual, or the Policies. (11 N.C. ADMIN. CODE 20.0202(9)).

NC-10 Eligibility. A mechanism for Participating Providers to verify the eligibility of Covered Persons (based on current information held by Company or Payor, as applicable) before rendering health care services will be made available in accordance with the "Eligibility Determinations" section of the Agreement. (11 N.C. ADMIN. CODE 20.0202(10)).

NC-11 Records. Each Participating Provider shall: (a) maintain confidentiality of Covered Person medical records and personal information as required by N.C. Gen. Stat. Title 58, Article 39 and other health records as required by all applicable law; (b) maintain adequate medical and other health records according to industry and Company and/or Payor standards; and (c) make copies of such records available to Company, Payors and the North Carolina Department of Insurance in conjunction with its regulation of Company or Payor. (11 N.C. ADMIN. CODE 20.0202(11)).

NC-12 Grievance Procedures. Each Participating Provider shall cooperate with Covered Persons in grievance procedures in accordance with this Section NC-12, the Policies of Company or Payor, and the Agreement. (11 N.C. ADMIN. CODE 20.0202(12)).

NC-13 Discrimination Prohibition. Each Participating Provider shall not discriminate against any Covered Person based on race, color, national origin, gender, age, religion, marital status, health status, or health insurance coverage. (11 N.C. ADMIN. CODE 20.0202(13)).

NC-14 Compensation. The methodology to be used as a basis for payment (for example, Medicare DRG reimbursement, discounted fee for service, withhold arrangement, HMO provider capitation, or capitation with bonus) to the Participating Provider under the Agreement is set forth in the Compensation Schedule set forth or described in one or more Attachments to the Agreement. (11 N.C. ADMIN. CODE 20.0202(14))

NC-15 Data. Company will provide certain data and other information to the Participating Provider, if applicable, such as: (a) performance feedback reports or information, if compensation is related to efficiency criteria, or (b) information on benefit exclusions, administrative and utilization management requirements, credential verification programs, quality assessment programs, and provider sanction policies and/or program. Company will also provide advance notice of changes in such requirements in accordance with the Agreement to allow Participating Providers time to comply with such changes. (11 N.C. ADMIN. CODE 20.0202(15)).

NC-16 Programs. Each Participating Provider shall comply with Company's or Payor's utilization management programs, credential verification programs, quality management programs, and provider sanctions programs. Notwithstanding the foregoing or any other provision of the Agreement, none of these programs override the professional or ethical responsibility of the Participating Provider or interfere with the Participating Provider's ability to provide information or assistance to their patients. (11 N.C. ADMIN. CODE 20.0202(16)).

NC-17 Use of Name. Each Participating Provider authorizes Company or Payor to use of the name of the Participation Provider or the Participating Provider's group in the provider directory distributed to Covered Persons in accordance with this Section NC-17 and the "Use of Name" provision of the Agreement. Company or Payor, as applicable, will include the name of the Participating Provider or the Participating Provider's group in the provider directory. (11 N.C. ADMIN. CODE 20.0202(17)).

NC-18 Disputes. The process to be followed to resolve contractual differences between the Health Plan and/or Company, as applicable (including any Company acting as Payor), and a Participating Provider is set forth in the "Dispute Resolution" Article of the Agreement. (11 N.C. ADMIN. CODE 20.0202(18)).

NC-19 Assignment. The Participating Provider's duties and obligations under the Agreement may not be assigned, delegated, or transferred without the prior written consent of Health Plan. Health Plan shall notify the Participating Provider, in writing, of any duties or obligations that are to be delegated or transferred by Participating Provider, before the delegation or transfer (i.e., Health Plan will send prior written notice of the delegation or transfer to the Participating Provider). (11 N.C. ADMIN. CODE 20.0202(19)).

NC-20 Intermediary Contracts. If Provider is an Intermediary, the following apply. (11 N.C. ADMIN. CODE 20.0204(b))

a. Provider's contracts with health care providers will comply with, and include the applicable provisions of, 11 N.C. ADMIN. CODE 20.0202, which, as of the Effective Date, are set forth in this Exhibit.

b. Company and Payor each retains its legal responsibility to monitor and oversee the offering of services to Covered Persons and the Payor retains its financial responsibility to Covered Persons.

c. Provider is prohibited from subcontracting its services without the written permission of Health Plan.

d. Company or Payor may approve or disapprove the participation of each health care. provider contracted with Provider for inclusion in or removal from the network (i.e., the status as a Participating Provider with respect to a Coverage Agreement).

e. Provider shall make available for review by the Department of Insurance all provider contracts and subcontracts held by Provider.

f. If Provider assumes risk from Health Plan, pays its health care providers on a risk basis or is responsible for claims payment to its providers, (1) Provider shall provide Health Plan will documentation of utilization and claims payment, and maintain accounting systems and records necessary to support the arrangement; (2) Provider will cooperate with Health Plan in order for it to arrange for financial protection of itself and Covered Persons through such approaches as hold harmless language, retention of signatory control of the funds to be disbursed, or financial reporting requirements; and (3) to the extent provided by law, the Department of Insurance will have access to the books, records and financial information to examine activities performed by Provider on behalf of Health Plan. Provider shall maintain such books and records in the State of North Carolina.

g. Provider shall comply with all applicable statutory and regulatory requirements that apply to the functions delegated by Health Plan and assumed by Provider.

NC-21 Intentionally Omitted.

NC-22 Notices. The name or title and address for notices to each Party under the Agreement, including notices of proposed amendments, are set forth in the "Notices" provision of the Agreement. (N.C. GEN. STAT. § 58-50-275).

NC-23 Amendments. Health Plan may amend the Agreement (including any Product Attachment) by sending written notice of the proposed amendment to the notices contact of the Provider set forth in the

Agreement. Unless Provider notifies Health Plan in writing of its objection to such amendment during the sixty (60) day period following receipt of the proposed amendment, Provider will be deemed to have accepted the amendment. If Provider objects to a proposed amendment, then the proposed amendment is not effective, and the Health Plan may terminate the Agreement (and/or the applicable Product Attachment(s)) upon sixty (60) days' written notice to Provider. In addition, Health Plan and Provider may amend the Agreement at any time through mutual written agreement, documented by the signatures of duly authorized representatives of the Parties. (N.C. GEN STAT. § 58-50-280).

NC-24 Recovery of Overpayments. Health Plan shall provide at least thirty (30) days advance written notice to Provider of any offset made to future payments in connection with an overpayment recovery, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery.

NC-25 Compliance with Applicable Laws. This Product Attachment and the Agreement are intended to comply with all laws applicable to the Individual Market Product Attachment and, to the extent applicable to the Individual Market Product, Health Plan, Payors and Participating Providers, as applicable, shall comply with such laws, including N.C. GEN. STAT. § 58-3-225.

WellCare®
of North Carolina by Celtic Insurance Company