West Virginia | Mountain Health Trust

Provider Manual

800-782-0095 | provider.wellpoint.com/wv

Wellpoint

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Table of Contents

CHAPTER 1: INTRODUCTION

Welcome

Welcome and thank you for being part of the Wellpoint network.

Through the Mountain Health Trust program, managed by BMS, Wellpoint has been selected by the state of West Virginia Department of Human Services (DoHS) Bureau for Medical Services (BMS) to provide healthcare services for Medicaid and WVCHIP enrollees in all counties in West Virginia.
At Wellpoint, we are proud of local staff who work to maximize healthcare services for our members. The health plan has local field representatives who link network providers, members, and community agencies to Wellpoint resources. Staff is available to:

- Provide training for healthcare professionals and their staff regarding enrollment, covered benefits, managed care operations, and linguistic services.
- Provide member support services, including health education referrals, event coordination, and coordination of cultural and linguistic services.
- Coordinate access to community health education resources for breastfeeding, smoking cessation, diabetes, and asthma, to name a few.

There is strength in numbers; Wellpoint's health services programs, combined with those already available in the community, are designed to supplement providers' treatment plans. Our programs also serve to improve our members' overall health by informing, educating, and encouraging self-care in the prevention, early detection, and treatment of existing conditions and chronic disease.

About this manual

This provider manual is designed for physicians, hospitals, and ancillary providers. Our goal is to create a useful reference guide for you and your office staff. We want to help you navigate our managed healthcare plan to find the most reliable, responsible, timely and cost-effective ways to deliver quality healthcare to our members.

We recognize that managing our members' health can be a complex undertaking requiring familiarity with the rules and regulations of a complex healthcare system. This system encompasses a wide array of services and responsibilities (for example, initial health assessments (IHAs), case management, proper storage of medical records, and billing for emergencies). With this complexity in mind, we divided this manual into sections that reflect your questions, concerns, and responsibilities before and after a Wellpoint member walks through your doors. The sections are organized as follows:

- Legal requirements
- Contact numbers
- Before rendering services
- After rendering services

- Operational standards, requirements and guidelines
- Additional resources

Availity Essentials

Availity Essentials is a secure multi-payer platform that offers healthcare professionals free access to real-time information and instant responses in a consistent format regardless of the payer.

Through Availity, you can:

- Confirm eligibility.
- Determine if a prior authorization is required.
- Request authorizations via Interactive Care Reviewer (ICR).
- Submit claims.
- View the status of a claim.
- Dispute a claim.
- Submit a medical attachment.
- Report a member's pregnancy.

For more information on using Availity, see **Learn About Availity Platform** or visit the Availity Learning Hub to take on-demand courses with your Availity user ID and password.

Legal requirements

The information contained in this manual is proprietary, will be updated regularly, and is subject to change. This section provides specific information on the legal obligations of being part of the Wellpoint network.

Contacts

This section is your reference for important contact numbers, websites, and mailing addresses.

Before rendering services

This section provides the information and tools you will need before providing services, including *Member Eligibility* and a list of *Covered and Noncovered Services*. The section also includes a chapter on the prior authorization process and the coordination of complex care through our Utilization Management department.

We take pride in our proactive approach to health. The chapter on health services programs details how targeted programs can supplement your treatment plans to make the services you provide more effective. For example, the initial health assessment is our first step in providing preventive care. The emergency room action campaign is aimed at promoting proper use of emergency room services, and the health services programs under *Condition Management* take direct aim at

combating the most common and serious conditions and illnesses facing our members, including obesity, cardiovascular disease, diabetes, and asthma.

After rendering services

At Wellpoint, our goal is to make the billing process as streamlined as possible. The **After Rendering Services** section provides guidelines and detailed coding charts for fast, secure, and efficient billing and includes specific information about filing claims for professional and institutional services. In addition, the *Member Transfers* chapter outlines the steps for members who want to change their assignment of PCP or transfer to another health plan. When questions or concerns come up about claims or adverse determinations, our chapter on grievances and appeals will take you step-by-step through the process.

Operational standards, requirements, and guidelines

This section summarizes the requirements for provider office operations and access standards, thereby ensuring consistency when members need to consult with providers for IHAs, referrals, coordination of care and follow-up care. Additional chapters detail provider credentialing, provider roles and responsibilities, and enrollment and marketing guidelines. Chapters on both clinical practice and preventive health guidelines and case management outline the steps providers should take to coordinate care and help members take a proactive stance in the fight against disease. And finally, we included a chapter documenting our commitment to participate in the quality assessments that help Wellpoint measure, compare and improve our standards of care.

Additional resources

To help providers serve a diverse and ever-evolving patient population, we designed a special program, Culturally and Linguistically Appropriate Services, to improve provider/member communications by cutting through language and other cultural barriers. In addition, Wellpoint works with nationally recognized healthcare organizations to stay current on the latest healthcare breakthroughs and discoveries. This manual provides easy links to access that information. We also provide forms and reference guides on a wide variety of subjects.

Cultural competency training and other relevant trainings can be found at provider.wellpoint.com/wv > **Resources** > **Provider Training Academy**.

Accessing information, forms, and tools on our website

Throughout this manual, we will refer to items located on our provider website. To access the Medicaid provider website, go to provider.wellpoint.com/wv. Once there you will find various resources such as forms, provider training academy, policies, and guidelines, as well as this manual. Other useful information can be found under the **Claims**, **Patient Care**, and **Prior Authorization & Eligibility** tabs.

For the latest provider news and a full archive of past communications and newsletters, select the Communications tab. To access a PDF of this provider manual online, select the **Resources** tab and select **Manuals, Policies, and Guidelines**.

Helpful tip: provider.wellpoint.com/wv is a direct connect to **Provider Resources, Claims Resources, Prior Authorization & Eligibility** and much more.

Using the provider manual

Select any topic in the *Table of Contents* to view that chapter and select any web address to be redirected to that site. Each chapter may contain cross-links to other chapters, to the provider website or to external websites containing additional information.

Websites

The provider website and this manual may contain links and references to internet sites owned and maintained by third-party sites. Neither Wellpoint nor its related affiliated companies operate or control, in any respect, any information, products or services on third-party sites. Such information, products, services, and related materials are provided *as is* without warranties of any kind, either express or implied, to the fullest extent permitted under applicable laws. Wellpoint disclaims all warranties, express or implied, including, but not limited to, implied warranties of merchantability and fitness. Wellpoint does not warrant or make any representations regarding the use or results of the use of third-party materials in terms of their correctness, accuracy, timeliness, reliability, or otherwise.

CHAPTER 2: LEGAL AND ADMINISTRATIVE REQUIREMENTS

Proprietary information

The information contained in this provider manual is proprietary. By accepting this manual, Wellpoint providers agree:

- To use this manual solely for the purposes of referencing information regarding the provision of medical services to Wellpoint members enrolled for services through Wellpoint.
- To protect and hold the manual's information as confidential.
- Not to disclose the information contained in this manual.

Privacy practices

Wellpoint's latest *HIPAA*-compliant privacy and security statements may be found in the Notice of Privacy Practices. For more information, refer to the provider website at provider.wellpoint.com/wv. For directions on how to access our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

Throughout this manual, there are instances where information is provided as a sample or example. This information is meant to illustrate and is not intended to be used or relied upon.

There are places within the manual where you may leave the Wellpoint site and link to another operated by a third party. These links are provided for your convenience and reference only. Wellpoint and its subsidiary companies do not control such sites and do not necessarily endorse these sites. Wellpoint is not responsible for their content, products, or services.

Please be aware that when you link from the Wellpoint site to another site, you will be subject to the privacy policies (or lack thereof) of the other sites. Wellpoint cautions you to determine the privacy policy of such sites before providing any personal information.

Misrouted protected health information

Providers and facilities are required to review all member information received from Wellpoint to ensure no misrouted protected health information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email, or electronic remittance advice. Providers and facilities are required to destroy immediately any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please contact the Customer Care Center at **800-782-0095**.

Updates and changes

The provider manual, as part of your provider agreement and related addendums, may be updated at any time and is subject to change. In the event of an inconsistency between information contained

in the manual and the provider agreement between you or your facility and Wellpoint, the provider agreement shall govern.

In the event of a material change to the provider manual, we will make all reasonable efforts to notify you in advance of such change through web-posted newsletters, emails, fax communications (such as provider bulletins) and other mailings. In such cases, the most recently published information should supersede all previous information and be considered the current directive. Wellpoint will notify providers of any material change at least 30 days before the intended effective date of the change.

The manual is not intended to be a complete statement of all Wellpoint policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially targeted communications, as referenced above. This manual does not contain legal, tax or medical advice. Please consult your own advisors for such advice.

Nondiscrimination statement

Wellpoint does not engage in, aid, or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color or national origin in providing aid, benefits or services to beneficiaries. Wellpoint does not utilize or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. Wellpoint does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of or subjecting them to discrimination on the basis of gender or gender identity. In addition, in compliance with the *Age Act*, Wellpoint may not discriminate against any person on the basis of age or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Wellpoint provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when a Wellpoint representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so if the member requests assistance. We document, track, and trend all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at: https://ocrportal.hhs.gov
- By mail to:

  Centralized Case Management Operations
  U.S. Department of Health and Human Services
  200 Independence Ave. SW
  Room 509F HHH Building
  Washington, DC 20201.

- By phone at: **800-368-1019** (**TDD: 800-537-7697**).

Complaint forms are available at https://hhs.gov/ocr/complaints/index.html.

Wellpoint provides free tools and services to people with disabilities to communicate effectively with us. Wellpoint also provides free language services to people whose primary language isn't English (for example, qualified interpreters and information written in other languages). These services can be obtained by calling the Member Services number on their member ID card.

If you or your patient believe that Wellpoint has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with our member advocate via:

- Phone: **888-611-9958**
- Mail:

  Wellpoint
  Attn: Grievance and Appeals
  P.O. Box 91
  Charleston, WV 25321-0091

Equal program access on the basis of gender

Wellpoint provides individuals with equal access to health programs and activities without discriminating on the basis of gender. Wellpoint must also treat individuals in a manner consistent with their gender identity and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (that is, race, color, national origin, gender, gender identity, age, or disability).

Wellpoint may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual based on the fact that a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

Provider and facility digital guidelines

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

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

Digital guidelines establish the standards for using secure digital provider platforms (websites) and applications when transacting business with Wellpoint These platforms and applications are accessible to both participating and nonparticipating providers and facilities and encompass

Availity.com, electronic data interchange (EDI), electronic medical records (EMR) connections and business-to-business (B2B) desktop integration.

The *Digital Guidelines* outline the digital/electronic platforms Wellpoint has available to participating and nonparticipating providers and facilities who serve its members. The expectation of Wellpoint is based on our contractual agreement that providers and facilities will use these digital platforms and applications, unless otherwise mandated by law or other legal requirements.

Digital and/or electronic transaction applications are accessed through these platforms:

- Availity EDI Clearinghouse
- B2B application programming interfaces (APIs)
- EMR connections

Digital guidelines available through Availity Essentials include:

- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response
- Prior authorization submissions including updates, clinical attachments, authorization status, and clinical appeals
- Claim submission, including attachments, claim status
- Remittances and payments
- Provider enrollment
- Demographic updates

Additional digital applications available to providers and facilities include:

- Pharmacy prior authorization drug requests
- Services through Carelon Medical Benefits Management, Inc.
- Services through Carelon Behavioral Health, Inc.

Wellpoint expects providers and facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (paper, mail, fax, call, chat, etc.). All channels are consistent with industry standards. All EDI transactions use version 5010.

Note: As a mandatory requirement, all trading partners must currently transmit directly to the Availity EDI gateway and have an active Availity Trading Partner Agreement in place. This includes providers using their practice management software & clearinghouse billing vendors.

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

Section 1: Accepting digital ID cards

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

Section 2: Eligibility and benefits inquiry and response

- Providers and facilities should leverage these Availity Clearinghouse hosted channels for electronic eligibility and benefit inquiry and response:
- EDI transaction: X12 270/271 – eligibility inquiry and response
- Wellpoint supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- Availity Essentials
- The Eligibility and Benefits Inquiry verification application allows a provider and facility to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs
- Wellpoint has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration opportunities.

Section 3: Prior authorization submission, attachment, status, and clinical appeals.

Providers and facilities should leverage these channels for prior authorization submission, status inquiries and to submit electronic attachments related to prior authorization submissions:

- EDI transaction: X12 278 – prior authorization and referral:
  - Wellpoint supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per HIPAA.
- EDI transaction: X12 275 – patient information, including HL7 payload for authorization attachments:
  - Wellpoint supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.

- Availity Essentials:
  - Authorization applications include the Availity Essentials multi-payer Authorization and Referral application and the Interactive Care Reviewer (ICR) for authorization submissions not accepted through Availity Essentials' multi-payer application:
    - Both applications enable prior authorization submission, authorization status inquiry and the ability to review previously submitted authorizations.
- Provider desktop integration via B2B APIs:
  - Wellpoint has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Section 4: Claims: submissions, claims payment disputes, attachments, and status

Claim submissions status and claims payment disputes

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

- EDI transaction: X12 837 – Professional, institutional, and dental claim submission (version 5010):
  - Wellpoint supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.
  - 837 claim batch upload through EDI allows a provider to upload a batch/file of claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – claim status inquiry and response:
  - Wellpoint supports the industry standard X12 276/277 transaction set for claim status inquiry and response as mandated by HIPAA.
- Availity Essentials: The Claims & Payments application enables a provider to enter a claim directly into an online claim form and upload supporting documentation for a defined claim:
  - Claim status application enables a provider to access online claim status. Access the claim payment dispute tool from claim status when initiating a dispute by locating claim and selecting the Dispute Button. It is the expectation of Wellpoint that electronic claim payment disputes are adopted when and where it is integrated.
- Provider desktop integration via B2B APIs:
  - Wellpoint has also enabled real-time access to Claim Status via APIs, which can be directly integrated within participating vendor's practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Claim attachments

Providers and facilities should leverage these channels for electronic claim attachments from Availity.com:

- EDI transaction: X12 275 – Patient information, including HL7 payload attachment:

  - Wellpoint supports the industry standard X12 275 transaction for electronic transmission of supporting claim documentation including medical records via the HL7 payload.

- Availity Essentials – Claim Status application enables a provider or facility to digitally submit supporting claims documentation, including medical records, directly to the claim:
  - Digital Request for Additional Information (Digital RFAI) – The Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation including medical records are needed to process a claim.

Section 5: Electronic remittance advice and electronic claims payment

Electronic remittance advice

Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your claims. Wellpoint supports the industry standard X12 835 transaction as mandated per *HIPAA*.

Providers and facilities can register, enroll and manage ERA preference through https://Availity.com. Printing and mailing remittances will automatically stop thirty (30) days after the ERA enrollment date.

- Viewing an ERA on Availity Essentials is under Claims & Payments, Remittance Viewer. Features of remittance viewer, include the ability to search a two (2) year history of remittances and access the paper image.
- Viewing a portable document format (PDF) version of a remit is under Payer Spaces which provides a downloadable PDF of the remittance.

To stop receiving ERAs for your claims, contact Availity Client Services at **800-AVAILITY** (**282-4548**).
To re-enable receiving paper remittances, contact Provider Services.

Electronic claims payment

Electronic claims payment is a secure and fast way to receive payment, reducing administrative processes. There are several options to receive claims payments electronically:

- **Electronic Funds Transfer (EFT)**

  Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a provider's or facility's bank account at no charge for the deposit. Health plans can use a provider's or facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.

  To enroll in EFT: Providers and facilities can register, enroll, and manage account changes for EFT through EnrollSafe at enrollsafe.payeehub.org. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. For help with enrollment, use this convenient EnrollSafe User Reference Manual.
  To disenroll from EFT: Providers and facilities are entitled to disenroll from EFT.
  Disenroll from EFT payments through EnrollSafe at enrollsafe.payeehub.org.
- **Virtual Credit Card (VCC)**

For providers and facilities who don't enroll in EFT, and in lieu of paper checks, Wellpoint is shifting some reimbursements to virtual credit card (VCC). VCC allow providers and facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply.
Note that Wellpoint may receive revenue for issuing a VCC.
Opting out of virtual credit card payment. Providers and facilities are entitled to opt out of electronic payment. To opt out of virtual credit card payment, there are two (2) options:

- Enrolling for EFT payments automatically opts you out of virtual credit card payments. To receive EFT payments instead of virtual credit cards payments, enroll for EFT through EnrollSafe at enrollsafe.payeehub.org.

  OR

- To opt out of virtual credit card payments, contact Comdata at **800-833-7130** and provide your taxpayer identification number.

- **Zelis Payment Network (ZPN) electronic payment and remittance combination**

  The Zelis Payment Network (ZPN) is an option for providers and facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to Zelis.com. Zelis may charge fees for their services.
  Note that Wellpoint may receive revenue for issuing ZPN.
  ERA through Availity is not available for providers and facilities using ZPN.
  To disenroll from ZPN payment, there are two (2) options:

  - Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at enrollsafe.payeehub.org.

    OR

  - To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at **877-828-8770**.

Not being enrolled for EFT, VCC, or ZPN will result in paper checks being mailed.

CHAPTER 3: CONTACTS

Overview

When you need the right phone number, fax number, website or street address, the information should be right at your fingertips. With that in mind, we have compiled the most-used contacts for you and your office staff. The first chart gives you contact information for Wellpoint. The second chart is contact information for the health services programs and management topics handled by West Virginia.

Wellpoint contacts

Contact information for Wellpoint	
If you have questions about. . .	**Contact:**
Address	General address for all correspondence, including initial claims submission: Wellpoint P.O. Box 91 Charleston, WV 25321-0091 **Note:** For faster service, please indicate how you want the correspondence routed (for example, "Attn: Initial Claims Department").
Authorization	Effective July 1, 2024, all authorizations must be submitted using the electronic portal Interactive Care Reviewer (ICR). https://apps.Availity.com UM staff is available at least eight hours per day during normal business hours to answer and return UM-related calls. Phone: **866-655-7423** Physical Health preservice review fax: **855-402-6983** Physical Health current inpatient review fax: **855-402-6985** Behavioral Health inpatient fax: **855-325-5556** Behavioral Health outpatient fax: **855-325-5557** Hours: Monday to Friday, 8 a.m. to 5 p.m. Website: provider.wellpoint.com/wv
Availity Essentials	Availity Client Services Phone: **800-AVAILITY** (**800-282-4548**) https://Availity.com

If you have questions about. . .	Contact:
Benefits, eligibility, verifying PCP, and general provider questions	Customer Care Center Phone: **800-782-0095 (TTY 711)** Wellpoint Behavioral Health Crisis Line: **833-434-1261** Hours: Monday to Friday, 8 a.m. to 6 p.m. After hours, call the 24/7 NurseLine to verify member eligibility: **888-850-1108 (TTY 711)**
Case Management referrals	Phone: **304-347-2475** Hours: Monday to Friday, 8 a.m. to 5 p.m. Email: **wvcmreferrals@wellpoint.com** Response within three business days. Website: provider.wellpoint.com/wv
Claims overpayment	Mail overpayment to: Wellpoint Attn: Overpayment Recovery P.O. Box 73651 Cleveland, OH 44193 Address for overnight delivery: Wellpoint Attn: Overpayment Recovery Lockbox 92420 4100 West 150th St. Cleveland, OH 44135
Customer Care Center	You now have a new option to have questions answered quickly and easily with Availity Essentials' Chat with Payer. To access Availity Essentials Chat with Payer, go to https://Availity.com and select the appropriate payer space tile from the drop-down. Then, select Chat with Payer and complete the pre-chat form to start your chat. You also have the option when using claim status to chat with payer on claim status return. Hours: Monday to Friday, 8 a.m. to 6 p.m. Phone: **800-782-0095** Fax: **888-438-5209** After hours: Phone: **888-850-1108** TTY: **711** After hours, call the 24/7 NurseLine: **888-850-1108.**

If you have questions about. . .	Contact:
Dental services: SKYGEN	Member Information: Phone: **877-408-0917** TTY: **711** Hours: 8 a.m. to 6 p.m. Website: skygenusa.com Provider Line: **888-983-4686** Hours: Monday to Friday, 8 a.m. to 6 p.m.
Fraud and abuse	**Fraud Hotline** Phone: 866-847-8247 Hours: Monday to Friday, 8 a.m. to 6 p.m. Website: provider.wellpoint.com/wv Address: Special Investigations Unit 740 W Peachtree Street NW Atlanta, GA 30308
Grievances and appeals	For questions related to grievances or appeals, contact the Customer Care Center by phone: **800-782-0095** Hours: Monday to Friday, 8 a.m. to 6 p.m. Written correspondence: Wellpoint Attn: Grievance and Appeals Department P.O. Box 91 Charleston, WV 25321-0091 Fax: **844-882-3520**
Interpreter services	Customer Care Center Phone: **800-782-0095** Hours: Monday to Friday, 8 a.m. to 6 p.m. After hours, call the 24/7 NurseLine: **888-850-1108** For TTY and relay services please call **711**. Customer Care Center TTY line**:** • For voice to TDD: **800-982-8772** • For TDD to voice: **800-982-8771**
Wellpoint office	To obtain Wellpoint staff contact information, contact your provider relationship management consultant: • Phone: **888-611-9958** • Fax: **888-338-1320** • Hours: Monday to Friday, 8 a.m. to 5 p.m.

If you have questions about. . .	Contact:
	Address: Wellpoint 200 Association Drive, Suite 200 Charleston, WV 25311
24/7 NurseLine	Phone: **888-850-1108** TTY: **711** Hours: 24/7 Available after normal business hours to verify member eligibility.
Members with hearing or speech loss	West Virginia Relay Service is a toll-free TDD service. Call **711** or the following numbers: • For voice to TDD: **800-982-8772** • For TDD to voice: **800-982-8771** Website: westvirginiarelay.com
Pharmacy *Preferred Drug List (PDL)* inquiries	The PDL is part of the pharmacy service provided by BMS and is located on the BMS website at https://dhhr.wv.gov/bms/Pages/default.aspx. In the Providers section, select Pharmacy. In the top navigation menu, select Preferred Drug List. Scroll to select the most recently posted version.
Physician-administered drugs (preauthorization)	Phone: **877-375-6185** Fax: **844-487-9290** Peer-to-Peer: **833-293-0659, option 2**
Provider Claim Payment Dispute Unit	Written correspondence: Wellpoint Attn: Provider Payment Dispute Unit P.O. Box 91 Charleston, WV 25321-0091
Provider Services Department	For help with eligibility verification, claims, and general provider questions, please contact provider services via phone at **800-782-0095** or email a Provider Services associate by clicking the link below: provider.wellpoint.com/wv/contact-us/email Hours: Monday to Friday, 8 a.m. to 5 p.m.
Smoking Cessation Program	For questions regarding this program, call the Customer Care Center: Phone: **800-7820-095** TTY: **711** Hours: Monday to Friday, 8 a.m. to 6 p.m.

If you have questions about. . .	Contact:
	Materials available for download: • The "Quit Guide" Clearing the Air is available at the website: smokefree.gov • National Cancer Institute phone (for ordering): **800-4CANCER** (**800-422-6237**). Website: https://pubs.cancer.gov
Vision Services — Superior Vision	Website: superiorvision.com Contact information for members: Phone: **844-526-0198** TTY: **800-523-2847** Hours: Monday to Friday, 8 a.m. to 8 p.m. Contact information for providers (claims and membership questions): Phone: **844-526-0198** Hours: Monday to Friday, 8 a.m. to 8 p.m.

State of West Virginia contacts

Contact Information for the State of West Virginia	
If you have questions about...	**Contact:**
Breastfeeding support	Breastfeeding Education Coordinator, Office of Nutrition Services Phone: **304-558-0030** Website: https://www.wvdhhr.org/ons/breastfeeding.asp
Bureau for Behavioral Health (BBH)	BBH manages behavioral health services and is administered by the DHHR. Phone: **304-558-0627** Fax: **304-558-1008** Hours: Monday to Friday, 8:30 a.m. to 4:30 p.m. Website: https://dhhr.wv.gov/bbh/Pages/default.aspx
Bureau for Children and Families (BCF)	Phone: **304-558-0628** Fax: **304-558-4194** Website: https://dhhr.wv.gov/bcf
Bureau for Medical Services	BMS manages the Mountain Health Trust, which is administered by the Department of Human Services (DoHS). Website: dhhr.wv.gov/bms Phone: **304-558-1700** Toll free Provider Services: **888-483-0793** Address: Bureau for Medical Services 350 Capitol St., Room 251 Charleston, WV 25301

If you have questions about...	Contact:
Bureau for Public Health	Website: dhhr.wv.gov/bph Phone: **304-558-2971**
Children with Disabilities Community Services Program	Website: https://dhhr.wv.gov/bms/Programs/CDCSP/Pages/default.aspx Phone: **304-356-4867**
Commission for the Deaf and Hard of Hearing	Phone: **304-558-1675** TTY (in West Virginia only) toll free: **866-461-3578** Fax: **304-558-0937** Website: https://www.wvdhhr.org/wvcdhh Address: Commission for the Deaf and Hard of Hearing 100 Dee Drive Charleston, WV 25311
Department of Human Services	Phone: **304-558-0684** Fax: **304-558-1130** Website: https://dhhr.wv.gov/Pages/default.aspx Address: Department of Human Services One Davis Square, Suite 100 East Charleston, WV 25301
Division of Rehabilitative Services (DRS)	Website: wvdrs.org
Enrollment	In person: Visit your local DoHS office. To locate your local office, go to: https://dhhr.wv.gov/bcf/Documents/DHHR.BCF.LocalOffices.pdf Phone: Call the enrollment broker at **800-449-8466**. Website: https://wvpath.wv.gov/
Grievances and appeals: state fair hearing; board of review	State fair hearings website: https://dhhr.wv.gov/bcf Phone: **800-642-8589** Board of Review website (with the DoHS' Office of the Inspector General): https://wvpath.wv.gov/
Hearing or Speech Loss: West Virginia Relay Service	West Virginia Relay Service is a toll-free TDD service. Call **711** or the following numbers: • For voice to TDD: **800-982-8772** • For TDD to voice: **800-982-8771** Website: westvirginiarelay.com
Home health through BMS	Website: dhhr.wv.gov/bms/Programs/Pages/default.aspx Phone: **304-352-4221**

If you have questions about…	Contact:
	Address: Bureau for Medical Services Program Manager, Home Health Services 350 Capitol St., Room 251 Charleston, WV 25301
Hospice services through BMS	Website: dhhr.wv.gov/bms/Programs/Pages/default.aspx Phone: **304-352-4221** Address: Bureau for Medical Services Program Manager, Hospice Services 350 Capitol St., Room 251 Charleston, WV 25301
Office of Home and Community Based Services	Website: dhhr.wv.gov/bms/Programs/Pages/default.aspx To contact, call BMS: **304-352-4251**
Personal care through BMS (Medicaid only)	Website: dhhr.wv.gov/bms/Programs/Pages/default.aspx To contact, call BMS: **304-558-1700**
Private duty nursing through BMS (Medicaid only)	Website: dhhr.wv.gov/bms/Programs/Pages/default.aspx Phone: **304-352-4221** Address: Program Manager, Private Duty Nursing Services Bureau for Medical Services 350 Capitol St., Room 251 Charleston, WV 25301
West Virginia HealthCheck through Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Phone: **800-642-9704** Website: dhhr.wv.gov/healthcheck
West Virginia Women, Infants and Children (WIC)	Phone: **304-558-0030** Fax: **304-558-1541** Website: http://ons.wvdhhr.org Email: **dhhrwic@wv.gov** Address: Office of Nutrition Services West Virginia WIC Program 350 Capitol St., Room 515 Charleston, WV 25301-3715
West Virginia Children's Health Insurance Program	Phone: **304-558-2732** Fax: **304-558-2741** Helpline: **877-982-2447** Website: chip.wv.gov

If you have questions about...	Contact:
	Address: 350 Capitol Street, Room 251 Charleston, WV 25302
Retail pharmacy Medicaid & CHIP: • Rational Drug Therapy* (PAs) • Gainwell*	Medicaid & CHIP: Rational Drug Therapy for PAs: **800-847-3859** Gainwell: **888-483-0801** WVU's Rational Drug Therapy Program (RDTP) will continue to perform prior authorizations for prescription drugs. To request drug prior authorization, providers should contact RDTP at **800-847-3859** or via fax at **800-531-7787**.

CHAPTER 4: COVERED AND NONCOVERED SERVICES

You now have a new option to have questions answered quickly and easily. With live chat (https:/Availity.com), providers can have a real-time, online discussion through a digital service, available through Payer Spaces on Availity Essentials. Effective July 1, 2024, all authorizations must be submitted using the electronic platform via https://apps.Availity.com.

Customer Care Center phone:	800-782-0095
Customer Care Center fax:	888-438-5209
Hours of operation:	Monday to Friday, 8 a.m. to 6 p.m.
Website:	provider.wellpoint.com/wv

Wellpoint Provider-Administered Drug Authorizations

Phone:	877-375-6185
Fax:	844-487-9290

Dental services: SKYGEN

Phone:	877-408-0917
Hours:	Monday to Friday, 8 a.m. to 8 p.m.
Website:	skygenusa.com

Vision services: Superior Vision

Phone:	844-526-0198
Hours:	Monday to Friday, 11 a.m. to 8 p.m.
Website:	superiorvision.com

Wellpoint covered services

Covered services include, but are not limited to:

- Ambulance (emergency only); non-emergency medical transportation is covered through the State of West Virginia's fee-for-service program for Medicaid and WV CHIP.
- Behavioral Health services (subject to limits).
- Cardiac rehabilitation.
- Chiropractic (subject to limits).
- Clinic services: general clinics, birthing centers, lab and radiology centers, health department, rural health clinics (RHCs), federally qualified health centers (FQHCs).
- Dental services for adults (up to $2000 per two-year period; covered by SKYGEN).
- Dental services for children (covered by SKYGEN).
- Durable medical equipment (DME), supplies and prosthetic devices.
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): covers hearing, vision, dental, nutritional needs, healthcare treatment, routine shots/immunizations, and lab tests for children

under 21 years of age for Medicaid and under age 19 for WVCHIP members; also referred to as West Virginia HealthCheck.

- Family planning services and supplies.
- Gender affirmation for gender dysphoria.
- Handicapped children's services/children with special healthcare needs services.
- Home healthcare services.
- Hospice.
- Hospital services: inpatient and outpatient.
- Lab and radiology (not received in a hospital; also includes services received for substance abuse treatment).
- Nurse practitioner services.
- Physical or occupational therapy, speech pathology, and audiology (subject to limits).
- Physician (doctor) services (includes services received for substance abuse treatment. Also includes fluoride varnish services, applicable to members aged 6 months to 3 years).
- Podiatry services (foot care).
- Pregnancy and maternity care.
- Private duty/skilled nursing services (limited to members under the age of 21).
- Pulmonary rehabilitation.
- Rehabilitation services (physical therapy, speech therapy, occupational therapy, and acute inpatient rehabilitation).
- Right from the Start services.
- School-based services (physical therapy, speech therapy, occupational therapy, nursing care agency, or audiology. Limited to members under the age of 21 for Medicaid. Refer to the West Virginia fee-for-service provider manual for service limitations.).
- Transportation (emergency only).
- Vision services (covered by Superior Vision).

For coverage specifics, please refer to the BMS fee schedules located at dhhr.wv.gov/bms/FEES/Pages/default.aspx.

Coverage and authorization requirements can also be viewed using the Precertification Look Up Tool at provider.wellpoint.com/wv > **Prior Authorization Eligibility > Lookup Tool**

Benefits matrix for Wellpoint

Visit BMS website for details on coverage at https://dhhr.wv.gov/bms/pages/manuals.aspx.

Benefits under fee-for-service

Abortion — Includes drugs, devices, and procedures for termination of pregnancy. Abortion covered services are limited to specific conditions.

Early intervention services for children 3 and under— Early intervention services provided to children 3 years and under through the Birth to Three (BTT) program.

Hemophilia-related clotting factor drugs and hepatitis C virus-related drugs are covered by FFS.

Nursing facility services — Includes nursing, social services, and therapy.

Personal care services — Includes personal hygiene, dressing, feeding, nutrition, environmental support, and health-related functions. Room and board services require physician certification. May not exceed 60 hours per month without prior authorization.

Personal care for aged/disabled — Includes assistance with daily living in a community living arrangement, grooming, hygiene, nutrition, physical assistance, and environmental for individuals in the Age/Disabled Waiver. Limited on per unit per month basis. Requires physician order and nursing plan of care.

ICF/IID intermediate care facility — Includes physician and nursing services, dental, vision, hearing, lab, dietary, recreational, social services, psychological, habilitation, and active treatment for individuals with intellectual disabilities. Requires physician or psychiatrist certification.

Prescription drugs — Includes dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children, and prenatal vitamins. Weight gain, cosmetic, hair growth, fertility, and less than effective and experimental drugs are not covered. Drugs dispensed by a physician at no cost are not covered.

Organ transplant services — Generally safe, effective, and medically necessary transplants covered when no alternative is available. Cannot be used for investigational/research nature or for end-stage diseases. Must be used to manage disease.

School-based services — Service limitations are listed in the fee-for-service Medicaid provider manual.

Transportation — non-emergency medical transportation. Includes multi-passenger van services and common carriers (buses, cabs, and private vehicle transportation). Prior authorization is required by county DHHR staff. To get transportation, please call ModivCare at **844-549-8353**.

Visit BMS website for details on coverage at https://dhhr.wv.gov/bms/pages/manuals.aspx.

Dental services for Mountain Health Trust

Wellpoint has contracted with SKYGEN to provide fee-for-service dental services for children and adults. The West Virginia Bureau for Medical Services (BMS) is not responsible for payment of covered services. SKYGEN can be contacted as follows:

Phone: **888-983-4686**
Hours: Monday to Friday, 8 a.m. to 8 p.m.
Website: skygenusa.com or https://pwp.sciondental.com

Adult dental services:

- SKYGEN provides the following services for adults over 21. Services classified as diagnostic, preventive, and restorative in nature will have a coverage limit of $2,000 per two-year budget period. Covered diagnostic
- Preventive
- Restorative
- Accident and Emergency procedures to treat fractures, reduce pain, or eliminate infection

Dental services: dental screening and referral for children ages 0 to under 21

SKYGEN. Children ages 0 to under 21 years of age are eligible for the following:

- Covered diagnostic
- Preventive
- Restorative
- Periodontics
- Prosthodontics
- Maxillofacial prosthetics
- Oral and maxillofacial surgery/services
- Orthodontics, for the entire duration of treatment
- Extractions
- Complete or partial dentures
- Emergency treatment

Prior authorization may apply.

PCPs perform dental screenings as part of the initial health assessments (IHAs) for children. This inspection follows guidelines established under the U.S. Preventive Task Force Guidelines. Referrals to

a dentist will occur following the IHA for children and when determined to be medically necessary. PCPs should complete a direct referral to a dentist if a child has not completed a preventative dental screening in the past year.

PCPs may receive a reimbursement for fluoride varnish application. Providers must complete a certified training course from the WVU School of Dentistry prior to performing and billing Wellpoint for these services.

Phone: **800-642-9704**
Website: dhhr.wv.gov/healthcheck

Dental services for WVCHIP
Members under 18 years of age should visit their dentist for a checkup once every six months. Checkups begin at six months after an infant's first tooth erupts or by 12 months of age. Children and adolescents can get orthodontic services for the entire length of treatment and other services to fix dental problems.

Dental services covered under WVCHIP:
- Diagnostic services
- Preventive treatment
- Restorative treatment
- Endodontic treatment
- Periodontal treatment
- Surgical procedures and/or extractions
- Prosthodontics services
- Orthodontic treatment (Orthodontic services will be covered for the entire time of treatment even if the child is no longer eligible.)
- Oral and maxillofacial surgery services

Wellpoint does not cover:
- Experimental or investigational services
- Cosmetic procedures
- Dental services for the member's convenience or the convenience of the member's caretaker

Fluoride varnish
Fluoride varnish is a covered benefit for children ages 6 months to 3 years who may be at considerable risk of developing cavities. The fluoride varnish is given during the member's dental visit. The maximum number is two applications over one year.

Orthodontia services
Orthodontia services, covered for children up to age 21, must be medically necessary. They also need preapproval before the service is provided. Approved services will be paid for as long as treatment lasts. Medical necessity means at least one of the following needs is met:

- Overjet more than 7mm
- Severe malocclusion associated with dento-facial deformity
- True anterior open bite
- Full cusp classification from normal (Class II or Class III)
- Palatal impingement of lower incisors into the palatal tissue causing tissue trauma
- Cleft palate, congenital or developmental disorder
- Anterior crossbite (two or more teeth, in cases where gingival stripping from the crossbite is demonstrated and not correctable by limited orthodontic treatment)
- Unilateral posterior crossbite with deviation or bilateral crossbite involving multiple teeth including at least one molar
- True posterior open bite (not involving partially erupted teeth or one or two teeth slightly out of occlusion and not correctable by habit therapy)
- Impacted teeth (excluding third molars), permanent anterior teeth only

Dental prior authorizations
Dental will need to get approval from SKYGEN for some services. Getting an authorization will take no longer than five business days or two business days if requested electronically for non-urgent requests. If urgent, obtaining an authorization will take no more than two business days OR three calendar days — whichever is shortest. SKYGEN will send out notification letters to the dental provider and member if a service is denied. If you have questions about your dental services, please call SKYGEN at **877-408-0917 (TTY 800-508-6975).**

Vision services for Mountain Health Trust

Wellpoint members under the age of 21 are eligible for vision services through Superior Vision rendered by the following providers:

- Ophthalmologists
- Optometrists
- Opticians

Covered services include the following:

- Eye examination for children (1 exam every 12 months)
- Lenses and frames every 12 months
- Repairs
- Glasses (first pair after cataract surgery)

- Contact lenses for certain diagnoses

Covered services include the following:

- Annual exams
- Lenses/frames or contacts every 12 months ($125 limit per year) (providers may request authorization to exceed limit for CHIP members if medically necessary)

Behavioral health services for Mountain Health Trust

Behavioral health services are an integral part of healthcare management at Wellpoint. Our goal is to coordinate the physical and behavioral healthcare of members by offering a wide range of targeted interventions, education, and enhanced access to care to ensure improved outcomes and quality of life for members.

Wellpoint establishes collegial relationships with treatment service providers such as hospitals, group practices and independent behavioral healthcare providers, as well as community agencies and West Virginia comprehensive community behavioral health centers, licensed behavioral health clinics, and other resources to successfully meet the needs of members with behavioral health and substance use issues.

Behavioral health providers can be accessed directly by members and Wellpoint does not provide triage and referral services. Members do not have to contact Wellpoint for a referral.

Court-ordered services

Wellpoint will reimburse providers for court-ordered treatment services that are covered under the Medicaid or CHIP State Plan and deemed medically necessary. The court order documentation must accompany the prior authorization (PA) request. The court order determination of medical necessity is subject to review, determination, and the member appeal process.

Hospice care

Hospice care is a covered service and must be prior authorized. Note the following guidelines:

- Providers must contact the UM department for authorization prior to hospice admission.
- The hospice should bill for hospice services on the CMS-1450 claim form.
- The **Hospice Care** section of the *West Virginia Provider Manual* provides detailed billing instructions. For more information, access the Bureau for Medical Services (BMS) website at dhhr.wv.gov/bms. In the *Providers* section, select Provider Manual.

County and state-linked services

To ensure continuity and coordination of care for our members, Wellpoint enters into agreements with locally based public health programs. Providers are responsible for notifying Wellpoint's Case Management department when a referral is made to any of the West Virginia agencies listed below:

- Bureau for Behavioral Health: https://dhhr.wv.gov/bbh/Pages/default.aspx. Provides services for persons with mental illness, chemical dependency, and developmental disabilities for reintegration into the community.
- Bureau for Public Health: https://dhhr.wv.gov/bph/Pages/default.aspx. Provides public health programs in West Virginia.
- Division of Local Health: https://dhhr.wv.gov/localhealth/Pages/default.aspx. Serves as the state liaison to local health departments.
- Division of Rehabilitative Services (DRS): www.wvdrs.org. Provides independence through in-home services, supported employment, independent living, nutrition, services for members with hearing loss, blindness or visual impairment, and social security disability eligibility.
- Bureau for Family Assistance (BFA): https://dhhr.wv.gov/bfa/Pages/default.aspx. BFA is a non-Medicaid program administered by the West Virginia Department of Human Services (DoHS) that provides a number of different programs for children and their families, including protective services, financial assistance, and food stamps. Client Services Phone: **800-642-8589**

Wellpoint Case Management phone: **304-347-2475**
Wellpoint Case Management email: **wvcmreferrals@wellpoint.com**

Notifying Case Management ensures that case management nurses, social workers and counselors can follow up with members to coordinate their care. This notification also ensures that members receive all necessary services while keeping the provider informed.

Essential public health services

Wellpoint collaborates with public health entities in all service areas to ensure essential public health services for members. Services include the following:

- Coordination and follow-up of suspected or confirmed cases of childhood lead exposure
- Ensuring appropriate public health reporting (communicable diseases and/or diseases preventable by immunization)
- Investigation, evaluation, and preventive treatment of persons with whom the member has come into contact
- Notification and referral of communicable disease outbreaks involving members; Wellpoint provides written notification to all participating providers regarding their responsibilities.
- Referral for tuberculosis and/or sexually transmitted infections or HIV contact
- Referral for Women, Infants, and Children (WIC) services and information sharing

Directly observed therapy

Tuberculosis (TB) has re-emerged as an important public health problem at the same time as drug resistance to the disease continues to rise. In large part, this resistance can be traced to poor compliance with medical regimens. In directly observed therapy (DOT), the member receives

assistance in taking medications prescribed to treat TB. Refer members with TB who show evidence of poor compliance to the local health department for DOT services.

Reportable diseases

By state mandate, providers must report communicable diseases and conditions to local health departments. Wellpoint's providers are to comply with all state laws in the reporting of communicable diseases and conditions. Timely reporting is vital to minimize outbreaks and prevalence. Reportable diseases include, but are not limited to, the following primary types of diseases: sexually transmitted infections (STIs), TB, and communicable diseases (for example, HIV and AIDS). Wellpoint attests annually that we have provided written notification to participating providers about your responsibility to and procedures for reporting these primary types of diseases to the state.

Division of Surveillance and Disease Control Reporting healthcare practitioners and providers are required to report certain diseases by state law. This is to allow for disease surveillance and appropriate case investigation/public follow-up. The three primary types of diseases that must be reported are:

Sexually Transmitted Disease Program: Per WV Statute Chapter 16-4-6 and Legislative Rules Title 64, Series 7, practitioners, and providers must report cases involving a sexually transmitted disease to the Division of Surveillance and Disease Control.

Tuberculosis Program: Per WV Code §16-3D-1 through 9 and 64 CSR 76 and WV Regulations 16-25-3, practitioners and providers must report individuals with diseases caused by M. tuberculosis to the WV Bureau for Public, DSDC, and TB Program.

Communicable Disease Program: Per WV Legislative Rules Title 64, Series 7, practitioners, and providers must report cases of communicable disease noted as reportable in West Virginia to the local health departments in the appropriate time frame and method outlined in legislative rules. Per legislative rule, reports of category IV diseases, including HIV and AIDS, are to be submitted directly to the State Health Department, not to local jurisdictions.

Telehealth

Telehealth is the use of electronic information and telecommunications technologies to provide healthcare professionals the ability to connect patients with clinical experts in large hospitals or academic medical centers and can assure that patient in remote areas enjoy the same access to potentially life-saving technologies and expertise that are available to patients in more populated parts of the country.

The telecommunication system is defined as an interactive audio and video system that permits real time communication between the member at the originating site and the practitioner at the distant site. The telecommunication technology must allow the treating practitioner at the distant site to perform a medical examination of the member that substitutes for an in-person encounter.

Telehealth is used in the delivery of healthcare services by a secure interactive audio video platform for the purpose of diagnosis, consultation, and/or treatment of a covered injured worker in a location separate from the servicing provider. Telehealth services do not include the use of audio-only telephone, facsimile machine, or electronic mail.

Telehealth can connect a provider's office to a **specialty center** by:

- **Live video consult**: The PCP and specialist meet at the same time using *HIPAA* compliant video conferencing technology.

Telehealth offers multiple benefits to providers and members:

- The member can continue to be cared for by their local provider.
- The member does not need to travel long distances to receive specialist care.
- The PCP receives all records and test results from the encounter.
- The PCP consults with the specialist participating in the telehealth encounter to design any necessary course of treatment.

To find out more about telehealth, or for contracting questions, please call Customer Care Center at **800-782-0095**.

Equipment standards and requirements

To utilize telehealth services and render them effectively, providers must ensure that they follow all equipment standards and requirements as listed below:

- Minimum equipment standards are transmission speeds of 256kbps or higher over Integrated Services Digital Network (ISDN) or proprietary network connections including Virtual Private Networks (VPNs), fractional T1, or T1 comparable cable bandwidths. Software that has been developed for the specific use of Telehealth may be used if the software is *Health Insurance Portability and Accounting Act (HIPAA)* compliant and abides by a federal code pertaining to Telehealth.
- The audio, video, and/or computer telemedicine system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telemedicine. The telecommunication equipment must be of a quality to complete adequately all necessary components to document the level of service for the CPT® codes that are available to be billed. If a peripheral diagnostic scope is required to assess the patient, it must provide adequate resolution or audio quality for decision-making. The provider at the distant site is responsible to maintain standards of care within the scope of practice.
- All Medicaid and WVCHIP conditions and regulations apply to Telehealth services unless otherwise specified in this manual.
- All providers are required to develop and maintain written documentation of the services provided in the form of progress notes. The notes must meet the same guidelines as those required of an in-person visit or consultation, with the exception that the mode of communication (for example, Telehealth) must be noted.

- The operator of the Telehealth equipment must be an enrolled provider or an employee of the enrolled provider for compliance with confidentiality and quality assurance.
- The practitioner who delivers the service to a member shall ensure that any written information is provided to the member in a form and manner which the member can understand using reasonable accommodations when necessary.
- Member's consent to receive treatment via Telehealth shall be obtained and may be included in the member's initial general consent for treatment.
- Members may utilize Telehealth through their personal computer by utilizing a VPN established and maintained by the provider and meeting the equipment standards stated in this policy.
- Telehealth services are available via web-based applications and/or smartphone applications (apps) as long as they meet the current HIPAA and 42 CFR Part 2 regulations of compliance and utilize a VPN.
- If the member (or legal guardian) indicates at any point that he or she wishes to stop using the technology, the service should cease immediately, and an alternative method of service provision should be arranged.
- The provider who has the ultimate responsibility for the care of the patient must first obtain verbal and written consent from the recipient, including the following information:
  - The right to withdraw at any time.
  - A description of the risks, benefits, and consequences of telemedicine.
  - Application of all existing confidentiality protections right of the patient to documentation regarding all transmitted medical information.
  - Prohibition of dissemination of any patient images or information to other entities without further written consent.
- BMS Provider Manual standards apply to all services available through Telehealth unless otherwise described. Wellpoint will reimburse according to the fee schedule for services provided.
- Reimbursement is not available for a telephone conversation, electronic mail message (e-mail), third party applications that are not *HIPAA* compliant (for example, Skype or FaceTime) or facsimile transmission (fax) between a provider and a member.

Authorized distant site providers include:

- Physician Assistant (PA).
- Advanced Practice Registered Nurse (APRN).
- Certified Nurse Midwife (CNM).
- Clinical Nurse Specialist (CNS).
- Community Mental Health Center (CMHC).
- Licensed Behavioral Health Center (LBHC).

- Licensed Psychologist (LP) and Supervised Psychologist (SP).
- Licensed Independent Clinical Social Worker (LICSW).
- Licensed Professional Counselor (LPC), and FQHC and RHC may only serve as a distant site for Telehealth services provided by a psychiatrist or psychologist and are reimbursed at the encounter rate.

WIC referrals

The WIC program provides healthy food to pregnant women and mothers of young children. Providers have the following responsibilities for WIC program referrals:

- Complete the *WIC Program Referral Form*, documenting the following information:
  - Anthropometric data (height, current weight, pregravid weight)
  - Any current medical conditions
  - Biochemical data (hemoglobin, hematocrit)
  - Expected date of delivery
- Provide the member with the completed referral form. The member then presents the referral form to the local WIC agency.

The *WIC Program Referral Form* may be found on the state's website at https://ons.wvdhhr.org
West Virginia WIC phone: **304-558-0030**

CHAPTER 5: MEMBER ELIGIBILITY

Websites:	https://Availity.com
Customer Care Center phone:	800-782-0095
Customer Care Center fax:	888-438-5209
Hours of Operation:	Monday to Friday, 8 a.m. to 6 p.m.

Overview

Given the increasing complexities of healthcare administration, widespread potential for fraud and abuse, and constant fluctuations in program membership, providers need to be vigilant about member eligibility. This may mean taking extra steps to verify that any patient is, in fact, a currently enrolled Wellpoint member.

To prevent fraud and abuse, providers should confirm the identity of the person presenting the ID card. Providers must verify a member's eligibility before services are rendered. Verify eligibility at every visit because eligibility can change. Remember that claims submitted for services rendered to noneligible members will not be eligible for payment.

How to verify member eligibility

The West Virginia Bureau for Medical Services (BMS) determines eligibility and enrollment for Managed Care members. Providers can verify Managed Care eligibility, including vision services, in the following ways:

- To verify member eligibility, log on to Availity at https://Availity.com. From Availity's homepage, select **Patient Registration > Eligibility & Benefits**.

To register an organization for Availity Essentials, your designated Availity Administrator should go to https://Availity.com, select **Register,** and follow the registration wizard. If you have questions about registering for or using Availity, contact Availity Client Services at **800-282-4548**:

- Call Wellpoint's interactive voice response (IVR) system at **800-782-0095**. The IVR system is available 24 hours a day, 7 days a week. When asked to enter your provider identification, use either your billing NPI number or your TIN along with the member's ID number, date of birth, and ZIP code.
- For both Medicaid and WVCHIP members, call the BMS automated voice response system (AVRS) at **888-483-0793**.

Member identification cards

Following enrollment, eligible enrollees will receive their Wellpoint-issued member ID Card.

Wellpoint issued member identification Card

The member ID card issued by Wellpoint authorizes medical services to be provided to Wellpoint members; however, this does not guarantee payment for services rendered. This ID card is retained by members as long as they are managed by the same PCP. The ID card includes the following information:

- Member name
- Member ID number
- Coverage code
- Effective date
- PCP name and address
- Contact numbers: Wellpoint Customer Care Center, 24/7 NurseLine, vision, dental, eligibility, prior authorization (PA)/hospital admissions
- Address for medical claim submission
- Portal web address

If a card is lost, members may receive replacement cards upon request through our Customer Care Center or the member website. If the member transfers to a new PCP, Wellpoint issues a new ID card or the member can print a new card by logging in to the member website.

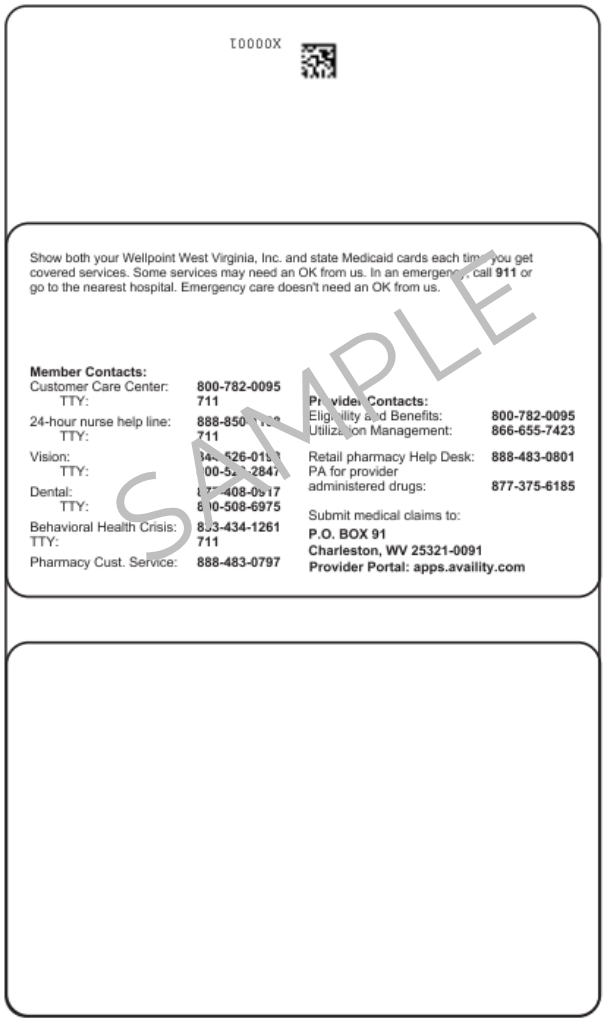
Please note: At each member visit, providers must ask to see both the state-issued ID card and the Wellpoint ID card. Verify eligibility before rendering services and before submission of claims to Wellpoint.

Managed care member ID card
Below are samples of state-issued member ID cards:

West Virginia Mountain Health Trust

Front

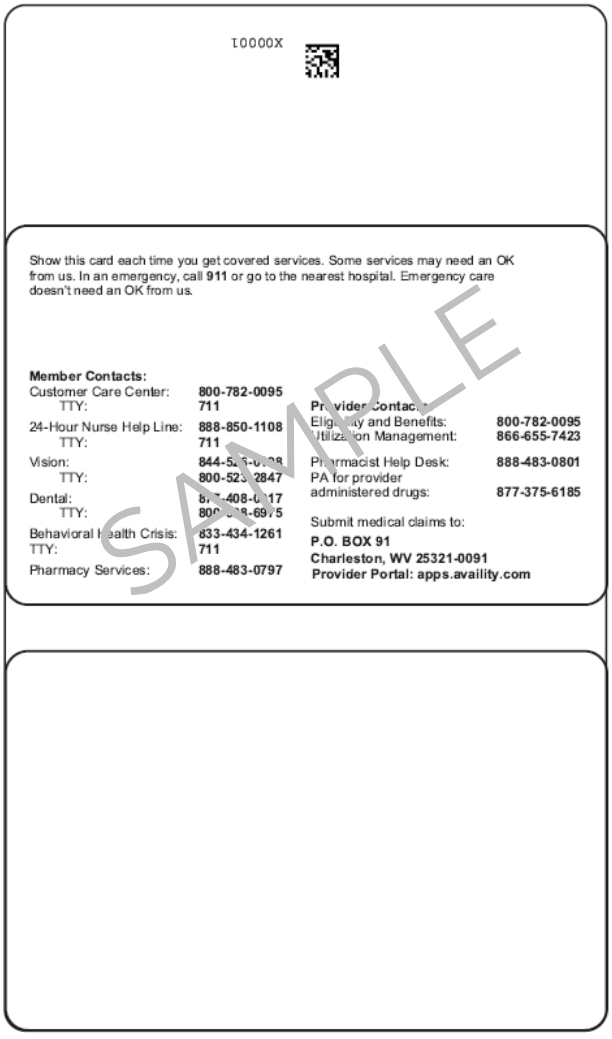
Back



West Virginia Children's Health Insurance Program

Front

Back



CHAPTER 6: UTILIZATION MANAGEMENT

Effective July 1, 2024, all authorizations must be submitted using the electronic platform via https://apps.Availity.com

Wellpoint's Utilization Management (UM) department contact information:

Phone:	**866-655-7423**
Physical Health preservice review fax:	**855-402-6983**
Physical Health current inpatient review fax:	**855-402-6985**
Behavioral Health inpatient fax:	**855-325-5556**
Behavioral Health outpatient fax:	**855-325-5557**

In the event of platform downtime, you can access appropriate forms posted at provider.wellpoint.com/wv > **Resources > Forms**.

Please note: Wellpoint ensures the availability of Utilization Management (UM) Department staff at least eight hours per day during normal business hours for inbound toll-free calls to answer member and provider questions related to utilization management issues. Communications (telephone, fax, and email) received after normal business hours are returned on the next business day and communications received after midnight Monday through Friday are responded to on the same business day. When making or receiving calls, the UM Department staff identifies him/herself, by name, and title and states the organization name.

Overview

Utilization management is a cooperative effort with providers to promote, provide, and document the appropriate use of healthcare resources. Our goal is to provide the right care, to the right member, at the right time, in the appropriate setting. Wellpoint makes determinations that consider the individual's healthcare needs and medical history in conjunction with evidence-based criteria.

The UM department takes a multidisciplinary approach to meet the medical and psychosocial needs of our members. Wellpoint's decision-making process reflects the most up-to-date UM standards from the National Committee for Quality Assurance (NCQA).

Authorizations are based on the following:

- Benefit coverage
- Established criteria
- Community standards of care

The decision-making criteria used by the UM department is evidence-based and consensus-driven. We update criteria at least annually and as standards of practice and technology change.

We involve practicing physicians in these updates and then notify providers of changes through web-posted newsletters, fax communications (such as provider bulletins), and other mailings.

These criteria are available free of charge to members and providers upon request by contacting the UM department at **866-655-7423**.

Hours: Monday to Friday, 8 a.m. to 5 p.m. Criteria are also available online at https://www.provider.wellpoint.com/global-wp-provider/medical-policies-and-clinical-guidelines.

If a member has other health insurance, Wellpoint defers all UM decisions to the primary insurer. If the requested service is not covered under the primary plan, you can submit the notice of noncoverage with the request to Wellpoint.

Based on sound clinical evidence, the UM department provides the following service reviews:

- Prior authorizations
- Continued stay reviews
- Post service reviews, when requested within 3 business days of the service being rendered

Decisions affecting the coverage or payment for services are made in a fair, impartial, consistent, and timely manner. The decision-making process incorporates nationally recognized standards of care and practice from sources, including:

- American College of Cardiology
- American College of Obstetricians and Gynecologists
- American Academy of Pediatrics
- American Academy of Orthopedic Surgeons
- American Psychiatric Association
- American Society of Addiction Medicine
- Cumulative professional expertise and experience

Please note: Our UM decisions are based only on appropriateness of care and service and existence of coverage. We do not reward practitioners and other individuals conducting utilization reviews for issuing denials of coverage or care. There are no financial incentives for UM decision-makers that encourage decisions resulting in under-utilization.

Wellpoint requires prior authorization of all elective inpatient admissions. The referring physician identifies the need to schedule a hospital admission and must submit the request to the Wellpoint Utilization Management (UM) department.

Routine requests for scheduled elective services should be submitted at least seven days prior to the scheduled admission. Urgent requests for services with all supporting documentation must be submitted a minimum of two business days prior to the scheduled admission. Failure to comply with notification rules may result in a denial.

Because we do not want the review process to delay care for our members, we accept prior authorization requests within three business days of the service being rendered. Clinical information for requests for services beyond three business days should be submitted with claims for post service clinical claims review. Documentation should support that the service provided was an emergency or show why the provider could not obtain prior authorization in a timely manner. The UM department does not backdate authorization requests beyond three business days.

The provider is responsible for contacting the UM department to request preservice review for both professional and institutional services. However, the hospital or ancillary provider should contact Wellpoint to verify preservice review status for all non-urgent care before rendering services. The hospital can confirm that authorization is on file by calling **800-782-0095** or via ICR through Availity Essentials.

Services requiring prior authorization

Common services requiring prior authorization include, but are not limited to:

- Advanced radiology services
- All out-of-network services
- Behavioral health outpatient services
- Dental services: Contact SKYGEN for specifics
- Durable medical equipment
- Genetic testing
- Home healthcare services, including hospice care
- Upon request for Home Health Services, authorization will be given for two visits per discipline to allow time for provider to complete initial evaluation:
- Inpatient hospital services including:
- Newborn stays for services **other than** well-baby care
- Rehabilitation facility admissions
- Sleep studies and treatment for sleep disorders
- Select outpatient surgeries/procedures including but not limited to:
- Hysterectomy
- Bariatric surgery
- Planned inpatient admissions
- Vision services: contact Superior Vision for specifics

The Prior Authorization Lookup Tool Online can assist with determining a code's prior authorization requirements, located at provider.wellpoint.com/wv > **Prior Authorization Eligibility > Lookup Tool**. For directions on how to access the *Provider Resources* page of our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

Services not requiring prior authorization

The following services do not require prior authorization for in-network providers:

- Behavioral health screening and assessment
- Community Psychiatric Supportive Treatment (First three days of treatment)
- Emergency services (notify Wellpoint within 24 hours or the next business day of inpatient admission)
- Family planning/well woman checkups:
  - Birth control
  - Breast and pelvic exams
  - U.S. Food and Drug Administration (FDA)-approved devices and supplies for family planning
  - Genetic counseling
  - Screening for HIV or sexually transmitted infections (STIs)
- Lab work
- Nebulizers
- Routine newborn and obstetrical care:
  - In-network physician visits and routine testing: no authorization required.
  - Pregnancy notification: To comply with West Virginia state law, submission of the completed Prenatal Risk Screening Instrument (PRSI) form is required to promote early identification of prenatal risk factor. The PRSI form is available on the Office of Maternal, Child & Family Health website at http://wvdhhr.org/mcfh/WV_PrentalRiskScreeningInstrument2016.pdf. Please ensure the entire form is completed and faxed to the Office of Maternal, Child and Family Health at **304-957-0176**.
- Wellpoint requires notification of pregnancy to identify pregnant members promptly and support our initiatives in mitigating high-risk factors and social obstacles encountered within our pregnancy community. You may also locate the PRSI form at provider.wellpoint.com/wv. You may send the completed PRSI form via fax to **877-833-5729** or email it to **prsi.wellpoint@wellpoint.com**:
  - Newborn delivery notification: Notification is required using the *Newborn Enrollment Notification Form*, available on our website at provider.wellpoint.com. For directions on how to access the provider website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**. Complete the entire form and fax it to **855-402-6985**:
- Physician referrals (for in-network specialists, consultation, or a nonsurgical course of treatment)

- Services where Wellpoint is the secondary payer
- Standard X-rays and ultrasounds (limited to one prenatal ultrasound per normal pregnancy)

Please note: For benefits to be paid, the member must be eligible on the date of service and the service must be a covered benefit. Except in an emergency, failure to obtain prior authorization may result in a denial for reimbursement.

The *PRSI* and *Newborn Enrollment Notification Report* forms can be downloaded on our website at provider.wellpoint.com. For directions on how to access the *Provider Resources* page of our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

Starting the process

When authorization of a healthcare service is required, contact us with questions and requests, including requests for:

- Routine, nonurgent care reviews
- Urgent or expedited preservice reviews
- Urgent concurrent or continued stay reviews

An urgent request is any request for authorization of medical care, behavioral healthcare or treatment that cannot be delayed because delay would result in one of the following:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment
- Would subject the member to severe pain that could not be adequately managed without the care or treatment that is the subject of the request. This assessment must be made by a practitioner with knowledge of the member's medical condition
- A delay in discharge from an inpatient facility

The UM department returns calls:

- Same day when the call is received during normal business hours
- Next business day when the call is received after normal business hours

To verify eligibility, check authorization status, or submit a new request, you can use ICR which is accessed through Availity Essentials. From Availity's home page select Patient Registration | Authorizations & Referrals. Use ICR to request, submit, update, and inquire on the case status of medical and behavioral health authorizations. All previously phoned, or faxed authorization requests are also available within ICR.

In accordance with W.Va. Code §33-15-4s, all requests must be submitted electronically. ICR offers a streamlined and efficient experience to request inpatient and outpatient medical and behavioral

health services for our members. Capabilities and benefits of the digital authorization application include:

- Initiating preauthorization requests online eliminating the need to fax. The application allows detailed text, photo images and attachments to be submitted along with your request.
- Making inquiries on previously submitted requests via phone, fax, or other online tools.
- Having instant accessibility from anywhere, including outside business hours.
- Utilizing a dashboard that provides a complete view of all utilization management requests with real-time status updates.
- View, download, and print UM letters.

Access ICR through Availity Essentials at https://Availity.com. From Availity's home page select **Patient Registration > Authorizations and Referrals**

Ask your Availity administrator to grant you the required authorization role assignment:

- To create and submit prior authorization requests you need the Authorization and Referral Request role assignment.
- To check the status of the case or results of the authorization request you need the Authorization and Referral Inquiry role assignment.

For an optimal experience, use a browser that supports 128-bit encryption. This includes Microsoft Edge, Chrome, and Firefox.

Requesting authorization

To request a preservice review or report a medical admission, submit a request electronically using the ICR through Availity Essentials for Wellpoint. Have the following information ready:

- Member name and identification (ID) number
- Diagnosis with the ICD code(s)
- Procedure with the CPT code(s)
- Date of injury or hospital admission
- Servicing provider and/or facility name, TIN and NPI
- Requesting provider or attending physician name, TIN and NPI
- Clinical justification for the request
- Level of care
- Lab tests, radiology, and pathology results
- Medications
- Treatment plan, including timeframes

- Prognosis
- Psychosocial status and history
- Exceptional or special needs issues
- Ability to perform activities of daily living
- Discharge plans
- ASAM dimensions
- Court-ordered documents (when applicable)

All providers, including physicians, hospitals, and ancillary providers are required to provide information to the UM department. Providers are encouraged to review their utilization and referral patterns.

Additional information the clinical reviewer may use includes:

- Office and hospital records
- History of the presenting problem
- Clinical exam
- Treatment plans, progress notes and discharge plan
- Information on consultations with the treating practitioner
- Evaluations from other healthcare practitioners and providers
- Photographs
- Operative and pathological reports
- Rehabilitative evaluations
- Printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members

Authorization requests

The prior authorization nurse or clinician will review the coverage request and the supporting medical documentation to determine the medical appropriateness of the requested services. When the clinical information received is in accordance with the definition of medical necessity and in conjunction with appropriate, evidence-based criteria, an authorization will be issued. All utilization management guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

If the prior authorization documentation is incomplete or inadequate, the prior authorization nurse or clinician will request additional information via ICR. If the request does not meet medical necessity criteria upon receipt of all clinical information, the clinician will not approve coverage of the request and will refer the request to the Wellpoint medical director. When appropriate, the prior authorization nurse or clinician will assist the provider in identifying alternatives for healthcare delivery as supported by the medical director. If the medical director denies the request, the appropriate denial letter, including the member's appeal rights, will be sent to the member, requesting, and servicing provider and facility, as applicable.

Administrative denial: a denial of services based on reasons other than medical necessity

Administrative denials are made when a contractual requirement is not met, such as late notification of admissions or lack of prior authorization. Appeals for administrative denials must address the reason for the denial (that is, why prior authorization was not obtained). If Wellpoint overturns its administrative decision, the case will be reviewed for medical necessity. If approved, the claim will be reprocessed, or the requestor will be notified of the action that needs to be taken. This allows Wellpoint to verify benefits and process the authorization request. For services that require prior authorization, Wellpoint makes case-by-case determinations that consider the individual's healthcare needs and medical histories in conjunction with criteria.

If you disagree with a UM decision and want to discuss the decision with the physician or peer reviewer, call the peer-to-peer number at **866-902-4628, option 3** and leave the pertinent information on the voice mail. The medical director or peer reviewer will return your call at the time you request. All peer-to-peer discussions must be requested within two business days of the denial notification. In accordance with W.Va. Code §33-15-4s, peer to peer discussions must occur within five business days of the request for peer to peer.

Electronic authorization requests

In accordance with W.Va. Code §33-15-4s, all requests must be submitted electronically. Access ICR from Availity Essentials for electronic submission of prior authorization requests. Ensure that you have the billing details for all providers to ensure that claims are paid correctly.

Electronic review time frame

For routine, nonurgent requests submitted via ICR, the UM department will review the request for complete information within two business days of the request. If we require additional information, we will send you a request for information (RFI) letter. Requested information must be returned to us within three business days. Upon receipt of clinical information, we will decide within two business days.

Urgent preservice requests

For urgent preservice requests, the UM department completes the preservice review within the shorter of two business days or three calendar days from the receipt of the request. This includes requests for DME when a member is hospitalized and the DME is required for timely discharge.

Requests with insufficient clinical information

When the UM department receives requests with insufficient clinical information, we will contact the provider with a request for the information needed to determine medical necessity. We will make at least one attempt to contact the requesting provider to obtain this additional information. If we do not obtain a response within the specified time after receiving the request, we will issue the appropriate denial letter, including the member's appeal rights, to the member, requesting and servicing provider and facility, as applicable.

Emergency conditions and services

Wellpoint does not require prior authorization for treatment of emergency conditions. In the event of an emergency, members may access emergency services 24/7. If the emergency services result in the member's admission to the hospital, providers must contact Wellpoint the next business day following admission or post-stabilization. Failure to comply with notification rules may result in a denial. Wellpoint is available via ICR 24 hours a day, 7 days a week to accept emergent admission notification.

Coverage of emergent admissions is authorized based on review by a licensed concurrent stay review (CSR) nurse or clinician. When the clinical information received meets criteria, an authorization will be issued to the hospital. If the notification documentation provided is incomplete or inadequate, the CSR nurse or clinician will not approve the request and will refer the request to the Wellpoint medical director. If the medical director denies coverage of the request, the appropriate denial letter, including the member's appeal rights, will be sent to member, requesting and servicing provider and facility, as applicable.

Members who call their PCP's office reporting a medical emergency (whether during or after office hours) are directed to dial 911 or go directly to the nearest hospital emergency department. All nonemergent conditions should be triaged by the PCP or treating physician, with appropriate care instructions given to the member.

Emergency stabilization and post-stabilization

The emergency department's treating physician determines the services needed to stabilize the member's emergency medical condition. After the member is stabilized, the emergency department's physician must contact the member's PCP for authorization of further services. The member's PCP is noted on the ID card. If the PCP does not respond within one hour, all necessary emergency services will be considered authorized by the PCP.

The emergency department should send a copy of the emergency room record to the PCP's office within 24 hours. The PCP should:

- Review and file the chart in the member's permanent medical record.
- Contact the member.
- Schedule a follow-up office visit or a specialist referral, if appropriate.

As with all nonelective admissions, notification must be made the next business day. The medical necessity of the admission will be reviewed upon receipt of the notification. A determination of the medical necessity will be rendered within the shorter of two business days or three calendar days of the notification. Failure to comply with notification rules can result in a denial. Wellpoint is available via ICR 24 hours a day, 7 days a week to accept emergent admission notification.

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
This HEDIS® measure assesses emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow-up visit for AOD. Two rates are reported:

1. ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Referrals to specialists

The Customer Service or Case Management departments are available to assist providers in identifying a network specialist and/or arranging for specialty care. Keep in mind the following when referring members. Authorization is:

- Not required if referring a member to an in-network specialist for consultation or a nonsurgical course of treatment.
- Required when referring a member to an out-of-network specialist.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
Provider responsibilities include documenting referrals in the member's chart and requesting that the specialist provide updates about diagnosis and treatment. Treatment provided by the specialist must be appropriate for the member's condition.

When a member is seen by a specialist, including any OON provider, the provider should share findings, progress, and treatment plan with the member's PCP.

Please note: Obtain prior authorizations *before* referring members to an out-of-network provider. For out-of-network providers, we require prior authorization for the initial consultation and each subsequent service provided. Failure to obtain authorization prior to services being rendered can result in denial of claims payment.

Out-of-network exceptions

There are geographical exceptions to using only in-network providers:

- Wellpoint members are allowed to use the services of out-of-network nurse practitioners if no nurse practitioner is available in the member's service area.
- Wellpoint makes covered services provided by federally qualified health centers (FQHCs) and rural health clinics (RHCs) available to members out-of-network if those clinics are not available in the member's service area and within Wellpoint's network.

- If Wellpoint is unable to provide necessary covered medical services within Wellpoint's provider network, Wellpoint authorizes out-of-network services and covers the services for as long as those services are not available in-network.

Continued stay review: hospital inpatient admissions

Hospitals must notify the UM department of inpatient medical, behavioral health and substance use disorder admissions within 24 hours of admission or by the next business day. If there is insufficient clinical information to determine medical necessity, the provider is contacted with a request for the clinical information reasonably necessary to make this determination. Evidence-based criteria are used to determine medical necessity and the appropriate level of care.

Note: Failure to notify UM within the designated time frame can result in an administrative denial of services.

Continued stay review: clinical information for continued stay review

When a member's hospital stay is expected to exceed the number of days authorized during preservice review, or when the inpatient stay did not require preservice review (that is, emergency admission), the hospital must contact us for continued stay review. We require clinical reviews on all members with covered benefit admitted as inpatient to:

- Acute care hospitals
- Long Term Acute Care facilities
- Inpatient rehabilitation facilities.
- Inpatient Behavioral Health and Substance Use Disorder facilities.
- Psychiatric Residential Treatment facilities.
- Substance Use Disorder Residential Adult Services.

Note: Failure to notify UM within the designated time frame can result in an administrative denial of services.

We perform these reviews to assess medical necessity and determine whether the facility and level of care are appropriate. Wellpoint identifies members admitted as inpatients by:

- Facilities reporting admissions.
- Providers reporting admissions.
- Preservice authorization requests for inpatient care.

The UM department will complete continued-stay inpatient reviews within the shorter of two (2) business days or three (3) calendar days of the receipt of request, consistent with the member's medical condition.

If the information meets medical necessity review criteria, we will approve the request within the shorter of two (2) business days or three (3) calendar days of the receipt of request. Requests that do not meet criteria for medical necessity are sent to the physician advisor or medical director for further review. We will send written notification to the member, requesting provider and servicing provider and facility, as applicable, of any denial or modification of the request.

Denial of service

Only the medical director or doctorate level practitioners with an active professional license or certification can deny services for lack of medical necessity, including the denial of:

- Procedures.
- Hospitalization.
- Equipment.

Note: Denials related to non-notification or failure to obtain prior authorization can be made administratively, without medical director review.

When a request is determined to be not medically necessary, the provider and member will be notified of:

- The decision.
- The process for appeal.
- How to reach the reviewing physician or peer reviewer for peer-to-peer discussion of the case.
- The reason and the criteria used to make the decision.

Providers may contact the physician clinical reviewer to discuss any UM decision by calling the peer-to-peer line at **866-902-4628**, **option 3** within two business days of the denial notification. In accordance with §33-15-4s, peer to peer discussions must occur within five business days of the request for peer to peer.

Self-referral

Members do not need prior authorization and may self-refer for the following services when rendered by qualified, in-network providers:

- Emergency services
- Family planning, including an annual examination provided by an OB/GYN
- Immunizations
- Behavioral health screening and assessment

Second opinions

Second opinions are covered services. The following are important guidelines regarding second opinions:

- A second opinion must be given by an appropriately qualified healthcare professional.
- The second opinion must come from a provider of the same specialty.
- The secondary specialist must be within Wellpoint's network and may be selected by the member.

When there is no network provider who meets the specified qualification, we may authorize a second opinion by a qualified provider outside of the network, upon request by the member or provider. A second opinion regarding medical necessity is a covered service.

Additional services: vision care

Wellpoint contracts with Superior Vision providers for basic vision care. For prior authorization of all vision services, contact **844-526-0198 (TTY: 711)**.

Additional services: dental care

Wellpoint covers emergency dental services only for adults 21 years of age and older. These services may be given by a dentist or oral surgeon.
We cover:

- Treatment of fractures of the upper or lower jaw
- Biopsy
- Removal of tumors
- Removal of a tooth when it is an emergency

For details about dental service coverage for children up to 21 years of age, refer to the **Dental Services: Dental Screening and Referral for Children Ages 0 to 21** section.

Gold Card program

Gold Card qualification/timeframe:

- Annually in December and effective January 1 of every year, Wellpoint will approve Gold Card providers:
- Providers may request exception for approval outside of yearly review.
- Providers will continue Gold Card status for the calendar year in which they were approved.
- Gold Card shall be issued to individual providers (individual NPI), not at the group practice level.
- Provider must have performed 30 procedures in a given calendar year (not code specific).
- Must have a 90% PA approval rate in a six-month timeframe within the review year (individual NPI).

Gold Card revocation and non-covered services:

- Wellpoint has the right to audit at any time.

- Revocation can occur based upon the following:
  - Not performing services in conformity with the benefit plan
  - Variances in utilization
  - Other anomalies in billing
- Services not included in the Gold Card PA exemption:
  - Experimental and investigational treatment
  - Non covered services
  - Out of network services
  - Services that are subject to authorization tiering, where a member is allowed a specified number of units or visits before prior authorization is required:
    - This includes physical, occupational and speech therapy; chiropractic services; behavioral health outpatient services.
  - Services related to gender-affirming care.
  - Gene therapy services.
  - Inpatient requests. The facility is responsible for submitting a request and indicating that this is a planned admission for a Gold Card provider.

Auditing:

- Each Gold Card provider will have no less than 10 cases audited per year to evaluate for medical necessity and to determine eligibility for renewal.
- Wellpoint will use a standard variance metric:
  - Total reimbursement increases more than 25% from previous year
  - Reimbursement per member increased more than 25%
  - Evaluate increase in volume and reimbursement
- Providers who are found non-compliant will be removed from Gold Card status immediately.

Billing guidelines:

- The claim for services rendered outside of the provider's office must include the referring/rendering provider NPI number.

If information is missing or incorrect, the claim could be denied for no PA.

CHAPTER 7: HEALTH SERVICES PROGRAMS

Customer Care Center phone: 800-782-0095
Customer Care Center fax: 888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Overview

Wellpoint's health services programs are designed to improve our members' overall health and well-being by informing, educating, and encouraging self-care in the early detection and treatment of existing conditions and chronic disease. These targeted programs supplement providers' treatment plans and are divided into the following categories:

- Preventive care programs, including the initial health assessment and well woman programs
- Health management programs (e.g., Condition Management promotes knowledge and encourages self-care for specific medical conditions and chronic disease, while New Mother and Baby Post Delivery Outreach is a program designed to identify mothers and babies with postdelivery needs)
- Health education, including the 24/7 NurseLine for all health-related questions (in addition, an emergency room action campaign instructs members on the proper use of emergency room services)

Healthy Rewards

Our Healthy Rewards program helps our members earn $20, $25, or $50 for their very own Healthy Rewards account by getting certain health services. At the same time, you increase your practice's quality scores by providing them with the vaccinations, screenings, visits, and medications they need. Every time our members complete one of the healthy activities, they get dollars added to their Healthy Rewards account. They can then use these Healthy Rewards dollars to redeem for a variety of gift cards on items they can use to stay healthy.

To help you in your practice, all our Healthy Rewards activities are tied to HEDIS scores and health initiatives. They include:

Who's eligible	Healthy Activities	Reward	Limit
Children (0-30 months)	Eight Ongoing Well-Child Visits	$50	Once per child
Children & adolescents (ages 3-21) for Medicaid and ages 3-19 for CHIP	Well Child Visit	$25	Once every 12 months
Females (ages 50-74)	Complete Breast Cancer Screening	$50	Once every 24 months
Females (21-64)	Complete Cervical Cancer Screening	$50	Once every 36 months
Adults with diabetes (ages 18-75)	Diabetic Retinal Eye Exam	$50	Once every 12 months

	Diabetic Blood Sugar (HbA1c)	$50	Once every 12 months
Members (ages 6 and up) who have been discharged from a hospital for a mental health condition	Outpatient visit with mental health practitioner within 7 days of discharge from mental health hospital.	$20 $80 max	Once per quarter; Maximum of 4x every 12 months
Pregnant women	1st prenatal visit (within 42 days of enrollment)	$25	Once per pregnancy
	Six prenatal care visits	$25	Once per pregnancy
	Postpartum Visit between 7 - 84 days after delivery	$25	Once per pregnancy
Annual dental visit ages 2 and up	Annual Dental Exam	$25	Once every 12 months
Member age 6-12 prescribed ADHD medication	Medication Refill	$25, max $50	1 per 6 months
Complete health needs screener	All ages, first year of enrollment.	$10	Once
HPV vaccination ages 9-13	Complete HPV series prior to 13th birthday	$50	Once

Please remind your patients about our Healthy Rewards program at their next office visit. By working together, we can help our members get the right care while they earn rewards. And we help you improve your scores and encourage good health habits with your patients, our members.

If your patients have questions regarding the program, please have the member call **888-990-8681** for more information.

Preventive care: health screenings and immunizations

One of the best ways to promote and protect good health is to prevent illness. Wellpoint members are covered for routine health screenings and immunizations. Additionally, our health services programs provide members with guidelines, reminders, and encouragement to stay well. Our members may receive:

- Information about health issues
- Flu shot reminders
- Health screening reminders, such as breast and cervical cancer screenings

Provider responsibilities

The following are provider responsibilities that help members maintain healthy lifestyles:

- Document all healthcare screenings, immunizations, procedures, health education and counseling in the member's medical record.

- Provide immunizations as needed at all well child visits and according to the schedule established by the Advisory Committee on Immunization Practices (ACIP), American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP).
- Refer members to dentists, optometrists/ophthalmologists or other specialists as needed; document referrals in the member's medical record.
- Schedule preventive care appointments for all children following the AAP periodicity schedule.

Preventive care: initial health assessments

The initial health assessment (IHA) gives providers the baseline necessary to assess and manage a member's physical condition. Once the IHA has been completed, providers can give our members the kind of educational support that allows members to become more actively engaged in their own treatment and preventive healthcare.

The IHA of new members should be performed by the PCP within 45 calendar days of enrollment. The IHA consists of the following categories of patient information:

- Patient history
- Physical examination
- Developmental assessment

Please note: An IHA is not necessary under the following conditions:

- If the new member is an existing patient of the PCP but is new to Wellpoint and has an established medical record showing baseline health status. This record must include sufficient information for the PCP to understand the member's health history and provide treatment recommendations as needed.
- If the new member is not an existing patient, transferred medical records meet the requirements for an IHA if a complete health history is included.

Preventive care: HealthCheck

In West Virginia, HealthCheck is the name given to the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program for children. HealthCheck is a preventive healthcare program for children from birth to age 21. The program covers initial and periodic examinations and medically necessary follow-up care. As an integral part of this program, PCPs may provide age-appropriate preventive care screening and testing during each well child visit and during an acute illness episode, if appropriate. Providers must answer the questions contained in the WV HealthCheck forms regardless of how materials are formatted.

WV HealthCheck Forms can be located at
http://dhhr.wv.gov/healthcheck/providerinfo/Pages/default.aspx

HealthCheck screening requirements
PCPs should offer health education, counseling and guidance to the member, parent or guardian at regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. An evaluation of age-appropriate risk factors should be performed at each visit. In addition, PCPs should perform the following:

- A comprehensive health and developmental history, including assessment of both physical and mental health development
- A comprehensive, unclothed physical exam
- Appropriate immunizations in accordance with the schedule for pediatric vaccines
- established by the Advisory Committee on Immunization Practices (ACIP)
- Dental assessment; direct referral to a dentist beginning six (6) months after first tooth erupts and is required by 12 months of age and should be completed for any member who hasn't completed a preventative visit in the past year
- Vision testing
- Hearing testing
- Health education (including anticipatory guidance)
- Laboratory tests (including blood lead screening appropriate for age and risk factors)
- Behavioral health screening

Wellpoint HealthCheck responsibilities
Information on our preventive care programs is provided in Wellpoint's Member Handbook, which is sent to members at the time of enrollment. Member newsletters and the member website include special features about the HealthCheck program, and ongoing reminders on the importance of an IHA, well-child visits, immunizations, and regular checkups.

In addition, Wellpoint provides services, which may include live calls, Interactive Voice Response (IVR) outreach, text messages or mailed materials to reach out to members as outlined below:

- IHA reminders to all newly enrolled members within 30 days of enrollment
- Immunization reminders to the parents/guardians of members
- Annual preventive care/well visit reminders to members 2 through 20 years of age on their birth months

Preventive care: childhood lead exposure testing and free blood test kits

CMS requires that all children enrolled in Medicaid be tested for lead exposure at 1 and 2 years of age. Children from 3 to 6 years of age who have not been tested need screening regardless of their risk factors.

Please note: Completion of a lead risk assessment questionnaire does not fulfill this screening requirement; a blood draw is required.

To order your free MEDTOX lead exposure blood testing kits, call MEDTOX toll free: **800-334-1116**. You may establish an account and arrange for an initial order. Establishing an account with MEDTOX allows you to re-order kits when necessary.

Preventive care: Well Woman

The Well Woman program was designed to remind and encourage women to have regular cervical and breast cancer screenings. The Well Woman Reminder Program sends a screening test reminder text to women who are not up to date with their recommended screenings. Providers are encouraged to refer members for screenings and/or schedule the exams.

PCP responsibilities for the care of female members include:

- Educating members on Preventive Health Care Guidelines for women
- Referring members for cervical cancer and breast cancer screenings
- Scheduling screening exams for members

Providers may access the Preventive Health Care Guidelines on our website at provider.wellpoint.com/wv. For directions on how to access our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

Health management: Taking Care of Baby and Me®

Taking Care of Baby and Me is a proactive case management program for all expectant members and their newborns. We use several resources to identify pregnancies as early as possible. Sources of identification include, state enrollment files, claims data, and hospital census reports as well as provider and member self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk.

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. Case managers collaborate with community agencies to ensure pregnant members have access to necessary services.

When it comes to our pregnant members, we are committed to keeping both parent and baby healthy. That's why we encourage all of our pregnant and postpartum members to take part in our Taking Care of Baby and Me program, a comprehensive case management and care coordination program which offers:

- Individualized, one-on-one case management support for women at the highest risk
- Care coordination for moms who may need a little extra support
- Digital perinatal educational tools

- Information on community resources
- Incentives to keep up with prenatal and postpartum checkups and well-child visits after the baby is born

As part of the Taking Care of Baby and Me program, perinatal members have access to a digital maternity program. The digital offering provides pregnant and postpartum members with timely, proactive, and culturally appropriate education via a smartphone app. Once members are identified as being pregnant, they will receive an invitation to access this program by downloading the app. After the app is installed and the member registers, they are asked to complete a pregnancy screener. The answers provided in the screener allow Wellpoint to assess their pregnancy risk.

After risk assessment is complete, the digital program delivers gestational-age-appropriate education directly to the member. This program does not replace the high-touch, individual case management approach for our highest risk pregnant members; however, it does serve as a supplementary tool to extend our health education outreach. The goal of the expanded outreach is to ensure maternity education is available to all perinatal members and help Wellpoint to identify members who experience a change in risk acuity throughout the perinatal period.

Provider assessment of pregnancy risk
The PCP or prenatal care provider should assess all pregnant members for high-risk indicators during the initial prenatal care visit. For all pregnant members, the provider needs to:

- Complete the West Virginia Department of Human Services *Prenatal Risk Screening Instrument* located on the Office of Maternal, Child & Family Health website at http://www.wvdhhr.org/mcfh/WV_PrentalRiskScreeningInstrument2016.pdf. Please ensure the entire form is completed and faxed to the Office of Maternal, Child and Family Health at **304-957-0176**.
- Email a completed *Prenatal Risk Screening Instrument* (*PRSI*) to **prsi.wellpoint@wellpoint.com** with "SECURE PRSI" in the subject line or fax it to **877-833-5729** within seven days of the first prenatal visit or as soon as possible. The *PRSI* form is available on our website at provider.wellpoint.com/wv **> Resources > Forms > Pregnancy and Maternal Child Services**. For directions on how to access the *Provider Resources* page of our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.
- Members identified as high risk (teens, those with a history of substance use disorder, those with a history of preterm birth, or those with serious health conditions) are referred to the high-risk obstetrical (HROB) team. High-risk members receive close monitoring and interaction from HROB nurse case managers. These members also have access to additional resources before and after giving birth.
- Refer members to prenatal education, childbirth education and breastfeeding classes; members register by calling the Case Management Department at **304-347-2475**.
- Document all referrals in the member's medical record.
- Schedule the member for a postpartum visit.

We encourage healthcare providers to share information about the Taking Care of Baby and Me program and the digital maternity tools offered at Wellpoint with members. Members may access information about the products that are available by visiting the Wellpoint member website.

For more information about the Taking Care of Baby and Me program or the digital maternity tools, reach out to your OB Practice Consultant or Provider Services at **800-782-0095**, or refer to our website at provider.wellpoint.com/wv > **Patient Care > Pregnancy and Maternal Child Services**.

Federal reporting requirements

Wellpoint is required to report the following to the state:

- Abortions must comply with the requirements of 42 CFR 441. Subpart E – Abortions. This includes completion of the information form, Certification Regarding Abortion.
- Hysterectomies and sterilizations must comply with 42 CFR 441. Subpart F – Sterilizations. This includes completion of the consent form.
- EPSDT services and reporting must comply with 42 CFR 441 Subpart B – Early and Periodic Screening, Diagnosis, and Treatment.

For a list of the state requirements and procedures for the above listed services, please refer to the Medicaid Physician Provider Manual at https://dhhr.wv.gov/bms/Pages/Manuals.aspx .

NICU case management

If a baby is born premature or with a serious health condition, they may be admitted to the NICU. We believe the more parents know, the better they will be able to care for their infant. To support them, we have a NICU Case Management program.

We extend our support by helping parents to prepare themselves and their homes for when baby is released from the hospital. After baby is home, our case managers continue to provide education and assistance in improving baby's health, preventing unnecessary hospital readmissions, and guiding parents to community resources if needed.

The NICU can be a stressful place, bringing unique challenges and concerns that parents may have never imagined. The anxiety and stress related to having a baby in the NICU can potentially lead to symptoms of post-traumatic stress disorder (PTSD) in parents and caregivers. To reduce the impact of PTSD among our members, we assist by:

- Helping parents engage with hospital-based support programs.
- Facilitating parent screenings for potential PTSD.
- Connecting parents with behavioral health program resources and community support as needed.
- Actively asking for parent feedback on the provided resources and how an increased awareness of PTSD has helped.

For more information about our NICU Case Management program, reach out to Provider Services at **800-782-0095**, or refer to our website at provider.wellpoint.com/wv > **Patient Care > Pregnancy and Maternal Child Services**.

Breastfeeding support tools and services

The American Academy of Pediatrics, the American College of Obstetrics and Gynecology, and the American Public Health Association recognize breastfeeding as the preferred method of infant feeding. Providers should encourage breastfeeding for all pregnant women unless breastfeeding is not medically appropriate. To support this goal, we ask you to:

- Assess all pregnant women for health risks that are contraindications to breastfeeding, such as AIDS and active tuberculosis.
- Provide breastfeeding counseling and support to postpartum women immediately after delivery.
- Assess postpartum women to determine the need for lactation durable medical equipment, such as breast pumps and breast pump kits.
- Document all referrals and treatments related to breastfeeding in the member's medical record. Pediatricians should document frequency and duration of breastfeeding in the baby's medical record.
- Refer members to prenatal classes prior to delivery by calling the Case Management Department at **304-347-2475**.
- Refer pregnant women to community resources that support breastfeeding such as Women, Infants and Children (WIC) at the WIC website: https://ons.wvdhhr.org. From the menu bar at the top of the page, select **Nutrition/Breastfeeding**. Select from topics on *Breastfeeding, Lactation Services, Food Package, Update* or *Breastfeeding Training*. Or members may call **304-558-0030**.
- Support continued breastfeeding during the postpartum visit.
- Refer to Customer Care Center for available Value Added Services

Health education: 24/7 NurseLine

We recognize that questions about healthcare prevention and management do not always come up during office hours. The 24/7 NurseLine, a phone line staffed by registered nurses, offers a provider support system and is a component of after-hours care. The 24/7 NurseLine allows members to closely monitor and manage their own health by providing the ability to ask questions whenever they come up. This phone line is available 24 hours a day, 7 days a week at **888-850-1108**.

Members may call the 24/7 NurseLine for:

- Self-care information, including assistance with symptoms, medications and side-effects, and reliable self-care home treatments
- Access to specialized nurses trained to discuss health issues specific to our teenage members
- Information on more than 300 healthcare topics through the audio tape library

Providers may use the 24/7 NurseLine as a resource for members to call for nonemergent questions and information.

Please note: Nurses have access to telephone interpreter services for members who do not speak English. All calls are confidential.

Health education: emergency room action campaign

Too often, our members use hospital emergency rooms as their first stop for nonemergent conditions. The Emergency Room Action Campaign (ER Action Campaign) was designed to cut down on the number of inappropriate emergency room visits by identifying members who use the emergency room for the wrong reasons. With this initiative, we can help members understand that nonemergency, preventive and follow-up care should always take place in their PCP's office.

The ER Action Campaign increases member visits to their PCP by educating members about:

- Seeking care for nonemergency events
- Contacting their PCP first before going to the ER
- Alternatives to ER use
- Importance of follow-up care by their PCPs

The ER Action Campaign is a multi-pronged communication program that includes the following:

- IVR calls made to members identified through a clinical analysis of members' medical claims. The IVR provides a predefined, finite list of barriers for the member to select to identify the reason for going to the ER rather than to a PCP.
- After completing the call, members either are warm transferred to the outbound call center (OBC) or are given information about how to contact the 24/7 NurseLine. The OBC also helps members who need information about their PCP or transportation assistance. The 24/7 NurseLine helps members determine if they have a medical emergency requiring a visit to the ER and provides assistance with other concerns, such as filling medications.
- A member's responses from the IVR call are used to generate a customized mailing to the member. The mailing addresses the barriers identified during the IVR call and provides resources the member can use instead of going to the ER, such as visiting their PCP.

We rely on the support of the providers, who remind members that the PCP's office and the 24/7 NurseLine should be their first stops for nonemergency conditions. Working together, we can replace the automatic urge to go to the emergency room with the more appropriate action of picking up the phone or returning to the PCP's office.

Health education: WW® (formerly known as Weight Watchers) membership

WW® (formerly known as Weight Watchers) membership is available with a PCP referral. Wellpoint provides eligible members with the Weight Watchers program at no cost. Because Weight Watchers

offers multiple weight loss plans, members can choose the option that fits their needs best. The program is open to adults 18 years of age and older. In addition, Weight Watchers is open to children from 10 to 17 years of age who are referred by their PCP and have their parents' consent. For more information about the program, members may call Wellpoint via tollfree phone: **888-611-9958.**

Health education: tobacco cessation programs

Wellpoint's tobacco cessation program is a health education program in the form of a booklet developed by the National Cancer Institute called Clearing the Air. This booklet enables each member to create a personalized "smoking cessation plan" by providing guidelines on how to prepare to quit. With this resource, the member is educated on the benefits of quitting, what to expect when they quit, health risks associated with tobacco use and strategies to become smoke free. The Smoking Cessation program provides each individual with the support, resources, and motivation to successfully achieve their goal.

Smoking Cessation offers numerous tools and resources to help members who want to quit smoking. The booklet Clearing the Air will be mailed to members upon request. Members or providers may view or download the Clearing the Air booklet by visiting either of the websites listed below. Additionally, the following websites provide a wealth of information about tobacco use that can be used to promote smoking cessation:

- Smokefree.gov
- Pubs.cancer.gov: The National Cancer Institute

The Smoking Cessation program helps members in any stage of cessation readiness and includes the following:

- Wellpoint offers smoking cessation classes to members at no cost; call the Customer Care Center for more information
- Nicotine replacement therapy (NRT) — when prescribed by a provider

Smoking cessation *Clinical Practice Guidelines* are posted on our website at provider.wellpoint.com. For directions on how to access our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

Provider assessment of tobacco use

The following are provider guidelines to help members quit smoking:

- Assess the member's smoking status and offer advice about quitting.
- Use the online *Prenatal Risk Screening Instrument* as a way to notify us, through the West Virginia Bureau for Medical Services (BMS), of pregnant women who smoke. The form is available on our website at provider.wellpoint.com.
- Encourage pregnant women to stop smoking and not resume after pregnancy.
- Offer members resources to stop smoking, including information on our Smoking Cessation program.

- Refer members to West Virginia's Tobacco Quit Line, a free, phone-based counseling service:
- Phone: **877-966-8784**
- Hours: Monday to Friday, 8 a.m.-8 p.m.; Saturday and Sunday, 8 a.m.-5 p.m.
- West Virginia's Tobacco Quit Line services include:
- Individual coaching
- Resources for providers who want to improve patient outcomes
- Support for family and friends who want to help loved ones stop smoking
- Refer members to National Institutes of Health smoking cessation phone at **800-QUIT-NOW** (**800-784-8669**)

Additional resources to help members stop smoking
Wellpoint offers the following educational resources to help women who are pregnant or of childbearing age to quit smoking, avoid starting again, or avoid exposure to secondhand smoke. To download a copy, access our website at provider.wellpoint.com. Select from the following documents:

- *Quit Smoking for Your Baby's Sake*
- *Yes, You CAN Quit Smoking*
- *Avoiding Second Hand Smoke*

For directions on how to access the *Provider Resources* of our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

Provider types who may perform tobacco cessation counseling include the following:

- Physicians
- Physician assistants
- Nurse practitioners
- Registered nurses
- Psychologists
- Pharmacists
- Dentists

Counseling is required as a part of any covered tobacco cessation course of treatment.

CHAPTER 8: BEHAVIORAL HEALTH SERVICES

Overview

Behavioral Health Services are an integral part of healthcare management at Wellpoint. Our program is to coordinate the physical and behavioral healthcare of members by offering a wide range of targeted interventions, education and enhanced access to care to ensure improved outcomes and quality of life for members.

Wellpoint establishes collegial relationships with treatment service providers such as hospitals, group practices and independent behavioral healthcare providers, as well as community agencies and West Virginia Comprehensive Community Behavioral Health Centers, Licensed Behavioral Health Clinics and other resources to successfully meet the needs of members with behavioral health and substance use issues.

Behavioral health providers can be accessed directly by members and Wellpoint does not provide triage and referral services.

Services provided to people with serious emotional disturbances and their families are best delivered based on the System of Care Values and Principles that are endorsed by SAMHSA and the Center for Mental Health Services (CMHS). Services should be:

- Person-centered and family-focused with the needs of the person and family dictating the types and mix of services provided.
- Community-based with the focus of services as well as management and decision-making responsibility resting at the community level.
- Culturally competent with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.
- Comprehensive, covering an array of services that address physical, emotional, social, educational and cultural needs.
- Personalized as evidenced by an individualized service plan formulated to meet unique needs and potential.
- Delivered in the least restrictive, most normative environment that is clinically appropriate.
- Integrated and coordinated between agencies and include mechanisms for planning, developing and coordinating services inclusive of case management or similar mechanisms to ensure that multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the person and their family.
- Delivered without regard to race, religion, national origin, gender, gender identity, physical disability or other characteristics.
- Oriented to recovery, providing services that are flexible and evolve over time.

Goals

The goals of Wellpoint's Behavioral Health program are to:

- Ensure and expand service accessibility to eligible members
- Promote the integration of the management and delivery of physical and behavioral health services
- Achieve quality initiatives including those related to HEDIS, NCQA and Bureau of Medical Services (BMS) performance requirements
- Work with members, providers and community supports to provide recovery tools and create an environment that supports members' progress toward their recovery goals
- Ensure utilization of the most appropriate, least restrictive, medical and behavioral healthcare in the right place at the right time

Objectives

The objectives of the Wellpoint Behavioral Health program are to:

- Promote continuity and coordination of care among physical and behavioral healthcare practitioners
- Enhance member satisfaction by implementing individualized and holistic support and care plans that allow members to achieve their recovery goals
- Provide member education on treatment options and pathways toward recovery
- Provide high quality case management and care coordination services that identify member needs and address them in a personal and holistic manner
- Work with treatment service providers to ensure the provision of medically necessary and appropriate care and services, including inpatient care, alternative care settings, and outpatient care at the least restrictive level
- Enhance provider satisfaction and success through collaborative and supportive relationships built on mutually agreed upon goals, outcomes and incentives
- Promote collaboration between all healthcare partners to achieve recovery goals through education, technological support and the promotion of recovery ideals
- Use evidence-based guidelines and clinical criteria and promote their use in the provider community
- Maintain compliance and accreditation standards with local, state and federal requirements

Guiding principles of Wellpoint's behavioral health program

A primary guiding principal of the Wellpoint Integrated Behavioral Health Program is recovery. Recovery is a member-driven process in which people find their paths to work, learn and participate fully in their communities Resiliency is the ability to live a fulfilling and productive life despite the continued presence of a disability. Physical and behavioral health services are rendered in a manner

that allows the achievement of recovery for members experiencing mental illness and substance use disorders. Treatment supports the development of resiliency for those facing mental illness, serious emotional disturbance and/or substance use disorder issues.

The Substance Abuse and Mental Health Services Administration (SAMHSA) released a consensus statement on mental health recovery reflecting the desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency. The ten fundamental components of recovery identified by SAMHSA are:

- **Self-direction:** members lead, control and determine their own paths of recovery by optimizing autonomy, independence and control of resources to achieve a self-determined life.
- **Individualized care:** There are multiple pathways to recovery based on an individual's unique strengths and resiliency, as well as his or her needs, preferences and experiences including past trauma and cultural background.
- **Empowerment:** members have the authority to choose from a range of options and to participate in all decisions, including the allocation of resources, which will affect their lives and are educated and supported in so doing.
- **Holistic:** Recovery embraces all aspects of life, including housing, employment, education, mental and healthcare treatment and services, complementary and naturalistic services (e.g., recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation and family supports as determined by the person.
- **Nonlinear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
- **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals.
- **Peer support:** Mutual support including the sharing of experiential knowledge, skills and social learning plays an invaluable role in recovery.
- **Respect:** Community, systems and societal acceptance and appreciation of consumers — including protecting their rights and eliminating discrimination and stigma — are crucial to achieve recovery.
- **Responsibility:** members have a personal responsibility for their own self-care and journeys of recovery.
- **Hope:** Recovery provides the essential and motivating message of a better future — that people can and do overcome the obstacles that confront them. Hope is internalized but can be fostered by peers, family, friends, providers and others. Hope is the catalyst of the recovery process.
- **Resiliency** is the ability of an individual or family to cope and adapt to the challenges and changes brought on by distress or disability. Becoming resilient is a dynamic developmental process that requires patience and effort to pursue steps that enhance positive responses to adverse circumstances. Accepting and managing one's life in a manner that displays optimism

for personal successes manifested by traits of self-efficacy and high self-esteem is achieved by building resiliency. Resilience is learned and developed.

Provider success

We believe the success of providers is necessary to achieve our goals. We are committed to supporting and working with qualified providers to ensure that we jointly meet quality and recovery goals. Our commitment includes:

- Supporting providers in delivering integrated, coordinated physical and behavioral health services to meet the needs of the whole person
- Simplifying precertification rules, referrals, claims and payment processes to help providers reduce administrative time and focus on the needs of members

To help providers serve a diverse and ever-evolving patient population, we designed a special program, Culturally and Linguistically Appropriate Services, to improve provider/member communications by cutting through language and other cultural barriers. In addition, Wellpoint works with nationally-recognized healthcare organizations to stay current on the latest healthcare breakthroughs and discoveries. This manual provides easy links to access that information.

Health plan clinical staff

All clinical staff is licensed and has at least two years of prior clinical experience. Our Medical Director is board certified in psychiatry. Our trained and experienced team of clinical care managers, case managers and support staff provide high quality care management and care coordination services to our members and work collaboratively with all providers.

CHAPTER 9: CLAIMS AND BILLING

Customer Care Center phone: 800-782-0095
Customer Care Center fax: 888-438-5209
Web: https://Availity.com
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Overview

Having a fast and accurate system for processing claims allows providers to manage their practices and our members' care more efficiently. With that in mind, Wellpoint has made claims processing as streamlined as possible. Share the following guidelines with your staff, billing service and electronic data processing agents:

- Submit clean claims, making sure that the right information is on the right form.
- Submit claims as soon as possible after providing service.
- Submit claims within the contract filing time limit.

Additional information covered in this chapter includes the following:

- Covered services
- Clinical submission categories
- Benefit codes
- Submitting present on admission indicators
- Submitting pregnancy notification reports
- National drug codes
- Common reasons for rejected and returned claims

Claims editing

Wellpoint uses claims editing software which incorporates editing rules to determine whether a claim should be paid, rejected or undergo manual processing. These editing rules assess CPT and HCPCS codes on the CMS-1500 claim form. A claim auditing action determines how the procedure codes and code combinations will be used to settle the claim. The auditing action recognizes historical claims related to current submissions and may result in adjustments to previously processed claims. Descriptions of specific reimbursement policies are available in this manual.

Edits may be updated periodically. Wellpoint will notify providers in advance when required. For the latest information and current editing rules, log on to our website at provider.wellpoint.com/wv.

Clear Claim Connection

Clear Claim Connection is a web-based tool enabling providers to review the claim auditing rules and clinical rationale of the claim processing software. Providers may access Clear Claim Connection

through the Availity Portal at https://Availity.com (Select Payer Spaces | Applications) to prescreen claims and inquire on claim disposition.

Submitting clean claims

Claims submitted correctly the first time are called clean, meaning that all required fields have been filled in and that the correct form was used for the specific type of service provided. The provider is responsible for all claims submitted using the provider number, regardless of who completed the claim form. If you use a billing service, you must ensure that your claims are submitted properly by the service.

A claim submitted with incomplete or invalid information may be returned. If you use the Electronic Data Interchange (EDI), claims will be returned for incomplete or invalid information. Claims may also be returned if they are not submitted with the proper HIPAA -compliant code set. In each case, an error report will be sent to you and the claim will not be sent through for payment. You and your staff are responsible for working with your EDI vendor to ensure that "errored out" claims are corrected and resubmitted.

Generally, the types of forms you will need for reimbursement are:

- *CMS-1500* for professional services: https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500
- *CMS-1450 (UB-04)* for institutional services: https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/15_1450

These forms are available in both electronic and hard copy/paper formats.

Please note: Using the wrong form, or not filling out the form correctly or completely, causes the claim to be returned, resulting in processing and payment delays.

ICD-10

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements and in accordance with the rule issued by the U. S. Department of Health and Human Services (HHS).

What is ICD-10?

International Classification of Diseases, 10th Revision (ICD-10) is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes; and in the United States, the codes are the foundation for documenting the diagnosis and associated services provided across healthcare settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:

- ICD-10-CM (Clinical Modification) used for diagnosis coding, and

- ICD-10-PCS (Procedure Coding System) used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaced the code sets, ICD-9-CM, Volumes 1 and 2 for diagnosis coding, and ICD-10-PCS replaced ICD-9-CM, Volume 3, for inpatient hospital procedure coding.

Social drivers of health

Many Wellpoint enrollees experience a various social needs such as transportation, housing, food access, unemployment, or education level. Wellpoint encourages billing of ICD-10 Z-codes where appropriate to collect data so that Wellpoint may assist these members in obtaining the necessary services.

Claims filing limits

Claims must be submitted within 180 days of the service date to be considered for payment. Claims submitted after that time period will be denied.

Please note: Wellpoint is not responsible for a claim never received. If a claim is submitted inaccurately, prolonged periods before resubmission may cause you to miss the filing deadline. Claims must pass basic edits to be considered received. To avoid missing deadlines, submit clean claims as quickly as possible after delivery of service.

Filing limits are determined as follows:

- If Wellpoint is the primary payer, use the length of time between the last date of service on the claim and Wellpoint's receipt date.
- If Wellpoint is the secondary payer, use the length of time between the other payer's remittance advice (RA) date and Wellpoint's receipt date.

Claim forms and filing limits

Refer to the provider contract to confirm the time limits to file.

Form	Type of service to be billed	Time limit to file
CMS-1500 claim form	• Physician and other professional services • Specific ancillary services including: – Audiologists – Ambulance – Ambulatory surgical center – Dialysis – Durable medical equipment – Diagnostic imaging centers – Hearing aid dispensers – Home infusion – Home health – Hospice – Laboratories – Occupational therapy – Orthotics – Physical therapy – Prosthetics – Speech therapy **Note:** Some ancillary providers may use a *CMS-1450* claim form if they are ancillary institutional providers. Ancillary charges by a hospital are considered facility charges.	Within 180 days of service date
CMS-1450 claim form	Hospitals, institutions, psychiatric facilities, and home health services	Within 180 days of service date

Other filing limits for Mountain Health Trust

Action	Type of service to be billed	Time frame
Third-party liability (TPL)	If the claim has TPL or requires submission to a third party before submitting to Wellpoint, the filing limit starts from the date on the notice from the third party.	File within 180 days of notice from the third-party vendor.

Action	Type of service to be billed	Time frame
Coordination of benefits (COB)	If the claim has COB, before submitting to Wellpoint, the filing limit starts from the date on the notice from the primary insurance.	File within 180 days of notice from the primary insurance.
Checking claim status	Claim status may be checked any time by calling the Customer Care Center Interactive Voice Response (IVR) system or by visiting the Availity at https://Availity.com. From Availity's home page, select **Claims & Payments**> **Claim Status.**	If you have submitted a claim and you have not received payment or denial notification within 30 calendar days after Wellpoint's receipt of a claim, submit a Follow-Up Request Form. Or call the Customer Care Center IVR.
Claim follow-up request	Submit a corrected claim after Wellpoint's denial or correction to a claim, or to follow up on a claim using the *Claim Follow-Up Form*. To access this form, go the provider website at provider.wellpoint.com/wv. For directions on how to access the *provider website*, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.	180 calendar days from the date of our remittance advice.
Mail back form	Wellpoint sends a request for additional information to you when we cannot process your claim due to incomplete, missing, or incorrect information in the original claim submission.	Return the requested information within 180 calendar days. In your response, include a copy of the *Mail back Form* you received, all supporting documentation deemed pertinent or requested by us (such as records or reports), and a copy of the original/corrected claim.
Claim filing with wrong health plan/insurance carrier	If the claim was mistakenly filed with the wrong health plan or insurance carrier, you may submit to us with the proper documentation for payment.	Provide documentation verifying the initial timely filing. Submit to us within 180 days of the date of the other carrier's denial letter or RA form. We will process your claim without denial for failure to file within time limits.

Action	Type of service to be billed	Time frame
Provider claim payment dispute	Submit a Provider Claim Payment Dispute in 3 different ways: 1. Customer Service 2. Availity Essentials Claim Status 3. Written: Wellpoint Attn: Provider Claim Payment Dispute Team P.O. Box 91 Charleston, WV 25321-0091	First-level dispute – Reconsideration – 180 calendar days from the date on the remittance advice. Second-level dispute – Claim Payment Appeal – 60 calendar days from the date on the *Reconsideration Determination Letter*
Acknowledgement letter	This process provides Wellpoint with response time to investigate and make a determination.	Wellpoint sends an acknowledgement within 15 calendar days of receipt of the dispute.
Wellpoint's response to provider dispute resolution request	A resolution letter is sent to the provider with the determination made on the dispute submission.	First-level dispute – Reconsideration We make a determination within 45 business days of receipt of the dispute. Second-level dispute – Claim Payment Appeal We make a determination within 30 calendar days of receipt of the dispute.

Methods for submission

The methods for submitting a claim are as follows:

- Electronically through Electronic Data Interchange (EDI) (preferred)
- Paper or hard copy

Electronic submission through Wellpoint's EDI is preferred for accuracy, convenience, and speed. Providers will receive notification within 24 hours that an electronic claim has been submitted. After filing a paper claim, you should receive a response from Wellpoint within 30 business days after we receive the claim. If the claim contains all required information, Wellpoint enters the claim into the claims system for processing and sends you a RA when the claim is finalized.

Electronic claims

Wellpoint encourages the submission of claims electronically through the Electronic Data Interchange (EDI).

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

Availity's EDI submission options

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

Payer ID
80314

Note: If you use a clearinghouse, billing, please work with them directly to determine payer ID.

Providers can register with Availity at https://Availity.com to become a direct submitter. To initiate the electronic claims submission process or obtain additional information, contact Availity Client Services at **800-AVAILITY (800-282-4548)**. Availity Client Services is available Monday through Friday from 8 a.m. to 8p.m. ET.

Use Availity for the following EDI transactions:

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

The Availity guide for EDI claims submission is found at https://Availity.com/documents/edi%20guide/edi_guide.pdf?cacheBust=1561475494. The EDI Claim Submission Guide includes additional information related to the EDI claim process.

Providers and vendors may contact Availity Client Services:

- Phone: **800-282-4548**
- Hours of operation: Monday to Friday, 8 a.m. to 8 p.m. Eastern

- Wellpoint's payer ID number: 80314

EDI response reports
Claims submitted electronically will return response reports that may contain rejections. If using a Clearinghouse or Billing Vendor, please work with them to ensure you are receiving all reports. It's important to review rejections as they will not continue through the process and require correction and resubmission. For questions on electronic response reports contact your Clearinghouse or Billing Vendor or Availity at **800-282-4548**.

For corrected electronic claims the following frequency code:
- 7 – Replacement of Prior Claim

EDI segments required:
- Loop 2300- CLM - Claim frequency code
- Loop 2300 - REF - Original claim number

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

Useful EDI documentation
Availity EDI Connection Service Startup Guide - This guide includes information to get you started with submitting Electronic Data Interchange (EDI) transactions to Availity, from registration to on-going support.
Availity EDI Companion Guide - This Availity EDI Guide supplements the HIPAA TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity.
Availity Registration Page - Availity register page for users new to Availity.
X12 Code Sets - X12 code descriptions used on EDI transactions.

National provider identifier

The NPI is a 10-digit, all numeric identifier. NPIs are issued only to providers of health services and supplies. As a provision of HIPAA, the NPI is intended to improve efficiency and reduce fraud and abuse.

NPIs are divided into the following types:
- Type 1: Individual providers, including, but not limited to, physicians, dentists, chiropractors, psychiatrists and psychologists
- Type 2: Hospitals and medical groups, including, but not limited to, hospitals, group practices, federally qualified health centers (FQHCs), rural health clinics (RHCs), comprehensive behavioral health centers (COMPs), community mental health centers (CMHCs) and licensed behavioral health centers (LBHCs)

For billing purposes, NPIs should be used with the following guidelines:
- Claims must be filed with the appropriate NPI for billing, rendering and referring providers.

The NPI must be attested with the West Virginia Bureau for Medical Services (BMS) and the West Virginia Children's Health Insurance Program in the same manner as with Wellpoint, including the effective dates for individual providers within groups.

- Claims will be denied when the NPI listed is not the same number attested with BMS and/or CHIP.

Attestation: The process of registering and reporting your NPI with the BMS and/or CHIP.

Providers may apply for a NPI online at the National Plan and Provider Enumeration System (NPPES) website at https://nppes.cms.hhs.gov/NPPES. Select Apply Online for an NPI, Login or Create Login to View or Update your NPI Data. Or obtain a paper application by calling NPPES at **800-465-3203**.

The following websites offer additional NPI information:

- CMS: www.cms.gov
- NPPES: https://npiregistry.cms.hhs.gov
- Workgroup for EDI: http://www.wedi.org
- National Uniform Claims Committee: www.nucc.org

Use of referring provider's NPI on claims submissions

If the PCP refers a member to a specialist or another provider, the PCP must give his/her NPI number to the specialist or provider. The specialist or provider is required to add the referring PCP's NPI when submitting claims for the member. If the PCP does not provide his/her NPI at the time of referral, the billing provider is responsible for obtaining that information. The billing provider may do so by calling the PCP's office or by going online to the NPI Registry website at https://npiregistry.cms.hhs.gov.

There are exceptions to the requirement of providing the referring PCP's NPI:

- If a provider is on call or covering for another provider. In this case, the billing provider must complete Box 17b of the CMS-1500 claim form to receive reimbursement.
- If the provider is in the same provider group, or has the same tax ID or NPI as the referring provider and is an approved provider type
- Services were provided afterhours
- Emergency services were performed in place of service 23
- Family planning services
- Diagnostic specialties such as lab and X-ray services
- Anesthesia claims
- Professional inpatient claims
- Obstetrics/gynecology claims

- If the billing or referring provider is from an FQHC or urgent care center

Also note that members may self-refer for certain services, including family planning services and emergency services.

Unattested NPIs

Wellpoint will deny claims with an unattested NPI, even if you provide legacy information. Providers serving Mountain Health Trust members are required to register and attest their NPIs with West Virginia's BMS. You can attest your NPI on the DoHS website at www.dhhr.wv.gov/bms.

Paper claims

Paper claims are scanned for clean and clear data recording. To get the best results, paper claims must be legible and submitted in the proper format. Follow these requirements to speed processing and prevent delays:

- Use the correct form and be sure the form meets CMS standards.
- Use black or blue ink. Do not use red ink because the scanner may not be able to read red ink.
- Use the "remarks" field for messages.
- Do not stamp or write over boxes on the claim form.
- Send the original claim form to Wellpoint and retain a copy for your records.
- Do not staple original claims together; Wellpoint will consider the second claim to be an attachment and not an original claim to be processed separately.
- Remove all perforated sides from the form. To help our equipment scan accurately, leave a ¼-inch border on the left and right sides of the form after removing perforated sides.
- Type information within the designated field. Be sure the type falls completely within the text space and is properly aligned.
- Do not highlight any fields on the claim forms or attachments. Highlighting increases the difficulty in creating a clear electronic copy during scanning.
- If using a dot matrix printer, do not use "draft mode" because the characters generally do not have enough distinction and clarity for the optical scanner to read accurately.
- When submitting claims each date of service should be billed on a separate line with the exception of DME. DME can be billed with a date range.

If you submit paper claims, include the following provider information:

- Provider name
- Rendering provider group or billing provider
- Federal provider tax identification number (TIN)
- NPI

- Medicare number, if applicable
- Wellpoint's Payer ID Number: 80314

Please note: Some claims may require additional attachments. Be sure to include all supporting documentation when submitting your claim.
Mail paper claims to:

Wellpoint
Attn: Initial Claims Processing
P.O. Box 91
Charleston, WV 25321-0091

Paper claims processing

All paper claims submitted are assigned a unique document control number (DCN). The DCN identifies and tracks claims as they move through the claims processing system. This number contains the Julian date, which indicates the date the claim was received. DCNs are composed of 11 digits:

- 2-digit plan year
- 3-digit Julian date
- 2-digit Wellpoint reel identification
- 4-digit sequential number

Claim is subjected to a comprehensive series of checkpoints called edits. These edits verify and validate all claim information to determine if the claim should be paid, denied or pended for manual review.

Member balance billing

Providers contracted with Wellpoint may not balance bill our members, meaning that members cannot be charged for covered services above the amount Wellpoint pays to the provider. Providers may not bill Wellpoint members for covered services that Wellpoint does not pay for. More specifically, a contracted provider cannot bill for the difference between the provider's charge and the allowed amount. Providers must be in compliance with Section 1902(n)(3)(B) of the Social Security Act, and Section 1417 of the Balanced Budget Act of 1997. A Mountain Health Trust Health Insurance program provider may bill a member only when all of the following conditions have been met:

- The service is not covered or the member has exceeded the program limitations.
- The member understands, before services are rendered, that the service is not covered and that the member is responsible for the charges associated with the service.
- The provider documents that the member voluntarily chose to receive the service and that the member was informed in advance that he or she was receiving a noncovered service.

Mountain Health Trust members are not held liable for covered services provided to the enrollee for which:

- the State or the MCO does not pay the individual or healthcare provider that furnished the services under a contractual, referral, or other arrangement
- payments for covered services furnished under a contract, referral, or other arrangement to the extent those payments are in excess of the amount that the enrollee would owe if the MCO covered the services directly

Please note: A generic consent form is not acceptable unless the form identifies the specific procedure to be performed and the member signs the consent before receiving the service. Refer to the *West Virginia BMS Provider Manual* for more information at www.dhhr.wv.gov/bms. **Providers are prohibited from collecting copays for missed appointments.**

Billing members for services not medically necessary

Providers may bill a Wellpoint member for a service that is not medically necessary if all of the following conditions are met before the service is rendered. **Please note:** Aside from these conditions, billing for non-medically necessary services is prohibited:

- The member requests a specific service or item that, in your opinion, may not be reasonable or medically necessary.
- The member requests a specific service or item that, in Wellpoint's opinion, may not be reasonable or medically necessary.
- The provider obtains a written acknowledgement to verify that the member was notified of financial responsibility for the services rendered.
- The member signs and dates the acknowledgement to accept responsibility to pay for the requested service.

Only non-par providers may balance bill a member when prior authorization of a covered service is denied. However, the provider must establish and demonstrate compliance with all of the following:

- Establish that prior authorization was requested and denied before rendering service.
- Notify the member that the service requires prior authorization and that Wellpoint has denied authorization. If out-of-network, the provider must explain to the member that covered services may be available without cost when provided by an in-network provider. In such cases, authorization of service is required.
- Inform the member of his or her right to file an appeal if the member disagrees with the decision to deny authorization.
- Inform the member of his or her responsibility for payment of nonauthorized services.

If the provider chooses to use a waiver to establish member responsibility for payment, the waiver must meet the following requirements. The waiver:

- Was signed after the member received appropriate notification.

- Does not contain any language or condition specifying that the member is responsible for payment in the case of denial of authorization.
- Is specific to each member visit that falls under the scenario of the noncovered service; providers may not use nonspecific waivers. The form must be obtained for each member visit.
- Specifies the:
- Services that fall under the waiver's application.
- Date the services will be provided.

The provider has the right to appeal lack of payment resulting from a denial of authorization.

Coordination of benefits

Wellpoint may coordinate benefits with any other healthcare program that covers Medicaid and WVCHIP members. Indicate other coverage information on the appropriate claim form. If you need to coordinate benefits, include at least one of the following items from the other healthcare program when submitting a coordination of benefits (COB) claim:

- Third-party remittance advice (RA)
- Third-party provider explanation of payment (EOP)
- Third-party letter explaining either the denial of coverage or reimbursement

COB claims received without at least one of these items will be mailed back to you with a request to submit to the other healthcare program first. Make sure the information you submit explains all coding listed on the other carrier's RA or letter. We cannot process the claim without this specific information.

Members who have primary insurance other than Medicaid are exempt from Medicaid cost-sharing obligations. When a third party has made a payment for a covered service and Wellpoint is the secondary payer, the Medicaid-allowed amount shall be calculated as the difference between the paid amount and the Medicaid-allowed amount compared to the sum of the coinsurance, copayment, and deductible amounts. Wellpoint is responsible for paying the lesser of either. For FQHCs and RHCs, the payment shall be the coinsurance or deductible paid the primary carrier, not the full encounter rate.

If a WVCHIP enrollee obtains third party coverage during the continuous enrollment period, Wellpoint will pay as secondary payer until such time that the enrollee has completed an eligibility review and been deemed ineligible for WVCHIP as a result of having third party coverage.

Claims filed with the wrong plan

If you initially filed a claim with the wrong insurance carrier, Wellpoint will process your claim without denying the claim for not filing within the time limit if you:

- Include documentation indicating that the claim was initially filed in a timely manner
- File the claim within 180 days of the date of the other carrier's denial letter or RA form

Payment of claims

After receiving a claim, we take the following steps:

1. Wellpoint analyzes the claim for covered services.
2. Wellpoint generates a RA statement, summarizing the services rendered and the action taken.
3. If payment is warranted, Wellpoint sends the appropriate payment to the provider.
   -or-
   If payment is not warranted, Wellpoint sends an RA to the provider with the specific claims processing information.

Wellpoint will adjudicate a clean electronic claim within 30 calendar days of the date the claim is received. Clean paper claims are processed within 30 calendar days. Wellpoint will pay interest on clean claims not adjudicated within these times frames. This policy is in alignment with BMS reimbursement policies. Interest will be paid to the in-network provider at 18% per annum, calculated daily for the full period in which the clean claim remains unpaid beyond the 30-day clean claim payment deadline.

Monitoring submitted claims

You may monitor submitted claims by logging on to the secure provider platform at https://Availity.com. Log in using your user ID and password. If your organization is not registered, select **Register**. To register, you will need your federal TIN, organizational name and NPI. Learn About Availity Registration. For directions on how to access our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

You may also monitor claims status through the Customer Care Center's IVR system at **800-782-0095**. Correct any errors and resubmit immediately to prevent denials due to late filing.

Please note: The IVR accepts either your NPI or your federal TIN for the provider ID. Should the system not accept those numbers, your call will be redirected to the Customer Care Center. For purposes of assisting you, we may ask again for your TIN.

Electronic remittance advice (835)

Wellpoint offers secure electronic delivery of ERAs, which explain claims in their final status, using EDI.

Electronic Remittance Advice (ERA)
The 835 eliminates the need for paper remittance reconciliation.
Use Availity to register and manage ERA account changes with these three easy steps:

- Log in to https://Availity.com
- Select **My Providers**
- Select **Enrollment Center** and select **Transaction Enrollment**

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

Electronic Funds Transfer (EFT)

Electronic Funds Transfer (EFT)
Electronic claims payment through electronic funds transfer (EFT) is a secure and fastest way to receive payment reducing administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.
Use EnrollSafe (https://enrollsafe.payeehub.org/) to register and manage EFT account changes.

Claims overpayment recovery procedure

Wellpoint seeks recovery of all excess claims payments from the person or entity to whom the benefit check is made payable. When an overpayment is discovered, Wellpoint initiates the overpayment recovery process by sending written notification.

Refund notifications may be identified by two entities, Wellpoint and its contracted vendors or the providers. Wellpoint researches and notifies the provider of an overpayment requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by Wellpoint, Wellpoint will notify the provider of the overpayment. The overpayment notification will include instructions on how to refund the overpayment. If payment is not received in 30 days, Wellpoint will commence recovery of such amounts through an offset against future claims payments.

If a provider identifies an overpayment and submits a refund, a completed *Refund Notification Form* specifying the reason for the return must be included. This form can be found on the provider website at provider.wellpoint.com/wv. For directions on how to access the provider website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**. The submission of the *Refund Notification Form* will allow Cost Containment to process and reconcile the overpayment in a timely manner. For questions regarding the refund notification procedure, please call the Customer Care Center at **800-782-0095**.

In instances where we are required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. As such, we will determine the cumulative adjusted reimbursement amount based on the new rates. In the event the outcome of this reconciliation results in a net amount owed to us, we will commence recovery of such amounts through an offset against future claims payments. Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement.

The *Patient Protection and Affordable Care Act (PPACA)*, commonly known as the *Healthcare Reform Act,* directly links the retention of overpayments to false claim liability. The language of *42 U.S.C.A. § 1320a-7k* makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act, including treble damages. In order to avoid such liability, healthcare providers and other entities receiving reimbursement under Medicare

or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the PPACA.

The provision entitled *Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments*, codified at 42 U.S.C.A. § 1320a-7k, clarifies the uncertainty left by the 2009 Fraud Enforcement and Recovery Act. This provision of the HealthCare Reform Act applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

Wellpoint seeks recovery of all excess claims payments from the person or entity to whom the benefit check is made payable. When an overpayment is discovered, Wellpoint initiates the overpayment recovery process by sending written notification.

If you are notified by Wellpoint of an overpayment, or discover that you have been overpaid, mail the check, along with a copy of the notification or other supporting documentation within 30 days to the appropriate address:

Wellpoint
Attn: Overpayment Recovery
P.O. Box 73651
Cleveland, OH 44193

For overnight delivery:

Wellpoint
Attn: Overpayment Recovery
Lockbox 92420
4100 West 150th St.
Cleveland, OH 44135

If you believe the overpayment notification was created in error, contact the Customer Care Center at **800-782-0095**.

For claims re-evaluation, send your correspondence to the address indicated on the overpayment notice. If Wellpoint does not hear from you or receive payment within 30 days, the overpayment amount will be deducted from your future claims payments. In cases where Wellpoint determines that recovery is not feasible, the overpayment will be referred to a collection service.

Third-party recovery

Providers may not interfere with or place any liens upon West Virginia's right or Wellpoint's right, acting as West Virginia's agent, to obtain recovery from third-party billing.

Hospital readmissions policy

Wellpoint does not reimburse for readmission for a related condition within 30 days of discharge from a previous hospital confinement, in accordance with the BMS and CMS policy for readmissions. Claims for new admission fees for hospital readmission will be denied.

Claims returned for additional information

Wellpoint will send you a request for additional or corrected information when the claim cannot be processed due to incomplete, missing or incorrect information. The request includes a form allowing you to return the requested information in an easy-to-follow format. This *Claim Follow-up Form* must be returned with the requested information. Wellpoint will use this same form to request additional information retroactively for a claim already paid. Provide any additional information within 180 calendar days from the date of the request or your claim may be denied.

To submit additional or corrected information, you should send:

- A copy of the letter requesting more information
- All supporting documentation you believe to be important or that was specifically requested by Wellpoint

Please note: Many of the claims returned for further information are returned for common billing errors. For additional information and tips, refer to the **Reference: Common Reasons for Rejected and Returned Claims** section of this chapter.

Claim resubmissions

When resubmitting a claim, use a *Claim Follow-Up Form*. The resubmission must be received by Wellpoint within 180 days from the date on the EOB or letter. Include the following information:

- Complete all required fields as originally submitted and mark the change(s) clearly.
- Write or stamp *Corrected Claim* across the top of the form.
- Attach a copy of the *EOB* and state the reason for resubmission.
- Send to:

  Wellpoint
  Attn: Claims Resubmissions
  P.O. Box 91
  Charleston, WV 25321-0091

Please note: You may send corrected CMS-1450 claim forms electronically. The third digit of the type of bill should indicate a correction or cancellation to the original submission.

If there has been no response from Wellpoint 30 calendar days after claim submission, follow up to determine the status. To follow up on a claim:

- Verify that the claim was not rejected by EDI or returned by mail.
- Call the Customer Care Center IVR at **800-782-0095**.
- Check the secure provider platform at https://Availity.com. Log in using your user ID and password. If your organization is not registered or select **Register**. To register, you will need your federal TIN, organizational name and NPI. Learn About Availity Registration. For directions on

how to access the website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

Please note: The IVR system accepts either your billing NPI or your federal TIN for provider ID. Should the system not accept those numbers, your call will be redirected to a Customer Care Center representative for assistance.

Provider claim payment disputes

If you are not satisfied with the outcome of a claim payment decision, you may begin the claim payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized, but you disagree with the outcome.

The Provider Claim Payment Dispute process consists of the following linear steps:

1. **Reconsideration**
2. **Claim Payment Appeal**

Please be aware there are three common, claim related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, we've defined them briefly here:

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

Locate the claim you want to dispute on Availity using **Claim Status** from the **Claims & Payments** menu. If available, select **Dispute Claim** to initiate the dispute. Go to **Request**" to navigate directly to the initiated dispute in the appeals dashboard add the documentation and submit.

Our Customer Care Center (CCC) helps you with claim inquiries. Just call **800-782-0085** and select the *Claims* prompt within our voice portal. We connect you with a dedicated resource team, called the Customer Care Center, to ensure:

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

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

Claim correspondence

Correspondence is when Wellpoint requires more information to finalize a claim. Typically, Wellpoint makes the request for this information through the *Explanation of Payment (EOP)*. The claim or part

of the claim may, in fact, be denied, but is only because more information is required to process the claim. Once the information is received, Wellpoint will use it to finalize the claim.

Medical necessity appeals
Medical Necessity appeals refer to a situation in which an authorization for a service was denied. Medical necessity/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the medical necessity appeal process.

A provider **Claim Payment Dispute** may be submitted for multiple reason(s), including:

- Contract payment issues.
- Disagreements over reduced or zero-paid claims.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues
- Timely Filing issues*

** We will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exist.*

Claim payment reconsiderations

The first step in the Claim Payment Dispute process is called Reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a Reconsideration without a finalized claim on file.

We accept Reconsideration requests in writing, verbally and through our secure provider website within 180 calendar days of the date on the *Explanation of Payment*. Reconsiderations filed more than 180 calendar days from the *Explanation of Payment* are considered untimely and denied unless good cause can be established.

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

Upon receipt of your Reconsideration request, an acknowledgement letter will be sent to you within 15 business days of our receipt. We will conduct an internal review that includes a thorough investigation of the claim payment by a trained analyst utilizing all applicable statutory, regulatory, contractual and provider subcontract provisions, Wellpoint policies and procedures, and all pertinent facts submitted from all parties.

The decision will then be communicated to you in a determination letter within 45 business days of the receipt of the reconsideration. If the outcome of the Reconsideration requires an adjustment to a claim payment, the adjustment will take place within 15 business days of the Reconsideration decision.

Claim payment appeal

If you are unsatisfied with the outcome of the Claim Payment Reconsideration, you may submit a Claim Payment Appeal within 60 calendar days of the Claim Payment Reconsideration outcome. You may submit your Claim Payment Appeal via Provider Online Portal or in writing. Verbal submissions are not accepted.

Upon receipt of your Claim Payment Appeal, an acknowledgement letter will be sent to you within 15 business days of our receipt. The decision will then be communicated to you in a determination letter within 30 calendar days of the receipt of the Claim Payment Appeal. If the outcome of the Claim Payment Appeal requires an adjustment to a claim payment, the adjustment will take place within 15 business days of the Claim Payment Appeal decision.

How to submit a Claim Payment Dispute

- **Online (for Reconsiderations and Claim Payment Appeals):** Use the secure Provider Availity Payment Appeal Tool at https://Availity.com.
  Note: Through Availity, you can upload supporting documentation and receive immediate acknowledgement of your submission. Locate the claim you want to dispute on Availity using **Claim Status** from the **Claims & Payments** menu. If available, select **Dispute Claim** to initiate the dispute. Go to **Request**" to navigate directly to the initiated dispute in the appeals dashboard add the documentation and submit.
- **Verbally (for Reconsiderations only): call the Customer Care Center: 800-782-0085**
- **Written (for Reconsiderations and Claim Payment Appeals):** Mail all required documentation (see below for more details) to:

  Claims Payment Reconsideration Department
  Wellpoint
  P.O. Box 91
  Charleston, WV 25321-0091

Required documentation for claim payment disputes

Wellpoint requires the following information when submitting a claim payment dispute (Reconsideration or Claim Payment Appeal):

- Your name, address, phone number and either your NPI or TIN
- The member's name and member ID number
- A listing of disputed claims, including the claim number and the date(s) of service(s):

  - Providers may submit one dispute for multiple claims as long as the issue is similar. Multiple claim disputes that are not similar in nature will be sent back to request separate submissions.
- All supporting statements and documentation

Wellpoint makes every effort to resolve Claim Payment Disputes. However, if additional information is required to make a determination, we will send a letter identifying the documents we are needing you to send in. You have 30 calendar days to submit the requested information back to us to prevent the denial of untimely filing.

Claim correspondence

Claim correspondence is different from a payment dispute. Correspondence is when Wellpoint requires more information to finalize a claim. Typically, Wellpoint makes the request for this information through the *Remittance Advice*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, Wellpoint will use it to finalize the claim.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of issue	What do I need to do?
Rejected claim(s)	Contact your vendor when your claim was submitted electronically but was never paid or was rejected. If submitting direct submission to Availity, review your response reports or contact Availity Client Services at **800-Availity (282-4548)**.
RA requests for supporting documentation (Itemized Bills and Invoices)	Submit a *Claim Follow-up Form*, a copy of your *RA* and the supporting documentation to: Wellpoint Attn: Claims P.O. Box 91 Charleston, WV 25321-0091
RA requests for medical records	Submit a *Claim Follow-up Form*, a copy of your *RA* and the medical records to: Wellpoint Attn: Claims P.O. Box 91 Charleston, WV 25321-0091
Need to submit a corrected claim due to errors or changes on original submission	Submit a *Claim Follow-up Form* and your corrected claim through Availity or mail to: Wellpoint Attn: Claims

Type of issue	What do I need to do?
	P.O. Box 91 Charleston, WV 25321-0091 For corrected electronic claims the following frequency code: • 7 – Replacement of Prior Claim EDI segments required: • Loop 2300- CLM - Claim frequency code • Loop 2300 - REF - Original claim number Please work with your vendor on how to submit corrected claims. Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 180 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Wellpoint to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI *EOB*.
Submission of coordination of benefits (COB)/third-party liability (TPL) information	Submit a *Claim Follow-up Form*, a copy of your RA and the COB/TPL information through Availity or mail to: Wellpoint Attn: Claims P.O. Box 91 Charleston, WV 25321-0091

Medical necessity appeals

Medical necessity appeals refer to a situation in which an authorization for a service was denied prior to the service. Medical necessity appeals/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the medical necessity appeal process.

Reference: **CHAPTER 4: COVERED AND NONCOVERED SERVICES**

Reference: clinical submission categories

The following is a list of claim categories for which we may routinely require submission of clinical information before or after payment of a claim. If the claim:

- Involves precertification, prior authorization, predetermination or some other form of utilization review, including, but not limited to, claims that are:
  - Pending for lack of precertification or prior authorization
  - Involving medical necessity or experimental/investigative determinations
  - Involving physician-administered drugs that require prior authorization
- Requires certain modifiers, including, but not limited to, modifier 22
- Includes unlisted codes
- Is under review to determine if the service is covered. Benefit determination cannot be made without reviewing medical records. This category includes, but is not limited to, pre-existing condition issues, emergency service/prudent layperson reviews and specific benefit exclusions
- Involves possible inappropriate or fraudulent billing and is under review
- Is the subject of an internal or external audit, including high-dollar claims
- Involves individuals under case or condition care
- Is under appeal or is otherwise the subject of a dispute, including claims being mediated, arbitrated or litigated

Other situations in which clinical information might be routinely requested:

- Accreditation activities
- Coordination of benefits
- Credentialing
- Quality improvement/assurance efforts
- Recovery/subrogation
- Requests relating to underwriting, including, but not limited to, member or provider misrepresentation/fraud reviews and stop-loss coverage issues

Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.

Reference: benefit codes

Submit claims with the appropriate benefit code for services, as required:

- For electronic claims, add the benefit code in SBR Loop 2000B, SBR03.
- For paper claims, add the benefit code in Box 11c on the CMS-1500 claim form.

If a benefit code is not applicable, leave the field blank.

Reference: submitting present on admission indicators

To comply with federal regulations, providers must include the present on admission (POA) indicators for paper and electronic inpatient claims. POA indicators demonstrate whether or not a condition was present when the member was admitted, or if the condition occurred while the member was in the facility. Include a POA indicator for each "primary" and "other" diagnosis code. Do not submit a POA indicator for the "admitting" diagnosis code.

Acceptable POA indicators are:

- **Y** - Yes, present at the time of admission.
- **N** - No, not present at the time of admission.
- **U** - Unknown. The documentation is insufficient to determine if the condition was present or not at the time of admission.
- **W** - Clinically undetermined. The provider is unable to determine clinically whether or not the condition was present at the time of inpatient admission.
- 1, 'space', or 'left blank' - Valid if either the facility or the diagnosis code is exempt from reporting of POA.

Reference: submitting pregnancy notification reports

When submitting claims regarding a member's pregnancy, providers must:

- Submit the *Prenatal Risk Screening Instrument* (*PRSI*) to Wellpoint within seven days of the first prenatal visit or as soon as possible. A completed *PRSI* must be emailed to **prsi.wellpoint@wellpoint.com** with "SECURE PRSI" in the subject line or faxed to **877-833-5729**.
- Use CPT Code 99213, along with the TH modifier when billing Wellpoint for each prenatal visit. When billing Wellpoint for an ultrasound or fetal non-stress test, also use modifier 25. Use modifier 25 only if you document a distinct, separately identifiable reason for the visit in the member's record.

Reference: national drug codes

Providers must include national drug codes (NDCs), unit of measurement and quantity of drug on all Wellpoint claims, including physician-administered drugs. This applies to drugs dispensed in both professional and institutional outpatient settings.

West Virginia's BMS requires that Wellpoint report NDC information every month. BMS submits this data to pharmaceutical manufacturers to obtain rebates under the Medicaid Drug Rebate Program. Following these instructions is important for West Virginia to receive timely Medicaid Drug Rebates from drug manufacturers.

Wellpoint will deny professional and outpatient institutional claims containing physician-administered drugs if any of the following elements are missing or invalid:

- NDCs

- Unit of measurement
- Quantity of drug

Please note: The NDC is an 11-digit code on the package or container from which medication is administered.

Reference: telehealth

The originating site must bill with the appropriate Telehealth originating site code (Q3014), and distant site providers must bill the appropriate Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT)/(HCPCS) code with the appropriate Place of Service code 02. The GT modifier is no longer required to be billed with the service code.

The originating site may bill for an office, outpatient, or inpatient evaluation and management (E&M) service in addition to the Telehealth service and for other Wellpoint-covered services the distant site orders, or for services unrelated to the medical problem for which the Telehealth service was requested. The provider may not bill originating site code when the originating site is the home of the member.

Reference: common reasons for rejected and returned claims

Many claims are returned for common billing errors, as defined in the table below.

Problem	Explanation	Resolution
Member's ID number is incomplete	Missing the correct member ID number listed on the state's ID card.	Use the member's Wellpoint ID number on the state's ID card.
Duplicate claim submission	Overlapping service dates for the same service create a question about duplication. claim was submitted to Wellpoint twice without additional information for consideration.	List each date of service, line by line, on the claim form. Avoid spanning dates, except for inpatient billing. Read RAs for important claim determination information before resubmitting a claim. Additional information may be needed. A corrected claim needs to be clearly marked as "Corrected" so that we do not process the claim as a duplicate.
Authorization number missing/does not match services	The authorization number is missing, or the approved services do not match the services described in the claim.	Confirm the authorization number is provided on the claim form and that approved services match the provided services. On the *CMS-1500* claim form, use Box 24. On the *CMS-1450* claim form, use Box 63. Contact the Utilization

Problem	Explanation	Resolution
		Management department to revise the service for authorization if changes occur.
Missing codes for required service categories	Use current HCPCS and CPT manuals because changes are made to the codes quarterly or annually. Purchase manuals at any technical bookstore, through the American Medical Association (AMA) or the Practice Management Information Corporation.	Check the codebooks or ask someone in your office who is familiar with coding. Use only those codes recognized by BMS. Providers must check BMS billing instructions.
Unlisted code for service	Because some procedures or services do not have an associated code, use an unlisted procedure code.	Wellpoint needs a description of the procedure and medical records in order to calculate reimbursement. DME, prosthetic devices, hearing aids or blood products require a manufacturer's invoice. For drugs/injections, the J code is required.
By report code for service	Some procedures or services require additional information.	Wellpoint needs a description of the procedure, as well as medical records in order to calculate reimbursement. DME, prosthetic devices, hearing aids or blood products require a manufacturer's invoice. For drugs/injections, the J code is required.
Unreasonable numbers submitted	Unreasonable numbers, such as "9999", may appear in the Service Units fields.	Check your claim for accuracy before submitting the claim.
Submitting batches of claims	Stapling multiple claims together may make the subsequent claims appear to be attachments rather than individual claims.	Clearly identify each individual claim and do not staple to another claim.
Nursing care	Nursing charges are included in the hospital and outpatient care charges.	Do not submit bills for nursing charges.

Problem	Explanation	Resolution
	Nursing charges billed separately are considered unbundled charges and are not payable. In addition, Wellpoint will not pay claims using different room rates for the same type of room to adjust for nursing care.	
Hospital Medicare ID missing	The Medicare ID number is required to process hospital claims at their appropriate contracted rates.	On the *CMS-1450* claim form, hospitals must enter their Medicare ID number in Box 51.

Reimbursement policies

These reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if Wellpoint covered the service for the member's benefit plan. These policies can be accessed on the provider site. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines, including using industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities.

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

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

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

Reimbursement hierarchy

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

Review schedules and updates to reimbursement policies

Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to a Wellpoint business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policies to our provider website.

Medical Coding

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

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

Reimbursement by code definition

Wellpoint allows reimbursement for covered services based on their procedure code definitions or descriptors unless otherwise noted by state or provider contracts or state, federal or CMS contracts and/or requirements. There are eight CPT sections:

1. Evaluation and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services or procedures

Reimbursement for behavioral health inpatient acute care

Wellpoint is responsible for:

- All claims incurred within the inpatient behavioral health treatment settings covered by managed care.
- All claims incurred during involuntary inpatient facility stay.

Wellpoint is **not** responsible for:

- Any payments for inpatient behavioral health services that are covered by fee-for-service.
- Claims incurred within the inpatient behavioral health or residential treatment setting if a member entered the treatment setting as a fee-for-service member.
- Claims incurred within the inpatient behavioral health treatment settings if a member entered the treatment setting as a member of another MCO.
- Any claims incurred during psychiatric residential treatment facility stay for individuals 21 years of age or older Claims and Billing (Medicaid only)

Reimbursement for behavioral health inpatient care - children

Wellpoint is responsible for:

- All claims incurred within the inpatient behavioral health or psychiatric treatment settings covered by managed care (PRTF)
- All claims incurred during involuntary inpatient facility stay.

Wellpoint is **not** responsible for:

- Any payments for inpatient behavioral health services that are covered by fee-for-service.
- Claims incurred within the inpatient behavioral health or psychiatric treatment setting if a member entered the treatment setting as a fee-for-service member.
- Claims incurred within the inpatient behavioral health or psychiatric treatment settings if a member entered the treatment setting as a member of another MCO.

Wellpoint is required to reimburse providers for court-ordered treatment services that are covered by Wellpoint under the Medicaid or CHIP State Plan.

Outlier reimbursement audit and review process

Requirements and policies

This section includes guidelines on reimbursement to providers and facilities for services on claims paid by DRG with an outlier paid at percent of billed charge or where the entire claim is paid at percent of billed charge. Our vendor-partner or our internal team may review these claims as part of our itemized bill review (IBR) program to ensure appropriate reimbursement. Upon completion of the review, documentation, including a summary of adjusted charges, will be provided for each claim. Disputes related to the review may be submitted according to the instructions in the Claims Payment Disputes section of this manual.

In addition to any header in this section, please refer to all other service-specific sections which may have more stringent guidelines. There may be multiple sections that apply to any given reimbursable service.

Audits/Records requests
At any time, a request may be made for on-site, electronic, or hard copy medical records, utilization review documentation and/or itemized bills related to Claims for the purposes of conducting audit or reviews.

Blood, and blood products
Blood and blood products such as platelets or plasma are reimbursable. Administration of Blood or Blood Products by nursing/facility personnel is not separately reimbursable on inpatient claims. Administration of Blood or Blood Products by nursing/facility personnel billed on outpatient claims are separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage, transportation, processing, and preparation such as thawing, splitting, pooling, and irradiation are also not separately reimbursable. Lab tests, such as typing, Rh, or matching, are separately reimbursable charges.

Emergency room supplies and services charges
The Emergency Room level reimbursement includes all monitoring, equipment, supplies, time, and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services.

Facility personnel charges
Charges for Inpatient Services for facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), professional therapy functions, including physical, occupational, and speech call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Charges for outpatient services for facility personnel are also not separately reimbursable. The reimbursement is included in the payment for the procedure or Observation charge.

Implants
Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors and radioactive seeds, in addition to non-soluble, or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the member's body upon discharge from the inpatient stay or outpatient procedure.

Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices and supplies shall not be considered implants. Implants that are deemed contaminated and/or considered waste and/or were not implanted in the member will not be reimbursed.

IV sedation and local anesthesia

Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the Operating Room (“OR”) time/procedure reimbursement. Medications used for IV sedation and local anesthesia are separately reimbursable.

Lab charges

The reimbursement of charges for specimen collection are considered facility personnel charges and the reimbursement is included in the room and board or procedure/Observation charges. Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws.

Processing fees, handling fees, and referral fees are considered included in the procedure/lab test performed and not separately reimbursable.

Labor care charges

Reimbursement will be made for appropriately billed room and board or labor charges. Payment will not be made on both charges when billed concurrently.

Nursing procedures

Fees associated with nursing procedures or services provided by facility nursing staff or unlicensed facility personnel (technicians) performed during an inpatient ("IP") admission or outpatient ("OP") visit will not be reimbursed separately. Examples include, but are not limited, to intravenous ("IV") injections or IV fluid administration/monitoring, intramuscular ("IM") injections, subcutaneous ("SQ") injections, IV or PICC line insertion at bedside, nasogastric tube ("NGT") insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, etc.) and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration or OP chemotherapy administration which are submitted without observation/treatment room charges.)

Operating room time and procedure charges

The operating room ("OR") charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse’s notes. The Operating Room is defined as surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac Cath labs, Hybrid Rooms, X-ray, pulmonary and cardiology procedural rooms. The operating room charge will reflect the cost of:

- The use of the operating room
- The services of qualified professional and technical personnel

- Any supplies, items, equipment, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services. Refer to Routine Supplies section of the manual.

Personal care items and services

Personal care items used for patient convenience are not separately reimbursable. Examples include but are not limited to breast pumps, deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste, bedpans, chux, hot water bottles, icepacks, pillows, sitz baths, and urinals.

Pharmacy charges

Reimbursement will be made for the cost of drugs prescribed by the attending physician. Additional separate charges for the administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel will not be reimbursed separately. All other services are included in the drug reimbursement rate. Example of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy ("Rx") cart.

Portable charges

Portable Charges are included in the reimbursement for the procedure, test, or x-ray, and are not separately reimbursable.

Pre-operative care or holding room charges

Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure and are not separately reimbursed. In addition, nursing care provided in the pre-operative care areas will not be reimbursed separately.

Preparation (set-up) charges

Charges for set-up, equipment, or materials in preparation for procedures or tests are included in the reimbursement for that procedure or test.

Recovery room charges

Reimbursement for recovery room services (time or flat fee) includes the use of all and/or available services, equipment, monitoring, and nursing care that is necessary for the patient's welfare and safety during his/her confinement. This will include but is not limited to cardiac/vital signs monitoring, pulse oximeter, medication administration fees, nursing services, equipment, supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Recovery room services related to IV sedation and/or local anesthesia

Separate reimbursement will not be made for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post

procedure room or a phase II recovery (step-down) Examples of procedures include arteriograms and cardiac catheterization.

Supplies and services
Items used for the patient which are needed as a direct result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable.

Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately reimbursable in the inpatient and outpatient environments.

Special procedure room charge
Special procedure room charges are included in the reimbursement for the procedure. If the procedure takes place outside of the OR suite, then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: ICU, GI lab, etc.

Stand-by charges
Standby equipment and consumable items which are on stand-by, are not reimbursable. Standby charges for facility personnel are included in the reimbursement for the procedure and not separately reimbursable.

Stat charges
Stat charges are included in the reimbursement for the procedure, test, and/or X-ray. These charges are not separately reimbursable.

Supplies and equipment
Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, oxygen, and isolation carts and supplies are not separately reimbursable.

Telemetry
Telemetry charges in ER/ ICU/CCU/NICU or telemetry unit (step-down units) are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable.

Time calculation:
- **Operating room ("OR")**: Time should be calculated on the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.
- **Hospital/Technical anesthesia**: Reimbursement of technical anesthesia time will be based on the time the patient enters the operating room (OR) until the patient leaves the room, as documented in the OR nurse's notes. The time the anesthesiologist spends with the patient in pre-op and the recovery room will not be reimbursed as part of the hospital anesthesia time.
- **Recovery room**: The reimbursement of Recovery Room charges will be based on the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit ("PACU") record.

- **Post recovery room:** Reimbursement will be based on the time the patient leaves the Recovery Room until discharge.

Video or digital equipment used in operating room

Charges for video or digital equipment used in a surgery are included in the reimbursement for the procedure and are not separately reimbursable. Charges for batteries, covers, film, anti-fogger solution, tapes etc., are not separately reimbursable.

Additional reimbursement guidelines for disallowed charges

The disallowed charges (charges not eligible for reimbursement) include, but are not limited to, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by your specific agreement. Please refer to your contractual fee schedule for payment determination.

The tables below illustrate examples of non-reimbursable items/services codes.

Examples of non-reimbursable items/services codes	
Typically billed under this/these Revenue Codes but not limited to the Revenue Codes listed below	**Description of excluded items**
0990 – 0999	Personal Care Items Courtesy/Hospitality Room Patient Convenience Items (0990) Cafeteria, Guest Tray (0991) Private Linen Service (0992) Telephone, Telegraph (0993) TV, Radio (0994) Non-patient Room Rentals (0995) Beauty Shop, Barber (0998) Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	Supplies and Equipment Blood pressure cuffs/stethoscopes Thermometers, temperature probes, etc. Pacing cables/wires/probes

	Pressure Pump, transducers, Transducer kits/packs SCD sleeves/compression sleeves/Ted hose Oximeter sensors/probes/covers Electrodes/electrode cables/wires Oral swabs/toothettes Wipes (baby, cleansing, etc.) Bedpans/urinals Bed scales/alarms Specialty beds Foley/straight catheters, urometers/leg bags/tubing Specimen traps/containers/kits Tourniquets Syringes/needles/lancets/butterflies Isolation carts/supplies Dressing change trays/packs/kits Dressings/gauze/sponges Kerlix/Tegaderm/OpSite/Telfa Skin cleansers/preps Cotton balls; Band-Aids, tape, Q-Tips Diapers/Chucks/Pads/Briefs Irrigation solutions ID/Allergy bracelets Foley stat lock Gloves/Gowns/Drapes/Covers/Blankets Ice Packs/Heating Pads/Water Bottles Kits/Packs (Gowns, Towels and Drapes) Basins/basin sets Positioning Aides/Wedges/Pillows Suction Canisters/Tubing/Tips/Catheters/Liners Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) Preps/prep trays Masks (including CPAP and Nasal Cannulas/Prongs) Bonnets/Hats/Hoods Smoke Evacuator Tubing Restraints/Posey Belts OR Equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets,

	transducers, fluid warmers, heparin, and saline flushes, etc.)
0220 – 0222, 0229, 0250	Pharmacy administrative fee (including mixing meds) Portable fee (cannot charge portable fee unless equipment is brought in from another facility) Patient transport fees
0223	Utilization review service charges
0263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing procedures
0230	Incremental nursing – general
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) Medication prep Nonspecific descriptions Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges IV Solutions 250 cc or less, except for pediatric claims Miscellaneous Descriptions Non-FDA Approved Medications
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	Specimen collection Draw fees Venipuncture Phlebotomy Heel stick Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399) Thawing/Pooling Fees

0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment Oxygen Instrument Trays and/or Surgical Packs Drills/Saws (All power equipment used in O.R.) Drill Bits Blades IV pumps and PCA (Patient Controlled Analgesia) pumps Isolation supplies Daily Floor Supply Charges X-ray Aprons/Shields Blood Pressure Monitor Beds/Mattress Patient Lifts/Slings Restraints Transfer Belt Bair Hugger Machine/Blankets SCD Pumps Heal/Elbow Protector Burrs Cardiac Monitor EKG Electrodes Vent Circuit Suction Supplies for Vent Patient Electrocautery Grounding Pad Bovie Tips/Electrodes Anesthesia Supplies Case Carts C-Arm/Fluoroscopic Charge Wound Vacuum Pump Bovie/Electro Cautery Unit Wall Suction Retractors Single Instruments Oximeter Monitor CPM Machines Lasers Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia Nursing care

	Monitoring Intervention Pre- or post-evaluation and education IV sedation and local anesthesia if provided by RN Intubation/Extubation CPR
410	Respiratory Functions: Oximetry reading by nurse or respiratory Respiratory assessment/vent management Medication Administration via Nebs, Metered dose (MDI), etc. Charges Postural Drainage Suctioning Procedure Respiratory care performed by RN
0940 – 0945	Education/training

CHAPTER 10: BILLING PROFESSIONAL AND ANCILLARY CLAIMS

Customer Care Center phone: 800-782-0095
Customer Care Center fax: 888-438-5209
Web: https://Availity.com
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Overview

Providers can depend on efficient claims handling and faster reimbursement when they follow Wellpoint's professional and ancillary billing requirements. These requirements include using standardized codes for most health services. This chapter is broken into health service categories to help you find the specific billing codes you need for each service.

You will also find information on billing members for services that are not medically necessary or not covered, billing for services for which the member is willing to pay, and complete information about completing the *CMS-1500* claim form.

To help you navigate the various billing requirements and codes, we have organized the service categories as follows:

- Adult preventive care
- Behavioral Health services
- Emergency services
- Family planning services
- Hospital readmission policy
- Immunizations covered by the Vaccines for Children Program (VFC)
- Immunization administration procedures covered under VFC
- Immunizations not covered by VFC
- Initial health assessments (IHAs)
- Maternity services
- Newborns
- On call services
- Preventive medicine services: new patient
- Preventive medicine services: established patient
- Self-referable services
- Sensitive services
- Sterilization claims

- Physician Office Lab

General guidelines

For the most efficient claims processing, accurately completed claims are essential. Follow these general guidelines for claims filing:

- Indicate the provider's NPI number in Box 24J of the CMS-1500 claim form. Missing or invalid numbers may result in nonpayment.
- Mid-level practitioners (such as physician assistants) should use their own NPI number in Box 24J of the CMS1500 claim form.
- Nurse practitioners and certified nurse midwives are credentialed providers and therefore enter their own NPI number in Box 24J.
- Use the member's ID number from the Wellpoint ID card.

Please note: Wellpoint does not accept global billing codes. If we receive a claim with global coding, we will return the claim to you with a *mailback form* asking you to rebill using itemized codes.

Coding

Wellpoint uses standardized codes in our effort to process claims in an orderly and consistent manner. HCPCS, sometimes referred to as national codes, provides coding for a wide variety of services.

The principal coding levels are referred to as level I and level II:

- Level I: CPT codes maintained by the American Medical Association (AMA) and represented by five digits.
- Level II: Codes that identify products, supplies and services not included in the CPT codes, such as ambulance supplies and durable medical equipment (DME). Level II codes sometimes are called the alphanumeric codes because they consist of a single alphabetical letter followed by four digits.

In some cases, two-digit/character modifier codes should accompany the level I or level II coding. Reference guides useful for coding claims are:

- The Current Procedural Terminology manual, published by the AMA. To order, call: **800-621-8335**.
- The Healthcare Common Procedure Coding System published by the Centers for Medicare and Medicaid Services (CMS). To order, call: **800-621-8335**.

National drug codes

Providers must include National Drug Codes (NDCs) on all claims involving products or services with an NDC. Wellpoint submits this NDC information to West Virginia with encounter claims submissions.

Initial health assessments

Wellpoint PCPs function as a member's medical home. For that reason, we strongly recommend that an IHA be conducted within forty-five (45) calendar days of the member's date of enrollment. The IHA should consist of a complete history, a physical exam, and preventive services.

When billing for IHAs, use the following ICD diagnosis codes:

- Z00.121 for children (newborn to 18 years old)
- Z00.00 for adults (19 years and older)

Adult preventive care

The following is a list of codes specific to adult preventive care:

Code	Description
82270	Fecal Occult Blood Test (lab procedure code only)
82465	Total Serum Cholesterol (lab procedure code only)
84153	PSA (lab procedure code only)
86580	Tuberculosis (TB) Screening (PPD)
88150	Pap Smear (lab procedure code only)
90658	Flu Shot
90732	Pneumovax

Preventive medicine services: new patient

Preventive medicine services for a new patient start with an IHA. This evaluation includes an age- and gender-appropriate history, examination, counseling, risk factor interventions, and the ordering of appropriate immunizations, laboratory, and diagnostic procedures. Bill for these services using the following codes:

Code	Description
99381	Infant (under 1 Year)
99382	Early Childhood (ages 1-4)
99383	Late Childhood (ages 5-11)
99384	Adolescent (ages 12-17)
99385	Ages 18-39
99386	Ages 40-64
99387	Ages 65 and older

Preventive medicine services: established patient

Preventive medicine services for an established patient involve re-evaluation and management of existing conditions, if any. This evaluation includes an age- and gender-appropriate history, examination, counseling, risk factor interventions, and the ordering of appropriate immunizations, laboratory, and diagnostic procedures.

Code	Description
99391	Infant (under 1 year)
99392	Early Childhood (ages 1-4)

Code	Description
99393	Late Childhood (ages 5-11)
99394	Adolescent (ages 12-17)
99395	Ages 18-39
99396	Ages 40-64
99397	Ages 65 and older

Self-referable services

Members may access the following services at any time without preauthorization or referral by their PCP:

- Behavioral Health services
- Family planning, associated services, and other sensitive services, supplies, or medications to members of childbearing age to temporarily or permanently prevent or delay pregnancy
- Obstetrics/gynecology (OB/GYN; in-network only from Wellpoint providers)
- Emergency care
- Vision care

Emergency and related professional services

Emergency services, as defined by state and local law, the provider contract, and our Member Handbook, are reimbursed in accordance with the Wellpoint provider contract and West Virginia's Bureau for Medical Services (BMS) policy.

Please note: Prior authorization is not required for medically necessary emergency services.

Emergency: Any condition manifesting itself by acute symptoms of sufficient severity such that a layperson possessing an average knowledge of health and medicine could expect that the absence of immediate medical care could:

- Place the member's health in serious jeopardy. Or, with respect to a pregnant woman, the health of the woman and her unborn child
- Cause serious impairment to bodily functions
- Cause serious dysfunction to any bodily organ or part

Covered emergency services include:

- Hospital-based emergency services (room and ancillary) needed to evaluate or stabilize the emergency medical or behavioral health condition
- Services by emergency providers

Family planning services

The following is a list of diagnostic codes specific to family planning services:

ICD-10	Description
T83.31XA	Breakdown (mechanical) of intrauterine contraceptive device, initial encounter
T83.32XA	Displacement of intrauterine contraceptive device, initial encounter
T83.39XA	Other mechanical complication of intrauterine contraceptive device, initial encounter
Z92.0	Personal history of contraception
Z30.011	Encounter for initial prescription of contraceptive pills
Z30.018	Encounter for initial prescription of other contraceptives
Z30.019	Encounter for initial prescription of contraceptives, unspecified
Z30.09	Encounter for other general counseling and advice on contraception
Z30.430	Encounter for insertion of intrauterine contraceptive device
Z30.2	Encounter for sterilization
Z30.8	Encounter for other contraceptive management
Z30.40	Encounter for surveillance of contraceptives, unspecified
Z30.41	Encounter for surveillance of contraceptive pills
Z30.431	Encounter for routine checking of intrauterine contraceptive device
Z30.49	Encounter for surveillance of other contraceptives
Z30.42	Encounter for surveillance of injectable contraceptive
Z30.49	Encounter for surveillance of other contraceptives
Z30.9	Encounter for contraceptive management, unspecified
Z31.0	Encounter for reversal of previous sterilization
Z31.89	Encounter for other procreative management
Z31.42	Aftercare following sterilization reversal
Z31.61	Procreative counseling and advice using natural family planning
Z31.69	Encounter for other general counseling and advice on procreation
Z98.51	Tubal ligation status
Z98.52	Vasectomy status
Z31.81	Encounter for male factor infertility in female patient
Z31.82	Encounter for Rh incompatibility status
Z31.83	Encounter for assisted reproductive fertility procedure cycle
Z31.84	Encounter for fertility preservation procedure
Z31.89	Encounter for other procreative management
Z31.9	Encounter for procreative management, unspecified
Z97.5	Presence of (intrauterine) contraceptive device

The following is a list of self-referable family planning codes payable without prior authorization:

HCPCS/CPT	Description
11976	Removal, Implantable Contraceptive Capsules
57170	Diaphragm fitting
58300	IUD insertion
58301	IUD removal only
58615	Occlusion of fallopian tubes by device (for example, band, clip, Falope ring), vaginal or suprapubic approach

HCPCS/CPT	Description
81025	Pregnancy test

Hospital readmission policy

Wellpoint does not reimburse for readmissions for a related condition if the member's readmission occurs within thirty days of discharge. Wellpoint may require medical records and review readmission within 30 days of discharge to determine if the member was discharged early. Claims for readmission within 30 days that are related to an early discharge may be denied. Facilities have the right to a submit payment dispute for a readmission denial believed to be due to an unrelated condition or an exclusion to the readmission policy. This Wellpoint Reimbursement policy is in line with the BMS reimbursement policy.

Immunizations covered by vaccines for children

Wellpoint providers who administer vaccines to children 0-18 years of age must enroll in the VFC Program. Wellpoint will reimburse the administration fee for any vaccine available through the VFC Program. To enroll, call: **800-642-3634**. Or complete the enrollment form online: www.dhhr.wv.gov/oeps/immunization/VFC.

When billing immunizations provided to you by the VFC Program, use the CMS-1500 claim form and do the following:

- In Box 24D, enter the appropriate CPT code with the SL modifier
- On another line of Box 24D, enter the appropriate administration procedure code (90471 through 90474)
- In Box 23, enter the PCP name

The following immunizations are covered under the VFC Program:
www.dhhr.wv.gov/oeps/immunization/providers/Documents/Section%2014/CPT_4212015.pdf

CPT code	Description
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular
90621	Meningococcal recombinant lipoprotein vaccine, serogroup B, 2 or 3 dose schedule, for intramuscular use
90633	Hepatitis A vaccine, pediatric/adolescent dosage, 2 dose schedule for intramuscular use.
90647	Hemophilus influenza B vaccine (Hib), PRP-OMP conjugate, 3 dose schedule for intramuscular use.
90648	Hemophilus influenza B vaccine (Hib), PRP-T conjugate, 4 dose schedule, for intramuscular use.
90649	Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 19, quadrivalent, 3 dose schedule, for intramuscular use.
90650	Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use

CPT code	Description
90651	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonvalent (HPV), 2 or 3 dose schedule, for intramuscular use
90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use.
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use.
90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use
90672	Influenza virus vaccine, quadrivalent, live, for intranasal use
90680	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use (Rotateq).
90681	Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use (Rotarix).
90685	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use
90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 years through 6 years of age, for intramuscular use.
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-HIB-IPV), for intramuscular use.
90700	Diphtheria, tetanus toxoids, acellular pertussis vaccine (DtaP), when administered to individuals younger than 7 years, for intramuscular use.
90702	Diphtheria and tetanus toxoids (DT), adsorbed when administered to individuals younger than 7 years, for intramuscular use.
90707	Measles, mumps, and rubella vaccine (MMR), live, for subcutaneous use.
90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
90713	Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use.
90714	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
90716	Varicella virus vaccine, live, for subcutaneous use
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult, or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use

CPT code	Description
90734	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diphtheria toxoid carrier (MenACWY-D) or CRM197 carrier (MenACWY-CRM), for intramuscular use (Menactra).
90744	Hepatitis B vaccine, pediatric/adolescent dosage; 3 dose schedule, for intramuscular use.

Modifier	Description
SL	State supplied vaccine

Immunization administration procedures covered under the VFC program

The following are the vaccine administration procedures and their billing codes:

CPT code	Description	Immunization administration
90471	One vaccine, single or combination vaccine/toxoid	Includes percutaneous, intradermal, subcutaneous, or intramuscular injections
90472	Each addition vaccine, single or combination vaccine/toxoid. List separately from the code for primary procedure	Includes percutaneous, intradermal, subcutaneous, or intramuscular injections
90473	One vaccine, single or combination vaccine/toxoid	Immunization administration includes intranasal or oral route
90474	Each addition vaccine, single or combination vaccine/toxoid. List separately from the code for primary procedure	Immunization administration includes intranasal or oral route

Immunizations not covered by vaccines for children

When billing for immunizations not covered by the VFC Program, use the *CMS-1500* claim form, and do the following:

- On a line of Box 24D, enter the appropriate CPT code
- On another line of Box 24D, enter the appropriate administration procedure code

Please note: The SL modifier is not required.

Additional services during EPSDT exams

If a member is evaluated and treated for a problem during the same visit as an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) annual exam or well-child visit, the problem-oriented exam may be billed separately if accompanied by the modifier 25. The problem must require an additional, moderate-level evaluation to qualify as a separate service on the same date. Use modifier 25 only if documenting a distinct, separately identifiable reason for the visit in the member's record.

Maternity services

Wellpoint requires itemization of maternity services when submitting claims for reimbursement. Please use the CMS-1500 claim form with the appropriate CPT, HCPCS codes and ICD diagnosis codes. Include the applicable Evaluation and Management (E&M) code, as well as coding for all other procedures performed.

Maternity billing guidelines are as follows:

- Wellpoint reimburses one delivery or cesarean section procedure per member in a seven-month period. Reimbursement includes multiple births.
- Maternity benefit ends after the postpartum period, 60 days from the birth of the baby (the last day of the month that the 60th day falls in). Example: 60th day after the birth of the baby falls on 9/15, the coverage would end 9/30.
- Delivering providers who perform regional anesthesia or nerve block may not receive additional reimbursement. Regional anesthesia and nerve block charges are included in the reimbursement for the delivery.
- Wellpoint reimburses anesthesia services and delivery at full allowance when rendered by the delivering provider. When billing Wellpoint, itemize each service individually and submit claims as the services are rendered. The filing deadline will be applied to each individual date of service submitted.
- Bill the laboratory and radiology services provided during pregnancy separately, including pregnancy tests. Wellpoint must receive these claims within 180 days from the date of service.
- Use of the appropriate E&M or CPT codes is necessary for appropriate reimbursement. Indicate the Estimated Date of Confinement (EDC) in Box 24D of the CMS-1500 claim form.
- If a member is admitted to the hospital during the course of her pregnancy, the diagnosis necessitating the admission should be the primary diagnosis on the claim.
- If a pregnancy is high risk, document the high-risk diagnosis on the claim form.
- Identify the nature of a high-risk care visit in the diagnosis field in Box 21 of the CMS-1500 claim form or in another appropriate field.
- Use the CMS-1500 claim form with itemized E&M codes.
- For professional claims only, include the date of the member's last menstrual period.
- Use CPT code 99213 with the TH modifier to bill for each prenatal visit. Wellpoint requires modifier 25 along with 99213-TH when the member has an office visit on the same date of service as an ultrasound (76801, 76802, 76805-76828) or fetal nonstress test (59025) in the provider's office. Use modifier 25 only if you document a distinct, separately identifiable reason for the visit in the member's record.
- Submit pregnancy notification to Wellpoint within seven days of the first prenatal visit or as soon as possible thereafter. Use the *Pregnancy Risk Screening Instrument* (*PRSI*) form, available on our website at provider.wellpoint.com/wv. Completed forms can be emailed to **prsi.wellpoint@wellpoint.com** with "SECURE PRSI" in the subject line or faxed to **877-833-5729**. For

directions on how to our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

For information about billing for termination of pregnancy, hysterectomy and sterilization, refer to the appropriate sections of **Chapter 10: Billing Institutional Claims: Termination of Pregnancy, Hysterectomy, or Sterilization**.

The following are the billing codes for maternity services:

Code	Description
59409	Vaginal delivery only (with or without episiotomy and/or forceps)
59412	External cephalic version, with or without tocolysis
59414	Delivery of placenta (separate procedure)
59514	Cesarean section only
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
59620	Cesarean section only, following attempted vaginal delivery after previous cesarean delivery

Maternity services: codes for prenatal, deliveries and postpartum services

Initial prenatal care visits are payable with the CPT code 99213, indicating an office/outpatient visit, and established — moderate severity. In addition, you must include a TH modifier, indicating an obstetrical treatment/service.

Postpartum care is payable with CPT code 59430, between days 7 and 84, indicating Postpartum Care Only.

Maternity services: Cesarean sections

Wellpoint restricts any Cesarean section, labor induction or any delivery following labor induction to the following criteria:

- Gestational age of the fetus should be determined to be at least 39 weeks or fetal lung maturity must be established before delivery.
- When the delivery occurs prior to 39 weeks, maternal and/or fetal conditions must dictate medical necessity for the delivery.

Any Cesarean section, labor induction, or delivery that follows labor induction and that occurs prior to 39 weeks of gestation will be denied if the procedure is considered to be not medically necessary. Records will be subject to retrospective review. If a Cesarean section, labor induction, or delivery following labor induction fails to meet the criteria for medical necessity, payments made will be subject to recoupment. Recoupment may apply to all services related to the delivery, including additional provider and hospital fees.

Maternity services: newborns

Wellpoint will reimburse providers for all medically necessary covered services provided under the standard benefit package to the newborn child or an enrolled mother for the first sixty (60) to ninety (90) calendar days of life based upon the cut-off date for MCO enrollment with the enrollment broker. The child's date of birth will be counted as day one.

Submit newborn claims using either the Wellpoint ID number of the mother or the West Virginia-issued Wellpoint ID number of the newborn. Do not use a temporary ID number, which an ID is ending in NB followed by one or more digits. Wellpoint rejects claims with temporary ID numbers.

Providers may bill using the mother's Wellpoint ID number:

- During the month of birth and up to an additional 60 days after the baby is born or
- Until the newborn is assigned his or her own Wellpoint ID number
- When billing for newborn charges under the mother's Identification number the provider must put the mother's information under the subscriber fields and the newborn information under the patient fields.

Also submit the name, date of birth and other pertinent information about the newborn on a *Newborn Enrollment Notification Report*. To prevent any delay in Wellpoint coverage for newborns, perform the following:

- Notify Wellpoint of all deliveries within 3 days of delivery. Use the *Newborn Enrollment Notification Report* found on our website at provider.wellpoint.com/wv. For directions on how to access the *Provider Resources* page of our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.
- Notify Wellpoint when you receive a newborn's permanent Wellpoint ID number. Use the *Newborn Enrollment Notification Report* found on the Wellpoint website at provider.wellpoint.com/wv.

Request that your patients take these important steps as soon as their babies are born:

- Immediately contact the West Virginia BMS or their Social Worker to request the required paperwork.
- Fill out and return the required paperwork to BMS to enroll their newborn in Wellpoint.

Maternity services: newborn billing instructions

When submitting claims to Wellpoint for the newborn during the first 30 days of life (and up to 60 days after the baby is born or the newborn is assigned his or her own Wellpoint Medicaid or WVCHIP ID number), please submit the newborn claims with the mother as the subscriber, using her Wellpoint member identification number.

The newborn baby will be the patient and should be billed as baby boy/baby girl and the appropriate date of birth (Newborn's First name, Last name and MI may also be used when available).

Multiple births should be billed as Boy/Girl A and Boy/Girl B, and so on (Newborn's First name, Last name and MI may also be used when available).

Authorization is required for newborns who require care other than normal newborn care or are transferred. All authorizations must be submitted within the required notification timeline outlined in the provider manual.

Claim form instructions

UB-04:

- Newborn's Name or Baby Girl/Baby Boy and Demographics in boxes 8, 9, 10, 11
- Entire claim data should reflect baby's visit with the exception of the Insurance information, which is the mother's.
- Mother's Info in Boxes 50,51,52,53, Mothers Name in box 58
- Field 59 should remain as 'Self'

CMS 1500:

- Newborn's Name or Baby Girl/Baby Boy and Demographics in boxes 2, 3, 5, and 6.
- Entire claim data should reflect baby's visit with the exception of the Insurance information, mother's name and demographics in boxes 1A, 4, 7, and 11a.

Hospitals should bill for newborn delivery and other newborn services on a separate claim from the services they provide to the mother.

As a reminder, it is a Medicaid policy for inpatient stays that the insurance at the time of admit is responsible for the entire stay. This is strictly a Medicaid policy and only applies to Wellpoint HP of WV Medicaid members.

Newborns: circumcision

Circumcision charges should be billed with appropriate CPT codes.

Code	Description
54150	Circumcision, Using Clamp or Other Device – Newborn
54160	Circumcision, Surgical Excision Other Than Clamp, Device or Dorsal Split – Newborn
54161	Circumcision, Surgical Excision Other Than Clamp, Device or Dorsal Split – Except Newborn

Physician Office Lab (POL)

Wellpoint will allow providers to perform select laboratory services in their office. The lab services are listed on the Physician Office Lab (POL) list. The member must be referred to a participating laboratory for lab services not included on the POL list. Claims submitted for laboratory services not on the POL list will be denied and the member cannot be balance billed. Providers must obtain the appropriate level of Clinical Laboratory Improvement Act (CLIA) certification to perform these services.

Physician Office Lab (POL) List

CPT code	Description
80047	BASIC METABOLIC PANEL (CALCIUM, IONIZED)
80048	BASIC METABOLIC PANEL
80051	ELECTROLYTE PANEL
80061	LIPID PANEL
80069	RENAL FUNCTION PANEL
80178	ASSAY OF LITHIUM
80305	DRUG TEST PRSMV DIR OPT OBS
81000	URINALYSIS, BY DIP STICK/TAB REAGENT FOR BILIRUBIN, GLUCOSE, HEMOGLOBIN, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; NON-AUTOMATED, WITH MICROSCOPY
81001	URINALYSIS, BY DIP STICK/REAGENT TAB, for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; AUTOMATED, WITH MICROSCOPY
81002	URINALYSIS, BY DIP STICK/TAB REAGENT for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; NON-AUTOMATED WITHOUT MICROSCOPY
81003	URINALYSIS, BY DIP STICK/TABLET REAGENT for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; AUTOMATED, WITHOUT MICROSCOPY
81015	URINALYSIS; MICROSCOPIC ONLY
81025	URINE PREGNANCY TEST, BY VISUAL COLOR COMPARISON METHODS
82010	Ketone body(s) (eg, acetone, acetoacetic acid, beta-hydroxybutyrate); quantitative
82040	Albumin; serum, plasma, or whole blood
82044	UR ALBUMIN SEMIQUANTITATIVE
82120	AMINES VAGINAL FLUID QUAL
82150	AMYLASE
82247	BILIRUBIN; TOTAL
82248	BILIRUBIN; DIRECT
82270	BLOOD, OCCULT, BY PEROXIDASE ACTIVITY (EG, GUAIAC); feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)
82271	OCCULT BLOOD OTHER SOURCES

CPT code	Description
82272	BLOOD, OCCULT, BY PEROXIDASE ACTIVITY (EG, GUAIAC); QUALITATIVE, FECES, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening
82465	Cholesterol, serum or whole blood, total
82550	Creatine kinase (CK), (CPK); total
82570	Creatinine; other source
82679	Estrone
82948	GLUCOSE; BLOOD, REAGENT STRIP
82950	GLUCOSE TEST; post glucose dose (includes glucose)
82951	GLUCOSE TOLERANCE TEST (GTT), 3 specimens (includes glucose)
82952	Glucose; tolerance test, each additional beyond 3 specimens (List separately in addition to code for primary procedure)
82962	Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use
82977	Glutamyltransferase, gamma (GGT)
82985	GLYCATED PROTEIN
83001	Gonadotropin; follicle stimulating hormone (FSH)
83002	Gonadotropin; luteinizing hormone (LH)
83014	HELICOBACTER PYLORI BREATH TEST ANALYSIS FOR UREASE ACTIVITY; DRUG ADMINISTRATION
83026	HEMOGLOBIN COPPER SULFATE method, non-automated
83036	HEMOGLOBIN; glycosylated (A1C)
83037	Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use
83516	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, multiple step method
83605	Lactate (lactic acid)
83655	LEAD
83718	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
83721	Lipoprotein, direct measurement; LDL cholesterol
83880	NATRIURETIC PEPTIDE
84075	ALKALINE PHOSPHATASE
84155	Protein, total, except by refractometry; serum, plasma or whole blood
84443	THYROID STIM HORMONE
84450	TRANSFERASE (AST) (SGOT)
84460	ALANINE AMINO (ALT) (SGPT)
84478	TRIGLYCERIDES
84550	BLOOD/URIC ACID
84703	GONADOTROPIN, CHORIONIC (HCG): QUALITATIVE
84830	OVULATION TESTS; , by visual color comparison methods for human luteinizing hormone
85013	BLOOD COUNT; SPUN MICROHEMATOCRIT
85014	BLOOD COUNT; HEMATOCRIT (HCT)

CPT code	Description
85018	BLOOD COUNT; HEMOGLOBIN (HGB)
85025	BLOOD COUNT; COMPLETE (CBC), AUTOMATED (HGB, HCT, RBC, WBC AND PLATELET COUNT) AND AUTOMATED DIFFERENTIAL WBC
85027	BLOOD COUNT; COMPLETE (CBC), AUTOMATED (HGB, HCT,RBC,WBC AND PLATELET COUNT)
85610	PROTHROMBIN TIME
85651	SEDIMENTATION RATE, ERYTHROCYTE; NON-AUTOMATED
85652	SEDIMENTATION RATE, ERYTHROCYTE; AUTOMATED
86140	C-REACTIVE PROTEIN
86294	IMMUNOASSAY TUMOR QUAL or semiquantitative (eg, bladder tumor antigen)
86308	HETEROPHILE ANTIBODIES; SCREENING
86318	IMMUNOASSAY INFECTIOUS AGENT antibody(ies), qualitative or semiquantitative, single-step method (eg, reagent strip);
86328	IMMUNOASSAY FOR INFECTIOUS AGENT ANTIBODY(IES), QUALITATIVE OR SEMIQUANTITATIVE, SINGLE STEP METHOD (EG, REAGENT STRIP); SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRUS DISEASE [COVID-19])
86580	SKIN TEST; TUBERCULOSIS, INTRADERMAL
86701	HIV-1ANTIBODY
86769	ANTIBODY; SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRUS DISEASE [COVID-19])
86780	Antibody; TREPONEMA PALLIDUM
86803	HEPATITIS C antibody;
87077	CULTURE, bacterial; aerobic isolate, additional methods required for definitive identification, each isolate
87210	SMEAR PRIMARY SOURCE WITH INTERPRETATION; WET MOUNT FOR INFECT AGENTS
87220	TISSUE EXAMINATION by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (for example, scabies)
87449	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; not otherwise specified, each organism
87502	Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or sub-types, includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, first 2 types or sub-types
87631	Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types, or subtypes, 3-5 targets
87634	Infectious agent detection by nucleic acid (DNA or RNA); respiratory syncytial virus, amplified probe technique

CPT code	Description
87651	Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, amplified probe technique
87804	INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOASSAY WITH DIRECT OPTICAL OBSERVATION; INFLUENZA
87807	INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOASSAY WITH DIRECT OPTICAL OBSERVATION; RESPIRATORY SYNCYTIAL VIRUS
87808	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Trichomonas vaginalis
87809	INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOASSAY WITH DIRECT OPTICAL OBSERVATION; ADENOVIRUS
87880	INFECTIOUS AGENT DETECTION BY IMMUNOASSAY WITH DIRECT OPTICAL OBSERVATION; STREPTOCOCCUS GRP A

Private pay agreement

Providers may bill a member for a requested service without a signed acknowledgement if the service is not a covered benefit and if the following conditions are met before the service is rendered:

- Inform the member that the requested service is not a Wellpoint covered benefit.
- Notify the member of his or her financial responsibility.
- Accept the member as a private pay patient.
- Advise the member that he or she:
  - Has been accepted as a private pay patient at the time of service.
  - Will be responsible for the cost of all services received.

Wellpoint strongly encourages providers to obtain an acknowledgement of the notification in writing.

On-call services

On-call services may be billed when the rendering physician is not the PCP but is covering for or has received permission from the PCP to provide service that day. Enter *On-Call for PCP* in Box 23 of the *CMS-1500* claim form.

Recommended fields for the *CMS-1500* claim form

All professional providers and vendors should bill Wellpoint using the most current version of the CMS-1500 claim form. The following field descriptions will assist in completing the CMS-1500 claim form. The letter M indicates a mandatory field.

Field	Title	Explanation
Field 1	Medicare Medicaid TRICARE CHAMPUS CHAMPVA Group Health Plan W FECA Blk Lung Other ID	If the claim is for Medicaid, put an "X" in the Medicaid box. If the member has both Medicaid and Medicare, put an X in both boxes. Attach a copy of the form submitted to Medicare to the claim. If the claim is for Chip, put an X in the other (ID#) box.
Field 1a (M)	Member's ID Number	Enter the 11 (eleven)-digit Medicaid member ID or the 10 (ten) digit-CHIP member ID number for member.
Field 2 (M)	Member's Name	Enter the last name, first name, and middle initial, if known, in that order. Do not use nicknames or full middle names.
Field 3 (M)	Member's Birth Date/Sex	Date of birth format: MM/DD/YYYY. For example, write September 1, 1963, as 09/01/1963. Check the appropriate box for the patient's sex.
Field 4 (M)	Insured's Name	"Same" is acceptable if the insured is the patient.
Field 5 (M)	Member's Address/Telephone	Enter complete address and phone number, including any unit or apartment number. Abbreviations for road, street, avenue, boulevard, place or other common ending to the street name are acceptable.
Field 6 (M)	Patient Relationship to Insured	Enter the patient's relationship to the member or subscriber.
Field 7 (M)	Insured's Address	"Same" is acceptable if the insured is the patient.
Field 8 (M)	Member Status	Check Single, Married or Other for marital status. If applicable, check Employed, Full-Time Student or Part-Time Student.
Field 9 (M)	Other Insured's Name	If there is insurance coverage in addition to the member's plan coverage, enter the name of the insured.
Field 9a (M)	Other Insured's Policy or Group Number	Referring to Field 9, enter the name of the insurance with the group and policy number.
Field 9b (M)	Other Insured's Date of Birth	Referring to Field 9, enter the date of birth in the following format: MM/DD/YYYY.
Field 9c (M)	Employer's or School Name	Referring to Field 9, enter the name of other insured's employer or school.
Field 9d (M)	Insurance Plan Name or Program Name	Referring to Field 9, enter the name of plan carrier.

Field	Title	Explanation
Field 10 (M)	Patient's Condition Related To	Include any description of injury or accident and whether it occurred at work or not.
Field 10a (M)	Related to Employment?	Y or N. If insurance is related to Workers' Compensation, enter Y.
Field 10b (M)	Related to Auto Accident/Place?	Y or N. Enter the state in which the accident occurred.
Field 10c (M)	Related to Other Accident?	Y or N.
Field 10d (M)	Reserved for local use	Leave blank.
Field 11 (M)	Insured's Policy Group or FECA Number	Insured's group number. Complete information about the insured, even if the same as the patient.
Field 11a (M)	Insured's Date of Birth/Sex	Date of birth format: MM/DD/YYYY. Sex: M or F.
Field 11b (M)	Employer's Name or School Name	Name of the organization from which the insured obtained the policy.
Field 11c (M)	Insurance Plan Name or Program Name	Plan carrier / EP1 benefit code for paper claims.
Field 11d (M)	Is There Another Health Benefit Plan?	Y or N. If yes, items 9A-9D must be completed.
Field 12	Patient's or Authorized Person's Signature	Signature and date. "Signature on file", indicating that the appropriate signature was obtained by the provider, is acceptable for this field.
Field 13	Member's or Authorized Person's Signature	Signature. "Signature on file" is acceptable for this field.
Field 14 (M)	Date of Current	Circle Injury, Illness or Pregnancy (if applicable) and enter the date.
Field 15	First Date	Date of first consultation for the patient's condition. Date format : MM/DD/YYYY
Field 16	Dates Patient Unable to Work in Current Occupation (From – To)	Date format: MM/DD/YYYY
Field 17 (M)	Name of Referring Physician or Other Source	Name of Physician, clinic or facility referring the patient to the provider.
Field 17a (M)	Blank	Field intentionally left blank. The provider ID of the referring physician. Note: 17a is not to be reported. However, 17b must be reported when a service was ordered or referred by a provider.

Field	Title	Explanation
Field 17b (M)	NPI	Use the referring provider NPI. FQHCs, health departments, West Virginia health centers, urgent care clinics and diagnostic specialists are not required to include the referring provider's NPI.
Field 18	Hospitalization Dates Related to Current Services (From – To)	Date format: MM/DD/YYYY
Field 19 (M)	Reserved for Local Use	For multiple transfers, indicate that the claim is part of a multiple transfer and provide the other client's complete name and Wellpoint number. Provide information about the accident, including the date of occurrence, how the accident happened, whether the accident was self-inflicted or employment related.
Field 20	Outside Lab? (Yes or no) and the $ Charge	Enter the appropriate information if lab services were sent to an outside lab.
Field 21 (M)	Diagnosis or Nature of Illness or Injury	Enter the appropriate diagnosis code or nomenclature. Check the CPT manual or ask a coding expert if you are not certain of what to enter.
Field 22	Wellpoint Resubmission	Under "Original Ref. No." enter the 17-digit transaction control number (TCN) associated with any claim being resubmitted that is older than 1 year (365 days). If additional space is needed, use Box 19.
Field 23	Prior Authorization Number	Enter authorization information in this field, such as a pre-service review, reference number or on call Physician for the PCP or a valid CLIA certification number
Field 24A (M)	Date(s) of Service	If dates of service cross over from 1 year to the next year, submit 2 separate claims. For example, 1 claim is for services in 2012, while another claim is for services in 2013. Itemize each date of service on the claim; avoid spanning dates.
Field 24B (M)	Place of Service	Enter a 2-digit code using current coding from the CPT manual.
Field 24C	EMG	Enter the appropriate condition indicator for medical checkups, if applicable.

Field	Title	Explanation
Field 24D (M)	Procedure, Services or Supplies	Enter the appropriate CPT codes or nomenclature. Indicate appropriate modifier when applicable. Do not use "not otherwise classified" (NOC) codes unless there is no specific CPT code available. If you use an NOC code, include a narrative description.
Field 24E (M)	Diagnosis Pointer	Use the most specific ICD code available.
Field 24F (M)	Dollar Charges	Enter the charge for each single line item.
Field 24G (M)	Days or Units	The quantity of services for each itemized line. For anesthesia, the actual time of the service rendered, in minutes.
Field 24H	EPSDT Family Plan	Indicate if the services were the result of a checkup or a family planning referral.
Field 24I (M)	ID. Qual. / NPI	Enter your NPI, if available. NPI is required for electronic claims, and we strongly encourage you to use your NPI number for paper claims.
Field 24J (M)	Rendering Provider ID #	Enter the rendering provider's NPI in the unshaded portion and enter the rendering taxonomy code in the shaded portion.
Field 25 (M)	Federal Tax ID Number	Enter the 9-digit number from your W-9.
Field 26 (M)	Patient's Account Number	This field is for the provider's use in identifying patients and allows use of up to 9 numbers or letters (no other characters are allowed).
Field 27 (M)	Accept Assignment?	All providers of Wellpoint services must check YES.
Field 28 (M)	Total Charge	Enter the total charge for each single line item.
Field 29 (M)	Amount Paid	Enter any payment that has been received for this claim.
Field 30 (M)	Balance Due	Must equal the amount in Box 28, less the amount in Box 29.
Field 31 (M)	Signature of Physician or Supplier, Including Degrees or Credentials	Actual signature or typed/printed designation is acceptable.
Field 32 (M)	Service Facility Location Information	Include any suite or office number. Abbreviations for road, street, avenue, boulevard, place or other common ending to the street name are acceptable.
Field 32A (M)	Blank	Field intentionally left blank. Enter the NPI of the service facility, as soon as the NPI is available.
Field 33 (M)	Billing Provider Info and Phone #	Provider name, NPI, street, city, state, ZIP code and telephone number.

Field	Title	Explanation
Field 33A (M)	Blank	Field intentionally left blank. Enter the NPI number.
Field 33B (M)	Blank	Field intentionally left blank. Enter the NPI number of the billing provider.

CHAPTER 11: BILLING INSTITUTIONAL CLAIMS

Customer Care Center phone: 800-782-0095
Customer Care Center fax: 888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Overview

Billing for hospitals and other healthcare facilities and services may require special attention because major services have their own set of billing requirements. Throughout this chapter, specific billing requirements will be broken down into the following service areas:

- Emergency room visits
- Urgent care visits
- Maternity
- Termination of pregnancy
- Inpatient acute care
- Hospital stays of less than 24 hours
- Inpatient sub-acute care
- Outpatient laboratory, radiology and diagnostic services
- Outpatient surgical services
- Outpatient therapies
- Outpatient infusion therapy visits and pharmaceuticals

Also included are helpful billing guidelines for the ancillary services that network providers use most often, including diagnostic imaging. These ancillary services include the following:

- Ambulance (emergency only; nonemergency transport is covered by BMS)
- Behavioral Health services (subject to limits)
- Chiropractic (subject to limits)
- Clinic services: general clinics, birthing centers, lab and radiology centers, health department clinics, rural health clinics (RHCs), federally qualified health centers (FQHCs)
- Dental services for adults (covered by SKYGEN)
- Dental services for children (covered by SKYGEN)
- Durable medical equipment (DME), supplies and prosthetic devices
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT): covers hearing, vision, dental, nutritional needs, healthcare treatment, routine shots/immunizations and lab tests for children under 21 years of age; also referred to as West Virginia HealthCheck
- Family planning services and supplies

- Handicapped children's services/children with special healthcare needs services
- Home healthcare services
- Hospice
- Hospital services: inpatient and outpatient
- Lab and radiology (not received in a hospital; also includes services received for substance abuse treatment)
- Nurse practitioner services
- Physical or occupational therapy, speech pathology and audiology (subject to limits)
- Physician (doctor) services (includes services received for substance abuse treatment. Also includes fluoride varnish services, applicable to members aged 6 months to 3 years)
- Podiatry services (foot care)
- Pregnancy and maternity care
- Private duty/skilled nursing services (limited to members under the age of 21)
- Rehabilitation services (physical therapy, speech therapy, occupational therapy and acute inpatient rehabilitation)
- School-based services (physical therapy, speech therapy, occupational therapy, nursing care agency or audiology. Limited to members under the age of 21. Refer to the West Virginia fee-for-service provider manual for service limitations.)
- Transportation (emergency only)
- Vision services

Please note: A member's benefits may not cover some of these services; confirm coverage before providing service.

And finally, this chapter will take a look at specific coding guidelines for the standard hospital and healthcare facilities' *CMS-1450* claim form.

Basic billing guidelines

In general, the basic billing guidelines for institutional claims submitted to Wellpoint are as follows:

- Use Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) or revenue codes. Valid HCPCS, CPT or revenue codes are required for all line items billed, whether sent on paper or electronically.
- Split year-end claims. Services that begin before or during December and extend beyond December 31 should be billed as a split claim at calendar year-end. Use two CMS-1450 claim forms and submit the forms together.

- Split dates of service for a provider contract change. When a provider contract change occurs during the course of treatment, split the dates of service to be reimbursed at the new rate.
- Itemize services.
- Provide medical records. Medical records for certain procedures may be requested for determination of medical necessity.
- Use modifiers in accordance with your specific billing instructions.
- Use codes for unlisted procedures. Because some provider services or procedures are not found in the CPT manual, specific code numbers for reporting unlisted procedures have been designated. When using an unlisted procedure code, include a description of the service to help us calculate the appropriate reimbursement. We may request the member's medical records.
- Complete the appropriate billing for supplies and materials. Do not use CPT code 99070, which is for supplies and materials provided over and above those usually included with an office visit or other services. Wellpoint does not accept CPT code 99070. In addition:
  - Healthcare providers must use HCPCS Level II codes, which provide a detailed description of the service.
  - Wellpoint will pay for surgical trays only for specific surgical procedures. Surgical trays billed with all other services will be considered incidental and will not be paid separately.

Please note: System edits are in place for both electronic and paper claims. Claims submitted improperly cannot be processed easily and most likely will be returned.

National drug codes Medicaid drug rebate program

Providers must include national drug codes (NDCs), unit of measurement and quantity of drug on all Medicaid Wellpoint claims that include physician-administered drugs. This applies to drugs dispensed in both professional and institutional outpatient settings.

West Virginia's Bureau for Medical Services (BMS) requires that Wellpoint report NDC information every month. BMS then submits this data to pharmaceutical manufacturers to obtain rebates under the Medicaid Drug Rebate Program. Following these instructions is important for the state to receive timely rebates from drug manufacturers.

Wellpoint Medicaid will deny professional and outpatient institutional claims containing physician-administered medications for Wellpoint members if any of the following elements are missing or invalid:

- NDCs (11-digit number on the package or container from which medication is administered)
- Unit of measurement
- Quantity of drug

To determine if a procedure code requires a NDC please refer to the BMS Drug Code List.

Emergency room visits

The billing requirements for an emergency room visit apply to the initial treatment of a medical or psychiatric emergency, but only if the patient does not remain overnight. If the emergency room visit results in an admission, all services provided in the emergency room must be billed according to the guidelines and requirements for inpatient acute care.

Reimbursement for emergency room services relates to the nature of the emergency diagnosis. There are five CPT procedure codes available for billing emergency room services. The reimbursement is an all inclusive fee, which is considered to include the following items:

- Use of emergency room
- Routine supplies (such as sterile dressings)
- Minor supplies (bandages, slings, finger braces, etc.)
- Pharmacy charges
- Suture, catheter, and other trays
- IV fluids and supplies
- Routine EKG monitoring
- Oxygen administration and O_2 saturation monitoring

Services determined to be outside of the standard emergency room episode of care may be considered for payment outside of the all-inclusive fee.

Specific coding is required for emergency room billing. Use the following guidelines:

- Bill each service date as a separate line item.
- Perform a screening examination on the member.
- Use one of the five appropriate CPT codes for emergency room billing.
- Use International Classification of Diseases (ICD) principal diagnosis codes, as required, for all services provided in an emergency room setting.
- Use revenue codes 0450-0452 and 0459, as required.

Please note: Unless clinically required, follow-up care should never occur in the emergency department. Members should be referred back to their PCP and correct billing should follow standard, nonemergency guidelines.

Emergency room billing does not apply when the member is admitted and treated for inpatient care following emergency room treatment.

Urgent care visits

The billing requirements for urgent care visits apply to all urgent care cases treated and discharged from the hospital outpatient department or emergency room.

Urgent care: Nonscheduled, nonemergency hospital services required to prevent serious deterioration of a patient's health as a result of an unforeseen illness or injury.

Urgent care billing should detail all diagnostic and therapeutic services, including, but not limited to:

- Equipment
- Facility use, including nursing care
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Other services incidental to the visit

Specific coding is required for urgent care billing. Use the following guidelines:

- Bill each service date as a separate line item.
- Use current ICD principal diagnosis codes, as required, for all services provided in an urgent care setting or designated facility.

Please note: Urgent care billing does not apply when the member is admitted and treated for inpatient care following urgent care treatment. If the member is admitted following urgent care, the billing shifts to acute or subacute care.

Observation

Observation is billed using Revenue Codes 760 and 762 and time units reported in one hour increments. The maximum number of units allowed for an episode of care is 48.

Observation is defined as "the use of a bed and periodic monitoring by hospital nursing or other staff which are reasonable and necessary to evaluate an outpatient's condition to determine the need for impatient admission."

The criteria for observation services include the following basic provisions:

- Observation services are covered only upon written order of a physician. This order must document the medical necessity for the services and is retained as part of the patient's medical record
- Observation does not require prior authorization
- Coverage of observation may not exceed 48 hours

- Charges for observation services which result in an inpatient admission are deemed to be part of the admission and not separately billable
- Ancillary services, laboratory, X-ray and other diagnostic procedures performed during the observation period may be billed separately and are subject to all prior authorization criteria.
- When Observation is billed with an emergency room visit the emergency room all-inclusive rules will be applied to ancillary services.

Maternity services

The billing requirements for maternity care apply to all live and stillbirth deliveries. Payment for services includes, but is not limited to, the following:

- Room and board for mother, including nursing care
- Nursery for baby, including nursing care
- Delivery room/surgical suites
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Other services incidental to admission

The maternity care rate covers the entire admission. If an admission is approved for extension beyond the contracted time limit for continuous inpatient days, the billing requirement for the entire admission shifts to inpatient acute care. This applies to each approved and medically necessary service day. Therapeutic abortions, treatment for ectopic and molar pregnancies and similar conditions are excluded from payment under the maternity care rate.

Inpatient maternity claims must be authorized if the maternity stay involves care for medical conditions beyond normal maternity care.

Hysterectomy

Providers must include the *Hysterectomy Acknowledgement Form* in the member's medical records. The provider's signature must be original script, not stamped or typed. Providers do not need to submit the form with the claim. The form is available on the state's website at: https://www.wvmmis.com/Forms/Forms/AllItems.aspx.

Sterilization

Providers must include the *Sterilization Consent Form* in the member's medical records. The provider's signature must be original script, not stamped or typed. Providers do not need to submit the form with the claim. The form is available on the state's website at: https://www.wvmmis.com/Forms/Forms/AllItems.aspx.

Hysterectomies and sterilizations must comply with 42 CFR 441. Subpart F — Sterilizations. This includes completion of the consent form.

Please note: Tubal ligation for Medicaid members should be billed directly to the state as fee for service.

Inpatient acute care

The billing requirements for inpatient acute care apply to each approved and medically necessary service day in a licensed bed. These requirements include, but are not limited to:

- Room and board, including nursing care
- Emergency room, if connected to admission
- Urgent care, if connected to admission
- Equipment
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies
- Surgical and recovery suites
- Other services incidental to the admission

Please note: Authorization is required for all admissions except routine vaginal delivery and term Cesarean sections.

Special billing requirements:

- The facility must be a West Virginia BMS facility
- Utilization Management department authorization is required for all admissions except routine deliveries.
- Observation room, or outpatient billing with an inpatient stay, should be completed on the *CMS1450* claim form. Complete the "From" box of Form Locator 6 (FL 6) and Form Locator 17 (FL 17) correctly to ensure the claim is processed. Note the following requirements:
- Ensure the dates reported in (FL 6) and (FL 17) are the same.
  - Verify the charges in (FL 6) and (FL 17) reflect the date the patient was admitted as an inpatient to the hospital.
  - Do not use (FL 6) and (FL 17) to include the date of any observation stay or outpatient charges that occurred prior to inpatient admission. This usage is incorrect and may cause processing delays.

Billing for hospital stays of less than 24 hours

Inpatient claims with next day discharge are assumed to be less than 24 hours if you do not provide medical records to the contrary. If you submit a claim for inpatient stays with the "through date" of service as being one day later than the "from date" of service, this claim will be subject to post-payment review.

When submitting a claim for a hospital stay of less than 24 hours, bill the claim as an Outpatient Hospital Services claim and follow these guidelines:

- Service codes: Include the correct CPT/HCPCS code for each service.
- Line items: Bill each service for each date as a separate line item.
- Revenue codes: Bill the revenue codes with the appropriate CPT/HCPCS codes.
- Type of bill: Enter the type of bill as 13X.
- Admission and discharge dates: Ensure these dates are not the same. If a patient is transferred out within 24 hours of admission, bill this visit as an outpatient claim.
- Discharge date: Ensure the discharge date is not the day following admission. If a patient is transferred out within 24 hours of admission, bill this visit as an outpatient claim.

A claim submitted for a stay of less than 24 hours will be denied.

Please note: These criteria do not apply to neonatal claims, which are one-day stays falling under the following diagnosis-related groups (DRGs):

- DRG 637: Neonate, died within one day of birth, born here
- DRG 638: Neonate, died within one day of birth, not born here
- DRG 639: Neonate, transferred less than five days old, born here
- DRG 640: Neonate, transferred less than five days old, not born here

Outpatient laboratory, radiology and diagnostic services

Specific billing requirements for services related to outpatient laboratory, pathology, radiology and other diagnostic tests include, but are not limited to:

- Facility use
- Nursing care, including incremental nursing
- Equipment
- Professional services
- Specified supplies
- All other services incidental to the outpatient visit

Please note: Outpatient radiation therapy is excluded from this service category and should be billed according to the requirements of the Other Services category.

Outpatient surgical services

Specific billing requirements related to outpatient surgical services include, but are not limited to:

- Facility use, including nursing care
- Blood
- Equipment
- Imaging services
- Implantable prostheses
- Laboratory
- Pharmaceutical
- Radiology
- Supplies
- All other services incidental to the outpatient surgery visit

Please note: Even if a service is classified by the hospital as an outpatient service, if the member is receiving that service as of midnight (12 a.m.), bill the service at the inpatient DRG rate.
Specific dates, codes and medical records may be required for billing:

- Follow the billing requirements for outpatient surgery when the respiratory therapy department performs an electrocardiogram (ECG/EKG) or electroencephalogram (EEG). Do not apply the outpatient therapy billing requirements.
- Include service dates for each procedure (both principal and other).
- Include CPT/HCPCS codes for each surgical procedure in Form Locator 44 (HCPCS/RATES).
- Provide medical records when Wellpoint needs to review and determine the correct grouping for services not defined in the surgery grouping.
- Use billing field entry 13X.
- Use revenue codes 036X, 0480, 0481, 0490, 070X, 071X, 075X, 076X, 079X and 0975, as required, along with the appropriate CPT/HCPCS code.
- Use the CPT/HCPCS code, as mandated by HIPAA, for outpatient surgery billing.

Outpatient therapies

Outpatient therapy services include physical, occupational, speech and respiratory therapies. An outpatient therapy visit has a single service date. Billing requirements for outpatient therapy visits include, but are not limited to:

- Facility use, including nursing care

- Therapist/professional services
- Equipment
- Pharmaceuticals
- Supplies
- Other services incidental to the outpatient therapy visit

Billing for outpatient therapy has specific requirements:

- Bill each service date as a separate line item.
- Use the required revenue codes:
- Occupational therapy: 043X
- Physical therapy: 042X
- Respiratory therapy: 041X
- Speech therapy: 044X
- Use the applicable CPT/HCPCS codes, as required.

Outpatient infusion therapies and pharmaceuticals

This section covers the following topics:

- Outpatient infusion therapies
- Outpatient infusion pharmaceuticals

Outpatient infusion therapies

Billing requirements for outpatient infusion therapy visits apply to each outpatient hospital visit and include, but are not limited to:

- Facility use, including nursing care
- Equipment
- Intravenous solutions, excluding pharmaceuticals
- Kinetic dosing
- Laboratory
- Professional services
- Radiology
- Supplies, including syringes, tubing, line insertion kits, etc.
- Other services incidental to the outpatient infusion therapy visit

Outpatient infusion pharmaceuticals
Billing requirements for outpatient infusion pharmaceuticals apply to drugs such as chemotherapy, hydration and antibiotics used during each outpatient infusion therapy visit. An important exception is for blood and blood products, which are billed under the Other Services category.
Specific codes and service dates are required:

- Use revenue codes 026X, 028X, 0331, 0335 or 0940, as required, for each outpatient infusion therapy visit.
- Use revenue code 0940 or 0949 with 36511-36513, 36516 or 36522 CPT/HCPCS codes when billing for therapeutic aphaeresis claims.
- List each drug for each visit as a separate line item and include the service date.
- Use HCPCS codes, as required, for all pharmaceuticals when:
  - Billed with revenue codes 0250-0252, 0256-0259, or 063X. Include the units with pharmaceutical CPT/HCPCS codes
  - Billed with revenue codes 026X, 028X, 0331, 0335, 0940
  - When using an unlisted CPT/HCPCS code, provide the name of the drug or medication in Box 43 of the CM*S-1450* claim form.

Ancillary billing overview

Medicaid follows ancillary billing guidelines as outlined in the state of West Virginia's provider manual, located at the BMS website at https://dhhr.wv.gov/bms > **Providers** > **Provider Manual**.

CHIP follows CMS guidelines for ancillary billing.

Most ancillary claims are submitted for laboratory/diagnostic imaging or DME. The following sections provide the special billing requirements for each.

Please note: Because the member's benefits may not cover some of the services listed, confirm benefit coverage first.

Ambulance services

Ambulance providers, including municipalities, should use the *CMS-1500* claim form to bill for ambulance services. Use the appropriate two-digit origin and destination codes that describe the "to" and "from" locations.

Note: Only emergency ambulance services should be billed to Wellpoint. For **Medicaid** and WVCHIP members all nonemergency transportation services are covered through the Fee-for-Service Medicaid program.

Ambulatory surgical centers

Most outpatient surgery delivered in an ambulatory surgery center requires prior authorization. Ambulatory surgical centers bill on the *CMS-1450* claim form.

Physical therapy

The physical therapy setting determines the correct billing form:

- *CMS-1500* claim form: When providing services in an office, clinic, or outpatient setting
- *CMS-1450* claim form: When providing services in a rehabilitation center or for physical therapists affiliated with home health agencies, providing services in a patient's home

Speech therapy

The speech therapy setting determines the correct billing form:

- *CMS-1500* claim form: When providing services in an office, clinic, or outpatient setting
- *CMS-1450* claim form: For speech therapists affiliated with home health agencies, providing services in a patient's home

Occupational therapy

The occupational therapy setting determines the correct billing form:

- *CMS-1500* claim form: When providing services in an office, clinic or outpatient setting
- *CMS-1450* claim form: For occupational therapists affiliated with home health agencies, providing services in a patient's home

Durable medical equipment

Billing for custom-made DME, prescribed to preserve bodily functions or prevent disability, requires prior authorization. Without such review, claims for DME will be denied. Prior to dispensing, contact Wellpoint's UM department.

Please note: The presence of an HCPCS code does not necessarily mean that the benefit is covered or that payment will be made. Some DME codes may be By Report (customized) and, therefore, require additional information for pre- or post-service review and processing.

DME billing requires a differentiation between rentals and purchased equipment, as well as specific codes and modifiers. Special guidelines for DME billing:

- Use the appropriate modifier to identify rentals versus purchases (new or used). Claims submitted without the right modifier will be reimbursed at the rental rate.
- Use HCPCS codes for DME or supplies.
- Use an unlisted or miscellaneous code, such as E1399, when an HCPCS code does not exist for a particular item of equipment.
- Use valid codes for DME and supplies. If valid HCPCS codes exist, unlisted codes will not be accepted.
- Attach the manufacturer's invoice to the claim if using a miscellaneous or unlisted code. The invoice must be from the manufacturer, not from the office making the purchase.

Please note: Catalogue pages are not acceptable as a manufacturer's invoice.

Durable medical equipment: rentals

Most DME is dispensed on a rental basis and requires medical documentation from the prescribing provider. Rented items remain the property of the DME provider until the purchase price is reached. Charges for rentals exceeding the reasonable charge for a purchase are not accepted. Rental extensions may be obtained only on approved items.

Please note: DME providers should use normal equipment collection guidelines. Wellpoint is not responsible for equipment not returned by members.

Durable medical equipment: purchase

DME may be reimbursed on a rent-to-own basis over a period of 10 months unless otherwise specified at the time of review by Wellpoint's UM department.

Durable medical equipment: wheelchairs and wheeled mobility aids

At Wellpoint, we follow CMS guidelines for calculating By Report (customized) wheelchair claims. Claims must include the following:

- Catalogue number
- Item description
- Manufacturer's name
- Model number

Mark each catalogue page or invoice line so we can match each item to the appropriate claim line. Enter the total manufacturer's suggested retail price (MSRP) of the wheelchair in the Reserved for Local Use field (Box 19) on the CMS-1500 claim form. The total MSRP includes:

- Accessories
- Modifications or replacement parts

Also provide the name of the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) -certified technician.

For wheeled mobility aids, we have an additional requirement: The invoice must include a price published by the manufacturer before August 1, 2003. If the item was not available before this date, list the date of availability in the Reserved for Local Use field (Box 19) of the CMS-1500 claim form. Attach to the claim the catalogue page where the item was first published.

If you are a wheelchair manufacturer billing as a provider, your billing must include all of the above as well as the MSRP from a catalogue page dated before August 1, 2003. If the item was not available before that date, the manufacturer's invoice must accompany the claim.

Dialysis

Dialysis centers and other entities performing dialysis should use the CMS-1450 claim form to bill for dialysis services.

Note: The fee has been removed from CPT code 90999 (unlisted dialysis procedure, inpatient or outpatient). Any future billing of this code requires documentation of the actual services rendered.

Home infusion therapy

Drugs used for home infusion services are covered. These drugs require prior authorization and must be justified by the ordering practitioner. Justification must include why oral therapy is unsuitable for the patient.

Total Parenteral Nutrition (TPN) is considered Durable Medical Equipment (DME) and supplies are not pharmacy POS covered services.

Laboratory and diagnostic imaging

For diagnostic imaging, use the CMS-1500 claim form and refer to the basic billing guidelines found in the **Overview** section of this chapter.

For laboratory services, we are bound by the Clinical Laboratory Improvement Amendments (CLIA) of 1988. The purpose of the CLIA program is to ensure laboratories testing specimens in interstate commerce consistently provide accurate procedures and services. As a result of CLIA, any laboratory soliciting or accepting specimens in interstate commerce for laboratory testing is required to hold a valid license or letter of exemption from licensure.

Claims that are submitted for laboratory services subject to the Clinical Laboratory Improvement Amendments of 1988 (CLIA) statute and regulations require additional information to be considered for payment.

To be considered for reimbursement of clinical laboratory services, a valid CLIA certificate identification number must be reported on a 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent for clinical laboratory services. The CLIA certificate identification number must be submitted in one of the following manners:

Claim format and elements	*CLIA* number location options	Referring provider name and NPI number location options	Servicing laboratory physical location
CMS-1500 (formerly *HCFA-1500*)	Must be represented in field 23	Submit the referring provider name and NPI number in fields 17 and 17b, respectively.	Submit the servicing provider name, full physical address and NPI number in fields 32 and 32A, respectively, if the servicing address is not equal to the billing provider address. The servicing provider address must match

			the address associated with the *CLIA* ID entered in field 23.
HIPAA 5010 837 Professional	Must be represented in the 2300 loop, REF02 element, with qualifier of X4 in REF01	Submit the referring provider name and NPI number in the 2310A loop, NM1 segment.	Physical address of servicing provider must be represented in the 2310C loop if not equal to the billing provider address and must match the address associated with the *CLIA* ID submitted in the 2300 loop, REF02.

To be considered for reimbursement of reference laboratory services, the referring laboratory must be an independent clinical laboratory. Modifier 90 must be submitted to denote the referred laboratory procedure. Per the Centers for Medicare & Medicaid (CMS), an independent clinical laboratory that submits claims in paper format may not combine non-referred or self-performed and referred services on the same CMS-1500 claim form. Thus, when the referring laboratory bills for both non-referred and referred tests, it must submit two separate paper claims: one claim for non-referred tests and the other for referred tests. If submitted electronically, the reference laboratory must be represented in the 2300 or 2400 loop, REF02 element, with qualifier of F4 in REF01.

Providers who have obtained a CLIA Waiver or Provider Performed Microscopy Procedure accreditation must include the QW modifier when any CLIA waived laboratory service is reported on a CMS-1500 claim form.

Laboratory procedures must be rendered by an appropriately licensed or certified laboratory having the appropriate level of CLIA accreditation for the particular test performed. Thus, any claim that does not contain the CLIA ID, has an invalid ID, has a lab accreditation level that does not support the billed service code, who render services outside of the effective dates of the CLIA certificate, does not have complete servicing provider demographic information and/or applicable reference laboratory provider demographic information, will be considered incomplete and rejected or denied.

Refer to Physician Office List for laboratory services allowed to be performed in a provider office under the appropriate level of licensure.

Home healthcare

All home healthcare requires prior authorization. Contact Wellpoint's UM department for prior authorization before delivery of service. When billing for a home healthcare visit, use the CMS-1450 claim form and bill using the appropriate revenue and HCPCS codes.

Please note: When billing for supplies and equipment used in a home healthcare visit, refer to the **Durable Medical Equipment** section in this chapter for billing requirements.

Hospice

Hospice services require prior authorization. Contact Wellpoint's UM department for prior authorization before hospice admission. When billing for hospice services, use the CMS-1450 claim form.

Additional billing resources

The following reference books provide detailed instructions on uniform billing requirements:

- Current Procedural Terminology, published by the American Medical Association (AMA)
- Healthcare Common Procedure Coding System, National Level II (*current year*)
- International Classification of Diseases (*current edition*) Volumes 1,2,3 (*current year*), published by the Practice Management Information Corporation

CMS-1450 claim form

All Medicare-approved facilities should bill Wellpoint using the most up-to-date version of the CMS-1450 claim form. All fields must be completed using standardized code sets. These code sets are used to ensure that claims are processed in an orderly and consistent manner. HCPCS provides codes for a variety of services and consists of Level I and Level II:

- Level I: CPT codes determined by the AMA and represented by five digits.
- Level II: Other codes identifying products, supplies and services not included in the CPT codes, such as ambulance services and DME. Sometimes referred to as the alphanumeric codes because they consist of a single alphabetical letter followed by four digits.

In some cases, two-digit/character modifier codes should accompany the level I or level II coding.

CMS-1450 revenue codes

CMS-1450 revenue codes are required for all institutional claims.

Institutional inpatient coding

For institutional inpatient coding, use the guidelines in the following code manuals:

- Use current ICD applicable and procedure codes in Boxes 74-74e of the CMS-1450 claim form when the claim indicates that a procedure was performed.
- Use modifier codes when appropriate; refer to the current edition of the provider's CPT manual published by the AMA.
- Refer to your provider's contract for DRG information.

Institutional outpatient coding

For institutional outpatient coding, use the guidelines in the following code manuals:

- The Current Procedural Terminology manual, published by the AMA.
- The Healthcare Common Procedure Coding System, published by the Centers for Medicare & Medicaid Services (CMS).

Please note: When using an unlisted CPT/HCPCS code, provide the name of the drug or medication in Box 43 of the CMS-1450 claim form.

Recommended fields for the CMS-1450 claim form

The following guidelines will assist in completing the CMS-1450 claim form. An "R" indicates a required or mandatory field.

Field #	Box title	Description
1 (R)	Blank	Field intentionally left blank. Facility name, address and phone number.
2	Blank	Field intentionally left blank. Required when the address for payment is different than that of the Billing Provider information located in Field 1.
3a	PAT. CNTL #	Member's account number.
3b	MED. REC #	Member's record number, which can be up to 20 characters long.
4 (R)	TYPE OF BILL	Enter the Type of Bill (TOB) code.
5 (R)	FED. TAX NO.	Enter the provider's federal tax identification number.
6 (R)	STATEMENT COVERS PERIOD	"FROM" and "THROUGH" date(s) covered by the claim being submitted.
8a–b (R)	PATIENT NAME	Member's name.
9a–e (R)	PATIENT ADDRESS	Member's complete address (number, street, city, state, ZIP code and telephone number).
10 (R)	BIRTHDATE	Member's date of birth in MM/DD/YY format.
11 (R)	SEX	Member's gender.
12 (R)	ADMISSION DATE	Member's admission date to the facility in MM/DD/YY format.
13 (R)	ADMISSION HR	Member's admission hour to the facility in military time (00 to 23) format.
14 (R)	ADMISSION TYPE	Type of admission.
15 (R)	ADMISSION SRC	Source of admission.
16 (R)	DHR	Member's discharge hour from the facility in military time (00 to 23) format.
17 (R)	STAT	Patient status.
18–28	CONDITION CODES	Enter Condition Code (81) X0 – X9.
29	ACDT STATE	Accident state.

Field #	Box title	Description
31–34 (R)	OCCURRENCE CODE OCCURRENCE DATE	Occurrence code (42) and date, if applicable.
35–36	OCCURRENCE SPAN (CODE, FROM and THROUGH)	Enter dates in MM/DD/YY format.
38	Blank	Field intentionally left blank. Enter the responsible party name and address, if applicable.
39–41	VALUE CODES (CODE and AMOUNT)	Enter value codes, if applicable.
42 (R)	REV. CD.	Revenue Code, required for all institutional claims.
43 (R)	DESCRIPTION	Description of services rendered.
44 (R)	HCPCS/RATE/HIPPS CODE	Enter the accommodation rate per day for inpatient services or HCPCS/CPT code for outpatient services.
45 (R)	SERV. DATE	Date of services rendered.
46 (R)	SERV. UNITS	Number/units of occurrence for each line or service being billed.
47 (R)	TOTAL CHARGES	Total charge for each line of service being billed.
48	NON-COVERED CHARGES	Enter any non-covered charges.
50	PAYER NAME	Payer Identification. Enter any third-party payers.
51 (R)	HEALTH PLAN ID	Leave blank. Assigned by Wellpoint.
52 (R)	REL. INFO	Release of information certification indicator.
53	ASG BEN.	Assignment of benefits certification indicator.
54	PRIOR PAYMENTS	Prior payments.
55	EST. AMOUNT DUE	Estimated amount due.
56 (R)	NPI	Enter the provider's National Provider Identifier (NPI) number.
57 (R)	OTHER PRIV ID	Enter the NPI of the other provider, if any.
58 (R)	INSURED'S NAME	Member's name.
59 (R)	P. REL	Patient's relationship to insured. Enter N/A if member is the insured.
60 (R)	INSURED'S UNIQUE ID	Enter the 11-digit member ID number.
61	GROUP NAME	Insured group name. Enter the name of any other health plan.
62	INSURANCE GROUP NO.	Enter the policy number of any other health plan.
63	TREATMENT AUTHORIZATION CODES	Authorization number or authorization information must be entered on this field.
64	DOCUMENT CONTROL NUMBER	The control number assigned to the original bill.
65	EMPLOYER NAME	Name of organization from which the insured obtained the other policy.
66 (R)	DX/PROC qualifier	Enter the diagnosis and procedure code qualifier (ICD version indicator).

Field #	Box title	Description
67 (R)	DX	Principal Diagnosis Codes. Enter the ICD diagnostic codes, if applicable.
67a–q (R)	DX	Other Diagnostic Codes. Enter the ICD diagnostic codes, if applicable. Indicate Present on Admission (POA).
69	ADMIT DX	Admission diagnosis code. Enter the ICD code.
70a–c	PATIENT REASON DX	Enter the member's reason for this visit, if applicable.
71	PPS CODE	Prospective Payment System (PPS) code (not required).
72	ECI	External cause of injury code.
74 (R)	PRINCIPAL PROCEDURE (CODE/DATE)	ICD principal procedure code and dates, if applicable.
74a–e (R)	OTHER PROCEDURE (CODE/DATE)	Other Procedure Codes.
76 (R)	ATTENDING	Enter the attending provider's ID number. The NPI is required.
77 (R)	OPERATING	Enter the provider number if you use a surgical procedure on this form. The NPI is required.
78–79	OTHER	Enter additional provider numbers, if applicable. The NPI is required.
80	REMARKS	Use this field to explain special situations.
81a–d (R)	CC	Enter the taxonomy code with qualifier B3.

CHAPTER 12: MEMBER TRANSFERS AND DISENROLLMENT

Customer Care Center phone: 800-782-0095
Customer Care Center fax: 888-438-5209
Availity Chat with Payer: https://Availity.com
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Member PCP reassignments

When members enroll in any of our programs, they choose a PCP or allow their PCP to be assigned. However, members may change their PCP at any time. If a member wants to make a change after enrollment, the member is instructed to call our Customer Care Center to request an alternate PCP or the member may make PCP changes and request new ID cards from the member website.

Wellpoint accommodates members' requests for reassignment whenever possible. Our staff works with the member to make the new selection and focuses on any special needs. Our policy is to maintain continued access to care and continuity of care during the reassignment process.

The effective date of a reassignment typically is the same as the date other member requests the change but may be assigned retroactively or upon discharge if the member is hospitalized. To support member reassignments, PCPs are encouraged to maintain open panels.

Open panel: The commitment by a Wellpoint provider to accept new Wellpoint members.

PCP initiated member reassignments

A PCP may request reassignment of a member from his or her primary care assignment. The PCP may request a member be reassigned if the member:

- Is abusive to the PCP, exhibiting disruptive, unruly, threatening or uncooperative behavior
- Is abusive to staff, exhibiting disruptive, unruly, threatening or uncooperative behavior
- Misuses or loans their membership card to another person
- Fails to follow prescribed treatment plans
- Falls outside of the provider specialty type

To request member reassignment to a different PCP, perform the following:

- Complete the *Wellpoint Provider Request for Member Deletion from Primary Care Physician (PCP) Assignment* form, located in the *Forms and Tools* section of the *Provider Resources* page of our website at provider.wellpoint.com/wv. For directions on how to access the provider website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.
- Mail or fax (preferred) the form to Wellpoint:
  Wellpoint
  P.O. Box 91
  Charleston, WV 25321-0091
  Fax: **888-438-5209**

State agency-initiated member disenrollment

Contracted state agencies inform Wellpoint of membership changes by sending monthly enrollment reports. These reports contain all active membership data and incremental changes to eligibility records. Wellpoint disenrolls members not listed on the monthly report.

Reasons for disenrollment may include:

- Continuous placement in a nursing facility, State institution or intermediate care facility for more than thirty (30) calendar days
- Change in eligibility status
- Death
- Loss of benefits
- Member has other nongovernment or government sponsored health coverage
- Permanent change of residence out of the service area
- Voluntary disenrollment

The provider is expected to coordinate service for up to 30 days after the date Wellpoint receives the change request form. Upon completing the PCP assignment change, Wellpoint forwards the form and any other information related to the case to the quality assurance facilitator. The facilitator informs the member of the change within five working days. The change will be effective on the day Wellpoint enters the change into the system.

Wellpoint notifies PCPs of member reassignments through monthly enrollment reports. PCPs may find these reports on our secure provider website at provider.wellpoint.com/wv. Providers may also call our Customer Care Center at **800-782-0095 or via the Availity Chat with Payer feature at** http://Availity.com. The effective date of a PCP reassignment will be the same date of the member request.

Member initiated disenrollment

Wellpoint enrollees may request disenrollment at any time for any reason. Disenrollment shall be effective no later than the first day of the second month in which the enrollee requests disenrollment. Members should contact the enrollment broker to initiate disenrollment. If an enrollee informs Wellpoint of a request to transfer to another MCO, Wellpoint will work with the enrollment broker to facilitate the process.

Involuntary member disenrollment

Involuntary beneficiary disenrollment from Wellpoint may occur for the following reasons:

- Loss of eligibility for Medicaid, CHIP or for participation in Medicaid or CHIP Managed Care
- The beneficiary's permanent residence changes to a location outside of Wellpoint's service area. However, if the resident moves to a location serviced by other MCOs, the resident must reenroll into a new MCO as soon as administratively possible

- Continuous placement in a nursing facility, state institution or intermediate care facility for individuals with intellectual disabilities for more than 30 calendar days
- Error in enrollment. This may occur if the beneficiary was inaccurately classified as eligible for enrollment with Wellpoint. If the beneficiary does not meet eligibility requirements for eligibility groups permitted to enroll with Wellpoint, or after a request for exemption is approved, if the enrollment broker enrolled the beneficiary while their exemption request was being considered.
- Beneficiary death
- Medicaid/CHIP member at any stage of the transplant process or living donors

When members enroll in our program, we provide instructions on disenrollment procedures. Disenrollment becomes effective on the last day of the calendar month following administrative cut-off or is subject to state cut-off.

If a member asks a provider how to disenroll from Wellpoint, the provider should direct the member to call the Customer Care Center at **800-782-0095**. The member will be transferred from the Customer Care Center to the state's enrollment broker phone number. The state's enrollment broker determines membership eligibility and performs enrollment and disenrollment procedures.

Please note: Providers may not take retaliatory action against any member for requesting reassignment.

CHAPTER 13: GRIEVANCES AND APPEALS

Customer Care Center and Grievance and Appeals phone: 800-782-0095
Customer Care Center fax: 888-438-5209
Grievance and Appeals fax: 844-882-3520
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Overview

We encourage providers and members to seek resolution of issues through our grievances and appeals process. Verbal complaints and written grievances are tracked and trended, resolved within established timeframes and referred to peer review when needed.

The Wellpoint grievances and appeals process meets all state of West Virginia requirements and federal laws. The member, or member's authorized representative with written consent, has a right to be informed about 1) how to obtain a hearing and the representation rules involved; 2) filing grievances and appeals and the requirements and time frames for filing; 3) assistance available with filing grievances and appeals; 4) the toll-free number to file oral grievances and appeals; 5) the right to request continuation of benefits during an appeal or state fair hearing filing although the member may be liable for the costs of any continued benefits if the action is upheld; and 6) any state-determined appeal rights to challenge the failure of the organization to cover a service.

The building blocks of this resolution process are the grievance and the appeal.

An **action** is a:

- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of a payment for a service.
- Failure to provide services in a timely manner, as defined by the state.
- Failure to act within the time frames specified by the state.

An **adverse benefit determination** is defined to mean any of the following actions taken by the health plan:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity,appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner.
5. The failure to act within the required timeframes for standard resolution ofGrievances and Appeals.
6. For a resident of a rural area with only one health plan, the denial of the
7. beneficiary's request to obtain services outside the network.
8. The denial of a beneficiary's request to dispute financial liability.

An **appeal** is a review by Wellpoint of an adverse benefit determination.

A **complaint** is the same as a grievance. It's an expression of dissatisfaction made about Wellpoint's decision or services received from Wellpoint when an informal grievance is filed; some complaints may be subject to appeal. If a distinction cannot be made between a grievance and an inquiry, it is considered a grievance.

An **expedited appeal** is an appeal when Wellpoint determines, or the provider indicates in making the request on the member's behalf or supporting the member's request, that taking the time for a standard appeal could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

A **grievance** is an expression of dissatisfaction about any matter other than an adverse benefit determination as defined below. Examples include but are not limited to:

- The member is unhappy with the quality of the care.
- The doctor the member wants to see does not have a contract with us to provide services to the member.
- The member is not able to receive culturally competent care.
- The member got a bill from a provider for a service that should be covered by Wellpoint.
- Rights and/or dignity were not respected.
- The member is recommending changes in policies and services.
- Any other access to care issues exist.

The term is also used to refer to the overall system of grievances and appeals handled by Wellpoint as well as access to the state fair hearing process. The NCQA classifies grievance requests as stages in the appeal process.

An **inquiry** is a request for additional information or clarification regarding benefit coverage or how to access medical care/covered benefits. An inquiry is an informational request that is handled at the point of entry or that is forwarded to the appropriate operational area for final response. An inquiry is not an expression of any dissatisfaction.

The provider or an authorized representative, with the written consent of the member, is able to request an appeal, file a grievance or request a state fair hearing on behalf of a member. Members have a right to ask for support in filing a grievance. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability. Providers may appeal on a member's behalf related to adverse determinations and nonmedical necessity claims determinations. This can only be done with the member's written consent.

If a member has a grievance, we would like to hear about the issue either by phone or in writing. Members have the right to file a grievance regarding any aspect of our services at any time. The member or member's authorized representative (including a provider, **with the member's written consent**) can file a grievance or appeal on the member's behalf.

Member grievances and appeals include but are not limited to:

- Access to healthcare services.
- Care and treatment by a provider.
- Issues with how we conduct business.

Wellpoint does not discriminate against members or providers for filing a grievance or an appeal on the member's behalf. In addition, providers are prohibited from penalizing a member in any way for expressing a complaint or filing a grievance.

Members: filing a grievance

If a member wants to file a grievance, the member may call the Customer Care Center, write a letter to the Grievance and Appeals department telling us about the problem or fill out a grievance form available on our website. Grievance forms are available wherever members receive their healthcare, such as at their PCP's office or at a local Wellpoint resources office. The member will need to tell us the following:

- Who is part of the grievance
- What happened
- When the incident happened
- Where the incident happened
- Why the member was not happy with the healthcare services

To file a grievance verbally, the member can call Customer Care Center at **800-782-0095**. The member can attach documents that will help us investigate the problem and should mail the written grievance form to:

Wellpoint
Attn: Grievance and Appeals Department
P.O. Box 91
Charleston, WV 25321-0091

To file a grievance in writing, the member may also fax the grievance to the Grievance and Appeals Department at **844-882-3520**.

The member does not have to be the person filing a grievance or appeal. Members will be required to sign an authorized representative form. If the member is a minor or is incompetent or incapacitated, the member's representative may submit the grievance or appeal on the member's behalf.

Other representatives may include the following:

- Relative
- Guardian
- Conservator
- Attorney
- Member's PCP or a provider on behalf of the member

If the member cannot mail the form or letter, he or she may call Wellpoint's Customer Care Center at **800-782-0095**, and we will provide assistance by documenting the request. We will send the member an acknowledgment letter confirm receipt of the grievance or appeal. - The acknowledgement letter includes the receipt date, as well as, the member Your Rights Under Wellpoint. Wellpoint will send a grievance resolution letter to the member within 90 calendar days after receiving the grievance.

The following are guidelines surrounding grievances:

- The Grievances and Appeals department may request medical records or an explanation from the provider(s) involved in the case.
- The Grievances and Appeals department notifies providers of the need for additional information either by phone, mail, or fax. Written correspondence to providers includes a signed and dated letter.
- Providers are expected to respond to requests for additional information within 10 days.
- If the Grievances and Appeals department is unable to resolve the grievance within the 90-day period, we will notify the member in writing and explain the reason for the delay. This may extend the case up to an additional 14 days for members. If the time frame is extended, for any extension not requested by the member, Wellpoint will give the member written notice of the reason for the delay.

Interpreter services and translation of materials into non-English languages and alternative formats are available, at no cost, to support members with the grievance and appeals process.

Members: appeals

An **adverse benefit determination** is a denial, modification, or reduction of services based on eligibility, benefit coverage, or medical necessity. It can mean any of the following:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner as defined by the state

- The failure of Wellpoint to act within the time frames in *§ 438.408(b) (1) (2)* regarding the standard resolution of grievances
- For a resident of a rural area with only one MCO: the denial of a member's request to exercise his or her right, under *§ 438.52(b) (2) (ii)*, to obtain services outside the network

Wellpoint informs members of their grievance, appeal, and state fair hearing rights in the member's enrollment materials. Members can only request a State Fair Hearing if it relates to a denial of a covered service, a reduction in service, termination of a previously authorized service, or failure to provide service timely. Appeals for non-covered services are not eligible for State Fair Hearings unless requested under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits. If a member would like to file an appeal, the member, or member's authorized representative with the member's written consent, must notify us within 60 calendar days of the date on the Notice of Adverse Benefit Determination letter. The request for an appeal may be verbal or written. Providers may submit appeals on a member's behalf **with written consent**.

All appeals are acknowledged in writing within five calendar days of receipt. Appeals are divided into two categories:

- **Standard appeal:** The appropriate process when a member, or his or her representative with written consent, requests that Wellpoint reconsider the denial of a service or payment for services, in whole or in part. West Virginia's standard appeal process requires resolution within 30 calendar days of receipt of the written appeal request or within an additional 14 (44 total) calendar days if the member requests an extension, or if Wellpoint and the DoHS determine it is in the best interest of the member to extend the decision time frame.
- **Expedited appeals:** An appeal when the amount of time necessary to complete a standard appeal process could jeopardize the member's life, health, or the ability to maintain or regain maximum function. West Virginia's expedited appeal process requires resolution within 72 hours of receipt of the expedited appeal request. Members may request an expedited appeal by calling our Customer Care Center at **800-782-0095**.

If we receive an expedited request and after clinical review, we decide the appeal does not meet expedited criteria, we will follow the standard timeframe. We provide oral notice to the member followed up by written notification to the member within two calendar days that explains to the member the appeal request does not meet criteria for an expedited review. The written notification tells the member they have a right to file a grievance with us if they are not happy with our decision to deny the expedited appeal.

Members: continuation of benefits during appeal

Wellpoint members will continue to receive benefits while their appeal or State Fair Hearing is pending, in accordance with federal regulations, when all of the following criteria are met:

- The member or representative must request the continuation of benefits within 13 days of our mail date of the adverse action notification, or prior to the effective date on the written notice if the initial notification was made by phone.

- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- Services were ordered by an authorized provider.
- The original period covered by the initial authorization has not expired.
- The member requests extension of benefits.

A member can request an extension of benefits by calling the Customer Care Center.

Members: extensions

If Wellpoint is unable to resolve the appeal within the standard 30 days or 72 hours, the resolution time frame for an appeal not related to an ongoing hospitalization or emergency may be extended up to 14 calendar days if:

- The member or representative requests an extension
- Wellpoint demonstrates there is a need for additional information and the delay is in the member's interest. Wellpoint will attempt to contact the member by phone to notify him or her of the extension on the resolution of the initial request. Notice is mailed within two calendar days and will include notification of the member's right to file a grievance if he or she disagrees with the extension. We maintain documentation of any extension request.

Members: response to expedited appeals

Wellpoint may request medical records or a provider explanation of the issues raised in an expedited appeal by:

- Phone
- Fax, with a signed and dated letter
- Mail, with a signed and dated letter

Providers are expected to comply with the request for additional information within 24 hours.

Members: state fair hearing

Wellpoint members may request a state fair hearing after they have exhausted all of Wellpoint's internal appeals processes. The request must be submitted in writing to the state of West Virginia within 120 calendar days from the date of the notice of action resolution letter:

For Medicaid:
Bureau for Medical Services
Office of Medicaid Managed Care
350 Capitol Street, Room 251
Charleston, WV 25301-3708

For CHIP:
Bureau for Medical Services
Attn: WV Children's Health Insurance Program
350 Capitol Street, Room 251
Charleston, WV 25301-3708

A State Fair Hearing is not allowed for non-covered services, except when the service is related to EPSDT for members under the age of 21. A provider does not have an appeal right with BMS.

The member process to file a State Fair Hearing is as follows:

- The state sends a notice of the hearing request to Wellpoint.
- Upon receipt of the request, all documents related to the request are forwarded to the state.
- The state notifies all parties of the date, time, and place of the hearing. Representatives from Wellpoint's administrative, medical, and legal departments may attend the hearing to present testimony and arguments. Wellpoint's representatives may cross-examine the witnesses and offer rebutting evidence.
- An administrative law judge renders a decision in the hearing within 90 days of the date the standard hearing request was made.
- If the State Fair Hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, Wellpoint will authorize the disputed service promptly and as expeditiously as the enrollee's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination. Additionally, in the event that services were continued while the appeal was pending, Wellpoint will provide reimbursement for those services in accordance with the terms of the final decision rendered.

Members: confidentiality

All grievances and appeals are handled in a confidential manner. Wellpoint does not discriminate against a member for filing a grievance or requesting a state fair hearing. We notify members of the opportunity to receive information about our grievances and appeals process. Members may request a translated version in a language other than English.

Members: discrimination

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when a Wellpoint representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident or is assisted in doing so, if he or she requests assistance.
We document, track and trend all alleged acts of discrimination, and review and trend cultural and linguistic grievances.

Providers: grievances relating to the operation of the plan

A provider may be dissatisfied or concerned about another provider, a member, or an operational issue, including claims processing and reimbursement. To file a grievance, download the *Provider*

Grievance Form available at provider.wellpoint.com/wv. For directions on how to access the provider website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

Provider grievances may be submitted in writing or verbally and must include the following:

- Provider's name
- Date of the incident
- Description of the incident

Mail the form to the following address:

Wellpoint
Attn: Grievance and Appeals Department
P.O. Box 91
Charleston, WV 25321-0091

Or fax the form to **844-882-3520**.
Or verbally by calling the Customer Care Center at **800-782-0095**.

A grievance may be filed any time a provider becomes aware of the problem. Wellpoint will send a written acknowledgement to the provider within five calendar days of receiving a grievance. Wellpoint may request medical records or an explanation of the issues raised in the grievance by:

- Phone.
- Fax, with a signed and dated letter.
- Mail, with a signed and dated letter.

The timeline for responding to the request for more information is as follows: For standard grievances or appeals, providers must comply with the request for additional information within 10 calendar days of the date that appears on the request.

Providers: grievance response timeline

Wellpoint notifies providers in writing of the resolution, including their right of appeal, if any. Findings or decisions of peer review or quality of care issues are not disclosed. Wellpoint sends a written resolution letter to the provider upon receipt of the grievance:

- Provider grievances: Wellpoint sends a written resolution letter to the provider within 90 calendar days of the receipt of the grievance.

Provider medical necessity appeals: Wellpoint sends a written resolution letter to the provider within 30 calendar days of the receipt of the appeal.

CHAPTER 14: CREDENTIALING AND RECREDENTIALING

Customer Care Center phone: 800-782-0095
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Overview

Credentialing is the process of validating the professional competency and conduct of network providers. The process involves verifying licensure, board certification, education and identification of adverse actions, including malpractice or negligence claims through the applicable state agencies and the National Practitioner Database.

We require recredentialing every three years to stay current with your professional information. Recredentialing is essential to our members as well, who depend on the accuracy of the information in the online Wellpoint Provider Finder®.

Wellpoint has streamlined the credentialing process by teaming up with the Council for Affordable Quality Healthcare (CAQH), nationally recognized for its thoroughness in collecting provider data.

Council for Affordable Quality Healthcare

Wellpoint strongly encourages West Virginia providers to use CAQH's ProView for initial credentialing and periodic recredentialing. CAQH is a not-for-profit alliance of the nation's leading healthcare plans and networks whose mission is to improve healthcare quality and access for more than 165 million Americans covered by these plans. The CAQH data collection system from over 1.3 million providers allows administrative requirements to be streamlined.

ProView is the industry standard for collecting the provider data used in credentialing. Providers in all 50 states and the District of Columbia are able to enter information free of charge, reducing paperwork for more than 550 participating healthcare plans. ProView allows providers to fill out a single application to meet the credentialing data needs of multiple organizations. For both Wellpoint and providers, recredentialing is helpful because this process:

- Supports Wellpoint's administrative streamlining and paper reduction efforts
- Helps to ensure the accuracy and integrity of the provider database
- Simplifies the credentialing application process, eliminating redundant application forms and streamlining paperwork for providers
- Enables providers to utilize the ProView database at no cost

CAQH ProView registration: first time users

Wellpoint providers must have CAQH provider identification number to register and begin the credentialing process. Perform the following steps if you are not registered with CAQH:

1. After you obtain a Wellpoint provider application packet and submit a current, signed Wellpoint agreement, Wellpoint will add your name to the CAQH roster.

2. Go to the CAQH website at https://proview.caqh.org/pr to obtain a CAQH ID number, complete your application and authorize Wellpoint. Providers who do not have Internet access should contact the CAQH Help Desk at **888-599-1771**.

Please note: Registration and completion of the online application are free.

CAQH/ProView registration: completing the application process

The ProView standardized application is a single, standard online form that meets the needs of all participating healthcare organizations. When completing the application, indicate which participating healthcare plans and healthcare organizations you authorize to access your application data. All data you submit through the ProView service is maintained by CAQH in its secure data center.

The following materials will be helpful while completing the ProView online application:

- Previously completed credentialing application
- List of previous and current practice locations
- Various ID numbers (NPI, Medicare, Medicaid, etc.)
- State license(s) applicable to your provider type
- Current Drug Enforcement Administration (DEA) Certificate, if applicable
- Current Controlled and Dangerous Substances Certificate, if applicable
- Internal Revenue Service (IRS) Form W-9(s)
- Current malpractice insurance face sheet
- Summary of all pending or settled malpractice cases within the past 10 years
- Curriculum vitae

After completing the online credentialing application, you will be asked to:

- Authorize access to your information by selecting the checkbox next to Wellpoint or selecting the global authorization option.
- Verify your data entry and attestation for accuracy and completeness.
- Upload supporting documents directly to the site. The following are required:
- State license(s) applicable to your provider type
- Current DEA Certificate, if applicable
- Current Controlled and Dangerous Substances Certificate, if applicable
- Current malpractice insurance face sheet
- Summary of all pending or settled malpractice case(s) within the past 10 years

- Curriculum vitae
- Current signed attestation
- *Hospital Coverage Letter* (required by Wellpoint from providers who do not have admitting privileges at a participating network hospital)

Please note: While the CAQH credentialing data set is substantially complete, Wellpoint may need to supplement, clarify or confirm certain responses on your application on a case-by-case basis. Wellpoint will reach out to the credentialing contact provided on the CAQH application to obtain additional information as necessary.

If you have any questions about accessing the ProView database, contact the CAQH Help Desk: **888-599-1771**. To download a quick reference guide about completing the CAQH registration process, go to https://proview.caqh.org.

CAQH/ProView registration: existing users

If you have registered your CAQH Provider ID and completed your online application through participation with another healthcare plan, log on to the ProView database and authorize Wellpoint to access your information. Follow these steps:

1. Go to: https://proview.caqh.org/pr.
2. In the *Sign In* section, enter your username and password and select **Sign In**.
3. Select the **Authorize** tab located under the CAQH logo.
4. Scroll down to locate Wellpoint. Select the checkbox next to Wellpoint or select the **global authorization** option.
5. Select **Save** to submit your changes.

Visit the CAQH website for more information about the CAQH Proview database and application process.

Additional CAQH resources

Contact information for the CAQH Help Desk:

Phone: **888-599-1771**
Operating hours: Monday to Thursday, 7 a.m. to 9 p.m.; Friday, 7 a.m. to 7 p.m.
Email: **providerhelp@proview.caqh.org**

Please note: Providers with vision and/or hearing challenges may call the CAQH Help Desk and complete the application by phone.

Wellpoint contracting process for hospital, facility-based providers, hospital, comprehensive behavioral health centers and licensed behavioral health centers

Hospital or facility-based providers must submit a request for contracting with and participating in the Wellpoint network. Hospital, Comprehensive Behavioral Health Centers and Licensed Behavioral Health Centers are expected to complete a Wellpoint Facility Application when adding any new facility after being credentialed and complete a Behavioral Health Addendum and if applicable. If you have questions about the Wellpoint contracting process, please contact our Customer Care Center at **800-782-0095**.

Eligible hospital or facility-based specialties include, but are not limited to the following:

- Anesthesiologist
- Emergency room provider
- Hospitalist
- Neonatologist
- Pathologist
- Radiologist

Hospital or facility-based providers must have the following:

- Hospital privileges
- Type 1 NPI number
- West Virginia Medical Board license (temporary permit is acceptable) or appropriate West Virginia licensure applicable to provider type
- Certificate/AANA# (applicable to Certified Nurse Anesthetist [CRNA] providers only)

Please note: Obtaining a Wellpoint provider record ID does not activate the network automatically. Claims will be processed out-of-network until the provider has applied for network participation and has been approved and activated in the network.
To complete the contracting process, hospital or facility-based providers must take the steps outlined in the following sections, as appropriate.

Medical group adding a provider

If you are part of a medical group that has a Group Agreement and this group is adding you as a facility-based provider: complete the *Provider Application* and fax the completed application to your local Network Management office for processing.

Solo provider or medical group interested in contracting with wellpoint
If you are a solo provider or medical group interested in contracting as a facility-based provider with the network, and you do not currently have an agreement, complete and sign either of the following documents:

- *Solo* or *Medical Group Agreement* (whichever is applicable)
- Provider application

Submit the completed document to your local Network Management office.

Credentialing updates

You must inform CAQH and Wellpoint of changes to your practice. Wellpoint members rely on the accuracy of the information in our online Wellpoint Provider Finder®. CAQH will send automatic reminders for you to review and attest to the accuracy of your data every four months. If you are a participating provider, you may submit most changes online by using the *Change Your Information* form available at https://proview.caqh.org/pr.

Recredentialing

When you are scheduled for recredentialing, Wellpoint will determine if you have completed the ProView credentialing process and have authorized Wellpoint to access your information or if you have selected global authorization. If you have made this authorization, Wellpoint obtains your current information from the ProView database and completes the recredentialing process without contacting you. If your recredentialing application is not available to Wellpoint through CAQH for any reason, Wellpoint will fax you a reminder to update the application.

Please note: You must enter your changes into the ProView database and grant access to Wellpoint during the credentialing and recredentialing process. Only healthcare plans participating in the ProView database and those to which you have granted access receive these changes.

Wellpoint's discretion

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

Credentialing scope

Credentialing requirements apply to the following:

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

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

The criteria listed above apply to practitioners in the following settings:
1. Individual or group practices;
2. Facilities;
3. Rental networks:
   a. That are part of Wellpoint's primary network and include Wellpoint members who reside in the rental network area.
   b. That are specifically for out-of-area care and members may see only those practitioners or are given an incentive to see rental network practitioners; and
4. Telemedicine.

Wellpoint credentials the following licensed/state certified independent healthcare practitioners:
- Medical doctors (MD)
- Doctors of osteopathic medicine (DO)
- Doctors of podiatry
- Chiropractors
- Optometrists providing health services covered under the health benefit plan
- Doctors of dentistry providing health services covered under the health benefit plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral healthcare specialists who provide treatment services under the health benefit plan
- Telemedicine practitioners who provide treatment services under the health benefit plan
- Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives

- Physician assistants (as required locally)
- Registered dietitians

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

- Certified behavioral analysts
- Certified addiction counselors
- Substance use disorder practitioners

Wellpoint credentials the following Health Delivery Organizations (HDOs):

- Hospitals
- Home Health agencies
- Skilled nursing facilities (nursing homes)
- Ambulatory surgical centers
- Behavioral health facilities providing mental health and/or substance use disorder treatment in inpatient, residential, or ambulatory settings, including:
  - Adult family care/foster care homes
  - Ambulatory detox
  - Community Mental Health Centers (CMHC)
  - Crisis stabilization units
  - Intensive family intervention services
  - Intensive outpatient – mental health and/or substance use disorder
  - Methadone maintenance clinics
  - Outpatient mental health clinics
  - Outpatient substance use disorder clinics
  - Partial hospitalization – mental health and/or substance use disorder
  - Residential Treatment Centers (RTC) – psychiatric and/or substance use disorder
- Birthing centers
- Home infusion therapy when not associated with another currently credentialed HDO
- Durable medical equipment providers

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

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
- End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission)
- Portable x-ray suppliers (CMS Certification)
- Home infusion therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural health clinics (CMS Certification)
- Orthotics and prosthetics suppliers (American Board for Certification in Orthotics and Prosthetics (ABCOP) or Board of Certification/Accreditation (BOC) or The National Examining Board of Ocularists (NEBO))

Credentials committee

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

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

for each line of business (e.g., Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

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

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

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

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

Nondiscrimination policy

Wellpoint will not discriminate against any applicant for participation in its plan programs or provider networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Wellpoint will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Wellpoint will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Wellpoint will take appropriate action to track and eliminate those practices.

Initial credentialing

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

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

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

A. Practitioners

Verification element
License to practice in the state(s) in which the practitioner will be treating members.
Hospital admitting privileges at a TJC, DNV NIAHO, CIHQ or ACHC accredited hospital, or a network hospital previously approved by the committee.
DEA/CDS and state-controlled substance registrations • The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating members. Practitioners who see members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance

Verification element
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

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

Re-credentialing

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

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

Health delivery organizations

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

Ongoing sanction monitoring

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

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

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

Appeals process

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

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

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation, or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid, or FEHB programs, has a criminal conviction, or Wellpoint's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment, or exclusion from Medicare, Medicaid, or FEHB are not eligible for informal review/reconsideration or formal appeal.

Reporting requirements

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

Wellpoint credentialing program standards

Eligibility criteria

Healthcare practitioners:

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

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

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

1. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.

2. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
3. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
4. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

    a. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:

        i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;
        ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
        iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Wellpoint's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

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

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

Criteria for selecting practitioners

New applicants (Credentialing):

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
4. No evidence of potential material omission(s) on application.
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to members.
6. No current license action.
7. No history of licensing board action in any state.
8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating members. Practitioners who treat members in more than one state must have a valid DEA/CDS registration for each applicable state.
10. Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:

    a. It can be verified that this application is pending.
    b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber;
    c. The applicant agrees to notify Wellpoint upon receipt of the required DEA/CDS registration.
    d. Wellpoint will verify the appropriate DEA/CDS registration via standard sources.

        i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day timeframe will result in termination from the network.

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

e. The applicant agrees that failure to provide the appropriate DEA registration within a 90-day timeframe will result in termination from the network.

Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:

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

11. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for Practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating Practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.
12. No history of or current use of illegal drugs or history of or current substance use disorder.
13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
14. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.
15. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
16. A minimum of the past 10 years of malpractice claims history is reviewed.
17. Meets Credentialing Standards for education/training for the specialty in which the practitioner wants to be listed in Wellpoint's network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons.
18. No involuntary terminations from an HMO or PPO.
19. No "yes" answers to attestation/disclosure questions on the application form except for the following:

    a. Investment or business interest in ancillary services, equipment or supplies;
    b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;

c. Voluntary surrender of state license related to relocation or nonuse of said license;
d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window.
g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

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

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

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
    a. Master or doctoral degree in social work.
    b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a doctor of social work will be viewed as acceptable.
    c. Licensure to practice independently.
2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC) or other master level license type:
    a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
    b. Master or doctoral degrees in divinity, masters in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
    c. Practitioners with PhD training as a clinical psychologist can be reviewed.
    d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
    e. Licensure to practice independently or in states without licensure or certification:
        i. Marriage & family therapists with a master's degree or higher:
            1. Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).
        ii. Mental health counselors with a master's degree or higher:

1. Provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) (proof of NBCC certification required) or meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).

3. Pastoral counselors:

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

4. Clinical nurse specialist/psychiatric and mental health nurse practitioner:

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

5. Clinical psychologists:

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

6. Clinical neuropsychologist:

   a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
   b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and

c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:

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

7. Licensed psychoanalysts:

   a. Applies only to practitioners in states that license psychoanalysts.
   b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Wellpoint Credentialing Policy (e.g., psychiatrist, clinical psychologist, licensed clinical social worker).
   c. Practitioner must possess a valid psychoanalysis state license.

      i. Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
      ii. Meet examination requirements for licensure as determined by the licensing state.

8. Process, requirements and verification – nurse practitioners:

   a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
   b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
   c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
   d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Wellpoint procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
   e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:

i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
ii. American Academy of Nurse Practitioners – Certification Program;
iii. National Certification Corporation;
iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner);
v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Wellpoint is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.
g. The NP applicant will undergo the standard credentialing processes outlined in Wellpoint's Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the NP may be listed in Wellpoint's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. NPs will be clearly identified:

i. On the credentialing file;
ii. At presentation to the CC; and
iii. Upon notification to network services and to the provider database.

9. Process, requirements and verifications – certified nurse midwives:

a. The certified nurse midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a certified nurse midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.

c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Wellpoint procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
e. All CNM applicants will be certified by either:

    i. The National Certification Corporation for Ob/Gyn and neonatal nursing; or
    ii. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

    This certification must be active and primary source verified. If the state licensing board primary source verifies one) of these certifications as a requirement for licensure, additional verification by Wellpoint is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.
f. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
g. The CNM applicant will undergo the standard credentialing process outlined in Wellpoint's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the CNM may be listed in Wellpoint's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. CNMs will be clearly identified:

    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

10. Process, requirements and verifications – physician's assistants (PA):

    a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.

b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Wellpoint procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Wellpoint is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Wellpoint health plan and submitted for individual review by the CC.
f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
g. The PA applicant will undergo the standard credentialing process outlined in Wellpoint's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the PA may be listed in Wellpoint provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. PA's will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

Currently participating applicants (re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;

2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Wellpoint's plan programs or provider networks, federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider networks as well as Wellpoint's other credentialed provider networks.
4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a network practitioner of similar specialty at a network HDO who provides inpatient care to members needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or substance use disorder;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:

    a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    b. Voluntary surrender of state license related to relocation or nonuse of said license;
    c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;

f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

15. No quality improvement data or other performance data including complaints above the set threshold.
16. Re-credentialed at least every three years to assess the practitioner's continued compliance with Wellpoint standards.

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

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

HDO eligibility criteria

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

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

2. Additional participation criteria for HDO by provider type:

HDO type and Wellpoint approved accrediting agent(s)

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

Facility type (behavioral health care)	Acceptable accrediting agencies
Acute Care Hospital—Psychiatric Disorders	DNV NIAHO, ACHC, TJC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, ACHC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Use Disorder	ACHC, CARF, COA, DNV NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, ACHC, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Use Disorder	CARF, DNV NIAHO, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Use Disorder	CARF, COA, DNV NIAHO, ACHC, TJC

Facility type (behavioral health care - tehabilitation)	Acceptable accrediting agencies
Acute Inpatient Hospital – Detoxification Only Facilities	TCT, DNV NIAHO, ACHC, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Use Disorder Clinics	CARF, TJC, COA,

Other West Virginia specific credentialing requirements:

Site visits
West Virginia regulations: Title 114 Legislative Rule, Insurance Commissioner Series 53, Quality Assurance

6.6. Representatives from the credentialing committee or members of their staff shall make an initial visit to each potential primary care practitioner's office and to the offices of obstetricians/gynecologists and other high-volume specialists. This process shall include documentation of a structured review of the site and of medical record keeping practices to ensure conformance with the HMO's standards.

7.e. The recredentialing process shall include an on-site visit to all primary care providers, obstetricians/ gynecologists and high-volume specialists and shall involve documentation of a structured review of the site and medical record keeping practices to ensure conformance with HMO standards.

Please note: Wellpoint does not recognize site accreditation to be used in lieu of an office site review.

Effective 7/1/2020, the 2020 Mountain Health Trust contract requires the plan to establish site visit criteria and evaluation as part of its credentialing process for Durable Medical Equipment (DME) providers and behavioral health providers.

Effective 1/1/2021, the 2021 Medicaid CHIP contract requires credentialing and verification for durable medical equipment (DME) providers and/or vendors that provide or supply these services to members. If the DME provider is Medicare-enrolled or certified direct site visits are not needed

During the initial credentialing process, the health plan must verify:

- Good standing of clinical privileges at the hospital designated by the provider as the primary admitting facility (this requirement may be waived for practices which do not have or do not need access to hospitals);
- Any enrollee complaints.

The health plan must verify that a Comprehensive Behavioral Health Center or a Licensed Behavioral Health Center holds a valid license through the West Virginia Office of Health Facility Licensure and Certification.

CHAPTER 15: ACCESS STANDARDS AND ACCESS TO CARE

Customer Care Center phone: 800-782-0095
Customer Care Center fax: 888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Overview

This chapter outlines Wellpoint's standards for timely and appropriate access to quality healthcare. Following guidelines set by the National Committee for Quality Assurance (NCQA), the American College of Obstetricians and Gynecologists (ACOG), and the West Virginia Bureau for Medical Services (BMS), these standards help ensure that medical appointments, emergency services and continuity of care for our members are provided fairly, reasonably and within specific time frames.

We recognize that cultural and linguistic barriers may affect our members' ability to understand or comply with certain instructions or procedures. To break through those barriers and ensure that our access standards can be met, we encourage providers to take advantage of Wellpoint's cultural competency resources: Cultural Competency Training, Caring for Diverse Populations Toolkit, and My Diverse Patients. We have included an introduction to these resources in **Chapter 24: Culturally and Linguistically Appropriate Services**. Locate the complete resources in the *Provider Training Academy* on our website at provider.wellpoint.com/wv > **Resources > Training Academy** under **Cultural Competency Resources**. For directions on how to access the *Provider Resources* page of our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

Wellpoint encourages providers to attend training in an effort to promote sensitivity to the special needs of our member population. Wellpoint supports continuous education through webinars, town hall meetings and provider orientations.

In addition to a monthly provider orientation webinar, Wellpoint offers Provider Pathways, a 24/7 educational resource that offers a foundation for doing business with Wellpoint. It's designed to be user friendly and gives you flexibility when scheduling training for yourself and your staff.

Provider Pathways is available on the Provider Training Academy of the provider website at provider.wellpoint.com/wv.

Below is a list of topics covered within Provider Pathways:

Module	Content covered
Join our Network	Contracting
	Credentialing
	Completing a roster
	Demographics
Members	Explain our population

	Explain why we offer benefits we do
	Benefits
	Eligibility
	Cultural Competency
	Patience 360
	Care Management
	SBIRT
Authorizations	Define the purpose and situations
	Prior Notification vs Authorization
	Prior Auth look up tool
	ICR
Claims Submissions	Availity
	Clearing House
	Paper vs Electronic
Getting Paid	Electronic Funds Transfers (EFT)
	Electronic Remittance Advice (ERA)
Grievances and Appeals	Claim
	Authorizations
Special Situations	Fraud Waste and Abuse
	Access and Availability

Wellpoint monitors provider compliance with access to care standards on a regular basis. Failure to comply may result in corrective action.

General appointment scheduling

PCPs and specialists must make appointments for members from the time of request according to the following guidelines:

Nature of visit	Appointment standards
Emergency examinations	Immediate access during office hours
Urgent examinations	Within 48 hours of request
Nonurgent “sick visits”	Within 72 hours of request
Nonurgent routine examinations*	Within 21 business days of member’s request
Adult baseline and routine physical	Within 30 business days

Nature of visit	Appointment standards
Specialty care examinations	Within 10 business days of request for routine referrals; within 24 hours for urgent referrals

* Exceptions are permitted for routine cases, other than clinical preventive services, when PCP capacity is temporarily limited.

Please note: Hours of operation must be no less than the hours of operation offered to enrollees not enrolled in Medicaid or WVCHIP. If the provider only sees Medicaid/WVCHIP enrollees, the hours of operation offered must be comparable to those for Medicaid FFS.

Services for members

Wellpoint strongly recommends that PCPs perform an initial health assessment (IHA) and preventive care assessment with new members.

Please note: An IHA is not needed if the member is an existing patient of the PCP group but new to Wellpoint. In addition, follow-up is not needed if there is an established medical record that shows baseline health status. This record should include sufficient information for the PCP to understand the member's health history and to provide treatment recommendations as needed. Transferred medical records meet the recommendations for an IHA if a completed health history is included.

Nature of visit	Appointment standards
IHAs	Newborns: Within 30 days of birth Children & Adults newly enrolled within (45) calendar days of the effective date of enrollment.
Preventive care visits	According to the American Academy of Pediatrics (AAP) periodicity schedule found within the preventive healthcare guidelines

Behavioral health access to care standards

This grid outlines standards for timely and appropriate access to quality behavioral healthcare.

Behavioral health	1. Emergent: Immediately 2. Emergent, Non-Life-Threatening/Crisis Stabilization; Within six hours of request. 3. Urgent: Within 48 hours of referral/request 4. Outpatient treatment by a BH provider (routine visits) within 10 business days: a. Outpatient following discharge from an IP Hospital: Within 7 days of discharge. b. Outpatient BH Exams: within 14 business days of request c. Members should be seen within 45 minutes of their scheduled appointment time (emergencies excluded) d. For those agencies who have an open access process meaning the member walks in and waits to be seen without an appointment, the provider needs to see the member within three hours or offer
Definitions	***Emergent:*** Treatment is considered to be an on-demand service and does not require precertification. Members are asked to go directly to emergency rooms for services if they are either unsafe or their conditions are deteriorating. ***Emergent, Non-Life Threatening/Crisis Stabilization:*** On demand is urgent but not life threatening and can be seen in the office within-6 hours or directed to the emergency room if they can't be seen in the office. ***Urgent:*** Means a service need that is not emergent and can be met by providing an assessment and services within 48 hours of the initial contact. If the member is pregnant and has substance use problems she is to be placed in the urgent category. ***Routine:*** Means a service need that is not urgent and can be met by receiving treatment within 10 calendar days of the assessment without resultant deterioration in the individual's functioning or worsening of his or her condition.

Prenatal and postpartum visits

Providers must make prenatal and postpartum appointments for members from the time of request according to the following guidelines:

Nature of visit	Appointment standards
First trimester	Within 14 calendar days of request
Second trimester	Within 7 calendar days of request

Nature of visit	Appointment standards
Third trimester	Within 3 business days of request or immediately if an emergency
High-Risk pregnancy	Within 3 business days of request or immediately if an emergency
Postpartum examination	Between 1 and 12 weeks after delivery

Missed appointment tracking

When a member misses an appointment, providers must do the following:

- Document the missed appointment in the member's medical record.
- Make at least three attempts to contact the member to determine the reason for the missed appointment.
- Provide a reason in the member's medical record for any delays in performing an examination, including any refusals by the member.

After-hours services

Our members have access to quality healthcare 24/7. This means that PCPs must have a system in place to ensure members may call after hours with medical questions or concerns. Wellpoint monitors PCP compliance with after-hours access standards on a regular basis. We recommend that PCPs advise their answering services to participate in any after-hours monitoring. Failure to comply may result in corrective action. PCPs must adhere to the answering service and answering machine protocols defined in the following sections.

Answering service

Answering service or after-hours personnel must:

- Ask the member if the call is an emergency. In the event of an emergency, direct the member to dial 911 immediately or proceed directly to the nearest hospital emergency room.
- Forward nonemergency member calls directly to the PCP or on-call provider or instruct the member that the provider will be in contact within 30 minutes.
- Have the ability to contact a telephone Interpreter to assist members with language barriers.
- Return all calls.

Members may call the 24/7 NurseLine any time of the day or night to speak to a registered nurse. 24/7 NurseLine nurses provide health information and options for accessing care, including emergency services, if appropriate.

Answering machines

Answering machine messages:

- May be used when provider office staff or an answering service is not immediately available.

- Must instruct members with emergency healthcare needs to dial 911 or proceed directly to the nearest hospital emergency room.
- Must provide instructions on how to contact the PCP or on-call provider in a nonemergency situation.
- Must provide instructions in English, Spanish and any other language appropriate to the PCP's practice.

We offer the following suggested text for answering machines:

"Hello, you have reached [*insert Physician office name*]. If this is an emergency, hang up and dial 911 or go to the nearest hospital emergency room. If this is not an emergency and you have a medical concern or question, please call [*insert contact phone or pager number*]. You will receive a return call from the on-call physician within [*time frame*]."

Please note: Wellpoint has implemented a system to report difficulties experienced with the 24/7 NurseLine, emergency care systems, or protocol failures. To report failures, contact the Customer Care Center at **800-782-0095**. Corrective action plans will be requested from contracted network hospitals with emergency departments that fail to meet the department/emergency room protocols.

Please note: Wellpoint prefers that PCPs use a Wellpoint-contracted, in-network provider for on-call services. When this is not possible, the PCP must use his or her best efforts to ensure the on-call provider abides by the terms of the Wellpoint provider contract.

Continuity of care

Wellpoint provides continuity of care for members with qualifying conditions when healthcare services are not available within the network or when the member or provider is in a state of transition.

Qualifying condition: A medical condition that may qualify a member for continued access to care and continuity of care. These conditions include, but are not limited to:

- Acute conditions (cancer, for example)
- Degenerative and disabling conditions or diseases caused by a congenital or acquired injury or illness requiring a specialized rehabilitation program or a high level of service, resources or coordination of care in the community
- Newborns, who are covered retroactive to the date of birth
- Organ transplant or tissue replacement
- Pregnancy, with 12 weeks or less remaining before the expected delivery date, through immediate postpartum care
- Scheduled inpatient/outpatient surgery that was approved and/or precertified through the applicable BMS process
- Serious chronic conditions (hemophilia, for example)

- Terminal illness

States of transition may be when the member is:

- Newly enrolled
- Moving out of the service area
- Disenrolling from Wellpoint to another health plan
- Exiting Wellpoint to receive excluded services
- Hospitalized on the effective date of transition
- Transitioning through behavioral health services
- Undergoing the West Virginia Preadmission Screening/Resident Review Screening for long-term care placement
- Scheduled for appointments within the first month of plan membership with specialists. These appointments must have been scheduled prior to the effective date of membership.

A state of transition is also applicable when the provider's contract terminates.

Wellpoint providers help ensure continuity and coordination of care through collaboration. This includes the confidential exchange of information between PCPs and specialists as well as behavioral health providers. In addition, Wellpoint coordinates care when the provider's contract has been discontinued to facilitate a smooth transition to a new provider.

Providers must maintain accurate and timely documentation in the member's medical record, including, but not limited to:

- Consultations
- Prior authorizations
- Referrals to specialists
- Treatment plans

All providers share responsibility in communicating clinical findings, treatment plans, prognosis and the member's psychosocial condition as part of the coordination process. Utilization management nurses review member and provider requests for continuity of care. These nurses facilitate continuation with the current provider until a short-term regimen of care is completed, or the member transitions to a new provider.

Please note: Wellpoint does not impose any pre-existing condition limitations on its members, nor require evidence of insurability to provide coverage to any Wellpoint member.

Provider contract termination

Wellpoint will arrange for continuity of care for members affected by a provider whose contract has terminated. The provider must notify members 60 days prior to the final date of termination. A terminated provider who is actively treating members must continue treatment for a period of at least 90 days after the date on which notice is given.

After Wellpoint receives a provider's notice to terminate a contract, we will make our best effort to notify all impacted members. A letter will be sent at least 30 days in advance to inform the affected members about:

- The impending termination of the provider
- The member's right to request continued access to care
- The Customer Care Center's phone number. The Customer Care Center can make PCP changes and/or forward referrals to Case Management for continued access to care consideration

Members under the care of specialists may submit requests for continued access to care, including continued care after the transition period. Members should contact the Customer Care Center at **800-782-0095**.

Newly enrolled

Our goal is to ensure that the healthcare of our newly enrolled members is not disrupted or interrupted. Wellpoint ensures continuity in the care of our newly enrolled members when the:

- Member's health or behavioral health condition has been treated by specialists
- Member's health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted

Wellpoint will pay a newly enrolled member's existing out-of-network provider for medically necessary, authorized, and covered services until that regimen of care is completed. Then, the member's records, clinical information, and care are transferred to a Wellpoint provider.

Payment to out-of-network providers is made within the same time period required for providers within the network. In addition, we will comply with out-of-network provider reimbursement rules as adopted by the BMS.

All new enrollees receive the Member Handbook and Evidence of Coverage (EOC) membership information in their enrollment packets, which provides information regarding members' rights to request continuity of care.

Members moving out of service area

If a member moves out of the service area, Wellpoint will provide services and pay out of network providers for the specific period left for which capitation on the member has been paid. For example, if a member's capitation covers the month of June, Wellpoint will provide and pay for medically necessary covered services through the end of June.

Services not available within network

Wellpoint will provide members with timely and adequate access to out-of-network services for as long as those services are medically necessary, approved and not available within the network. However, Wellpoint is not obligated to provide members with access to out-of-network services if such services become available from a network provider.

When a provider refers a member to another provider for additional treatment or services, the referring provider must forward notification of his/her NPI and the member's eligibility. Wellpoint has streamlined this process by providing a *Record of Referral to Specialty Care* form, on our website at provider.wellpoint.com/wv > **Resources > Forms > Patient Care**. For directions on how to access the *Provider Resources* page of our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

The referring PCP and the specialist perform the following:

- The PCP completes and faxes the form to the specialist, notifying the specialist of the PCP's NPI.
- If the referring PCP does not provide the NPI, the specialist is responsible for contacting the PCP's office to obtain the NPI.
- The member must be made aware that the provider they are being referred to is in-network or out of network.
- The OON provider should communicate findings, treatment and plan of care to the member's PCP

Please note: Referrals are valid for as long as the member is under the care of the specialist.

Second opinions

Wellpoint will help ensure that members have access to a second opinion regarding any medically necessary covered service. Members will be allowed access to a second opinion from a network provider, or, if a network provider is not available, from an out-of-network provider, with a prior authorization.

Emergency transportation

Wellpoint covers emergency transportation services without prior authorization. When a member's condition is life-threatening and requires the use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, we will provide emergency transport by ambulance.

Examples of conditions considered for emergency transport include, but are not limited to:

- Acute and severe illnesses
- Acute or severe injuries from auto accidents
- Extensive burns
- Loss of consciousness

- Semi-consciousness, having a seizure, or receiving cardiopulmonary resuscitation (CPR) treatment during transport
- Untreated fractures

Emergency transportation is available for facility-to-facility transfers when the required emergency treatment is not available at the first facility.

Nonemergency transportation

All nonemergency transportation for **Medicaid** is covered by the state of West Virginia through its fee-for-service program. Visit the West Virginia Bureau for Medical Service website for additional information at dhhr.wv.gov/bms/Pages/default.aspx.

Emergency dental services for adults

When a member has an accident and the treatment is the first repair of an injury to the jaw, sound natural teeth, mouth, or face, Wellpoint covers the initial dental work and oral surgery, including anesthesia and drugs, for services provided in the following settings:

- Outpatient
- Doctor's office
- Emergency care
- Urgent care

Emergency services are limited to the care needed to give proper treatment. Injury as a result of chewing or biting is not considered an accidental injury, but may be covered under the general adult dental benefits for Medicaid members. Initial dental work refers to services provided within 48 hours of the injury, or as soon as possible. Covered services include all exams and treatment to complete the repair, such as:

- Anesthesia
- Lab tests
- Mandibular/maxillary reconstruction
- Oral exams
- Oral surgery
- Prosthetic services
- Restorations
- X-rays

CHAPTER 16: PROVIDER ROLES AND RESPONSIBILITIES

Customer Care Center phone: 800-782-0095
Customer Care Center fax: 888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Overview

At Wellpoint, our goal is to provide quality healthcare to the right member, at the right time, in the appropriate setting. To achieve this goal, PCPs, specialists, and ancillary providers must fulfill your roles and responsibilities with the highest integrity. We rely on your extensive healthcare education, experience, and dedication to our members, who look to you to get well and stay well.

As required by *42 CFR 438.602(b)*, all participating providers that order, refer or render covered services must enroll with the Department through the fiscal agent as a participating Medicaid or WVCHIP provider. Enrollment with the Department does not obligate participating providers to offer services under the Fee-for-Service delivery system. Wellpoint is not required to contract with a provider enrolled with the Department that does not meet our credentialing or other requirements.

Primary care providers

PCPs are the principle point of contact for our members. The PCP's role is to provide members with a medical home, the member's first stop in the healthcare process and a centralized hub for a wide variety of ongoing healthcare needs. Wellpoint furnishes each PCP with a current list of enrolled members assigned to that PCP. The PCP's role is to:

- Coordinate members' healthcare 24 hours a day, 7 days a week
- Develop members' care and treatment plans, including preventive care
- Maintain members' current medical records, including documentation of all services provided by the PCP and any specialty or referral services
- Adhere to wait times, as outlined within the provider contract and the provider manual
- Referrals for specialty care and other medically necessary covered services, both in-network and out-of-network, consistent with Wellpoint's utilization management policies
- Coordinate with outpatient clinical services
- Provide complete information about proposed treatments and prognosis for recovery to our members or their representatives
- Facilitate interpreter services by presenting information in a language that our members or their representatives can understand
- Ensure that members' medical and personal information is kept confidential, as required by state and federal laws
- Obtain signed consent before providing care
- Adhere to Wellpoint and West Virginia managed care program policies

- Facilitate adherence to the EPSDT periodicity schedule

The PCP's scope of responsibilities includes providing or arranging for:

- Routine and preventive healthcare services
- Emergency care services
- Behavioral health services
- Hospital services
- Ancillary services
- Interpreter services
- Referrals for specialty services
- Coordination with outpatient clinical services, such as therapeutic, rehabilitative or palliative services

Please note: Services should be provided without regard to race, religion, gender, gender identity, sexual orientation, color, national origin, age or physical/behavioral health status.

Wellpoint keeps providers up to date with detailed member information. We also furnish each PCP with a current list of assigned members and provide medical information about the members' potential healthcare needs. Providers may use this information to provide care and coordinate services more effectively.

PCPs should provide services only to those Wellpoint members who have chosen you as their PCP. Verify that a member is assigned to you by using the following methods:

- Call Wellpoint's Customer Care Center at **800-782-0095**:
- Use the Interactive Voice Response (IVR) system
- Speak to a Customer Service representative
- Go to https://Availity.com and select Login to enter the secure provider platform. Then, log in to the provider online reporting tool to view the monthly PCP rosters.

You may experience delays in claims payments if you treat members who are not assigned to you on the date of service. If you must provide services to a Wellpoint member not assigned to you, obtain prior authorization first. If you are a noncontracted provider, you must obtain prior authorization before treating Wellpoint members.

Behavioral health provider roles and responsibilities

At Wellpoint, our behavioral healthcare benefit is fully integrated with the rest of our healthcare programs. This coordination of healthcare resources requires certain roles and responsibilities for behavioral health providers, including the following:

- Participate in the care management and coordination process for each Wellpoint member under your care, as clinically appropriate.
- Seek prior authorization for all services that require it.
- Notify the member's PCP of any significant changes in the member's status and/or change in the level of care as clinically appropriate.
- Ensure that members receiving inpatient psychiatric services are scheduled for an outpatient follow-up and/or continuing treatment prior to discharge. This treatment must be provided within 7 calendar days from the date of the member's discharge.
- Encourage members to consent to the sharing of substance abuse treatment information with other providers involved in the member's care as clinically appropriate.

Coordination of behavioral health and physical health treatment

Key elements of the model for coordinated and integrated physical and behavioral health services include:

- Ongoing communication and coordination, as clinically appropriate, between Primary Care providers (PCPs) and specialty providers, including behavioral health (mental health and substance use) providers.
- Screening by PCPs for behavioral health, substance use and co-occurring disorders.
- Screening by behavioral health provider for physical health conditions.
- Referrals to PCPs or specialty providers, including behavioral health providers, for assessment and/or treatment for consumers with co-occurring disorders and/or any known or suspected and untreated physical health disorders.
- Development of patient-centered treatment plans Involving members as well as caregivers and family members when appropriate.
- Case management and condition care programs to support the coordination and integration of care between providers.

Fostering a culture of collaboration and cooperation helps sustain a seamless continuum of care between physical and behavioral health and positively impacts member outcomes. To maintain continuity of care, patient safety and member well-being, communication between behavioral health and physical care providers, as clinically appropriate, is critical, especially for members with comorbidities receiving pharmacological therapy.

Procedure for closing a PCP panel

A PCP who no longer wishes to accept new members may submit a written notification to Wellpoint to close his or her panel. In this situation, any new member who is not an established patient cannot select a PCP with an approved closed panel. A PCP may re-open a "closed" panel by submitting a written notification to Wellpoint. When a member requests a PCP with a "closed" panel, the Customer Care Associate will notify the member of the physician's panel status. The Customer Care Associate

will contact the physician to see if an exception is allowed to accept the member, then facilitating an over-ride to assign member on a case-by-case basis.

Referrals

PCPs coordinate and make referrals to specialists, ancillary providers and community services. Providers should refer members to network facilities and providers. When network facilities and providers are not available, providers should follow the appropriate process for requesting out-of-network referrals. **Please note:** Specialty referrals to in-network providers do not require prior authorization.

All PCPs must perform the following regarding referrals:

- Help members schedule appointments with other healthcare providers, including specialists.
- Track and document appointments, clinical findings, treatment plans and care received by members referred to specialists or other healthcare providers.
- Refer members to health education programs and community resource agencies, when appropriate.
- Coordinate with the Women, Infants and Children (WIC) program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin.
- Coordinate with the local tuberculosis (TB) control program to ensure that all members with confirmed or suspected TB have a contact investigation and receive directly observed therapy (DOT).
- Report to the West Virginia Bureau for Medical Services (BMS) or the local TB control program any member who is noncompliant, drug resistant, or who is or potentially may become a public health threat.
- Screen and perform evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

Out-of-network referrals

We recognize that an out-of-network referral may be justified at times. Wellpoint's Utilization Management (UM) department will review requests and authorize out-of-network services based on medical necessity and the availability of in network services. To request prior authorization, submit a request via ICA, as described in Chapter 6 of this manual.

Interpreter services

Providers must notify members of the availability of interpreter services from Wellpoint. Providers should strongly discourage the use of friends and family members, especially children, acting as interpreters. Multilingual staff should carefully self-assess their non-English language speaking and comprehension skills prior to interpreting on the job. You may find the current recommended employee language skills self-assessment tool on our website at provider.wellpoint.com/wv > **Resources > Provider Training Academy**. For directions on how to access the *Provider Training*

Academy page of our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

For those instances when you cannot communicate with a member due to language barriers, interpreter services are available at no cost to you or the member. Face-to-face Interpreters for members needing language assistance, including American Sign Language, are available by placing a request at least 72 hours in advance. A 24-hour cancellation notice is required.

- To request interpreter services, call Wellpoint's Customer Care Center at **800-782-0095**.
- To request interpreter services after hours or TTY and Relay services, call the 24/7 NurseLine at **888-850-1108**.

Initial health assessment

PCPs should review their monthly eligibility list provided by Wellpoint and determine which members are newly enrolled since the last report. PCPs should proactively contact their assigned members to make an appointment for an initial health assessment (IHA) within 45 calendar days of enrollment. The PCP's office is responsible for contacting assigned members and documenting all attempts to do so. Members' medical records must reflect the reason for any delays in performing the IHA, including any refusals by the member to have the exam.

Transitioning members between medical facilities and home

When medically indicated, PCPs initiate or assist with the discharge or transfer of members:

- From an inpatient facility to the appropriate skilled nursing or rehabilitation facility, or to the member's home
- From an out-of-network hospital to an in-network hospital, or to the member's home with home healthcare assistance (within benefit limits)

The coordination of member transfers from noncontracted, out-of-network facilities to contracted, in network facilities is a priority that may require the immediate attention of the PCP. To obtain assistance, contact Wellpoint's UM department at **866-655-7423**.

Noncovered services

All PCPs must inform members of the costs associated with noncovered services prior to rendering the noncovered services. For more information, call our Customer Care Center at **800-782-0095**. Also refer to the **Private Pay Agreement** section of this manual.

Specialists

Specialists, licensed with additional training and expertise in a specific field of medicine, supplement the care given by PCPs. Specialists are charged with the same responsibilities as PCPs, including the responsibility of ensuring that prior authorization has been obtained before rendering services. Access to specialty care begins when the PCP refers a member to a specialist for medically necessary conditions beyond the PCP's scope of practice. Specialists diagnose and treat conditions specific to their area of expertise.

Please note: Specialty care is limited to Wellpoint benefits.

The following guidelines are in place for specialists:

- For urgent care, the specialist should see the member within 24 hours of receiving the request.
- For routine care, the specialist should see the member within two weeks of receiving the request.

In some cases, a member may self-refer to a specialist. These cases include, but are not limited to:

- Family planning and evaluation
- Diagnosis, treatment, and follow-up of sexually transmitted infections (STIs)
- Initial behavioral health evaluation

For some medical conditions, the specialists should be the PCP. In these instances, the specialist must be able to demonstrate the ability to provide comprehensive primary care. Members may request the specialist be assigned as the PCP if the member:

- Has a chronic illness
- Has a disabling condition
- Is a child with special healthcare needs

Hospital scope of responsibilities

PCPs refer members to Wellpoint-contracted network hospitals for medically necessary conditions beyond the PCP's scope of practice. Hospital care is limited to plan benefits. Hospital providers diagnose and treat conditions specific to their area of expertise. Hospital responsibilities include:

- Notification of admission and services
- Notification of preservice review decision

Refer to the following sections for specific information.

Notification of admission and services

The hospital must notify Wellpoint or the review organization of an admission or service at the time the member is admitted or the service is rendered. If the member is admitted or a service is rendered on a day other than a business day, the hospital must notify Wellpoint the morning of the next business day.

Notification of preservice review decision

The utilization management guidelines and the hospital agreement require that a hospital receive notice of a preservice review determination at the time of a scheduled admission or service. If this does not occur, the hospital should contact Wellpoint and request the status of the decision.

Any admission or service requiring preservice review that has not received the appropriate review will be subject to post-service review denial. Generally, the provider is required to perform all

preservice review functions with Wellpoint. Before services are rendered, the hospital must ensure the preservice review has been performed. If the preservice review has not been performed, the hospital risks post service denial.

Ancillary scope of responsibilities

PCPs and specialists refer members to plan-contracted network ancillary providers for medically necessary conditions beyond the PCP's or specialist's scope of practice. Ancillary providers diagnose and treat conditions specific to their area of expertise. Ancillary care is limited to plan benefits.
We have a wide network of participating healthcare providers and facilities. All services offered by the healthcare provider, and for which the healthcare provider is responsible, are listed in the ancillary agreement.

Responsibilities applicable to all providers

The following responsibilities, described below, are applicable to all Wellpoint providers:

- After-hours services
- Member disenrollment
- Enrollee eligibility verification
- Collaboration
- Confidentiality
- Continuity of care
- Licenses and certifications
- Mandatory reporting of abuse
- Medical records standards and documentation
- Office hours
- Open clinical dialog/affirmative statement
- Oversight of non-physician practitioners
- Preservice reviews
- Should not engage in prohibited activities
- Provider contract terminations
- Termination of ancillary provider/patient relationship
- Updating provider information

Office hours

To maintain continuity of care, providers' office hours must be clearly posted and members must be informed about the providers' availability at each site. There are strict guidelines for ensuring access to healthcare 24 hours a day, 7 days a week:

- Providers must be available 24 hours a day by telephone.
- An on-call provider must be available to take calls when the member's provider is not available.

After-hours services

All PCPs must have an after-hours system in place to ensure that our members can call with medical concerns or questions after normal office hours. The answering service or after-hours personnel must forward member calls directly to the PCP or on-call physician, or instruct the member that the provider will be in contact within 30 minutes. Wellpoint will monitor provider compliance with after-hours access standards on a regular basis. Failure to comply may result in corrective action. For additional information, refer to the **After-Hours Services** section of this manual.

Emergencies

The answering service or after-hours personnel must ask the member if the call is an emergency. In the event of an emergency, the member must be directed to dial 911 immediately or proceed to the nearest hospital emergency room.

If the PCP's staff or answering service is not available, an answering machine may be used. The answering machine message must instruct members who have emergency healthcare needs to dial 911 or go directly to the nearest hospital emergency room. The message must give members an alternative contact number to reach the PCP or on-call provider with medical concerns or questions.

Language-appropriate messages

Non-English speaking members who call their PCP after hours should expect to get language appropriate messages. In the event of an emergency, these messages should direct the member to dial 911 or proceed directly to the nearest hospital emergency room. In a nonemergency situation, members should receive instructions about how to contact the on-call provider. If an answering service is used, the service should know where to contact a telephone interpreter for the member. All calls taken by an answering service must be returned.

Network on-call providers

Wellpoint prefers that PCPs use network providers for on-call services. When that is not possible, the PCP must ensure that the covering on-call physician or other provider abides by the terms of the Wellpoint provider contract.

24/7 NurseLine

Members may call the 24/7 NurseLine 24 hours a day, 7 days a week at **888-850-1108** to speak to a registered nurse. 24/7 NurseLine nurses provide health information regarding illness and options for accessing care, including emergency services.

Licenses and certifications

Providers must maintain all licenses, certifications, permits, accreditations or other prerequisites required by Wellpoint and federal, state and local laws to provide medical services.

Eligibility verification

All providers must verify member eligibility immediately before rendering services, supplies or equipment. Because eligibility may change monthly, a member eligible on the last day of the month may not be eligible on the first of the following month. Wellpoint is not responsible for charges incurred by ineligible persons. For details, refer to the **How to Verify Member Eligibility** section of this manual.

Collaboration

Providers share the responsibility of giving respectful care, working collaboratively with Wellpoint specialists, hospitals, ancillary providers and members and their families. Providers must permit members to participate actively in decisions regarding medical care, including, except as limited by law, their decision to refuse treatment. The provider facilitates interpreter services and provides information about the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program.

Continuity of care

PCPs maintain frequent communication with specialists, hospitals and ancillary providers to ensure continuity of care. Wellpoint encourages providers to maintain open communication with members about appropriate treatment alternatives, regardless of the member's benefit coverage limitations. PCPs are responsible for providing an ongoing source of primary care appropriate to the member's needs.

Wellpoint has established comprehensive mechanisms to ensure continued access to care for members when providers leave our healthcare program. Under certain circumstances, members may finish a course of treatment with the terminating provider. For more information, refer to the **Provider Contract Termination** section of this manual.

Medical records standards

Medical records must be maintained in a manner ensuring effective and confidential member care and quality review. At Wellpoint, we perform medical record reviews upon signing a provider contract. We then perform medical record reviews at least every three years to ensure that providers remain in compliance with these standards. Quality chart reviews are periodically conducted based on HEDIS and quality information. These reviews are designed to be educational and support quality activities.

Medical records must be stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act. This act prohibits a healthcare provider from disclosing any individually identifiable information regarding a patient's medical history, treatment, or behavioral and physical condition, without the patient's or legal representative's consent or specific legal authority. Records required through a legal instrument may be released without patient or patient representative consent. Providers must be familiar with the *HIPAA* security requirements and be in compliance.

Additional information on medical record storage, standards and security may be found in Chapter 20, beginning with the **Medical Record Documentation Standards** section.

Mandatory reporting of child abuse, elder abuse or domestic violence

Providers must ensure that office staff is familiar with local reporting requirements and procedures regarding telephonic and written reporting of known or suspected cases of abuse. All healthcare providers must report immediately any actual or suspected child abuse, elder abuse or domestic violence to the local law enforcement agency by telephone. In addition, providers must submit a follow-up written report to the local law enforcement agency within the time frames required by law.

Updating provider information

Providers are required to inform Wellpoint of any material changes to their practice, no less than thirty (30) calendar days in advance. This includes changes in:

- Professional business ownership
- Business address or the location where services are provided
- Nine-digit federal Tax Identification Number (TIN)
- Specialty
- Demographic data
- Services offered to children
- Languages spoken
- Legal or governmental action initiated against a healthcare provider. This type of action includes, but is not limited to, an action for professional negligence, for violation of the law, or against any license or accreditation. If successful, this action would impair the ability of the healthcare provider to carry out the duties and obligations under the Provider Agreement.
- Any other problems or situations that may impair the ability of the healthcare provider to carry out the duties and obligations under the Provider Agreement care review and grievance resolution procedures
- Notification that the provider is accepting new patients

Use the *Provider Maintenance Form* to notify Wellpoint of changes by navigating to provider.wellpoint.com/wv and selecting **Forms**.

Oversight of nonphysician practitioners

All providers using nonphysician practitioners must provide supervision and oversight of these practitioners consistent with state and federal laws. The supervising physician and the non-physician practitioner must have written guidelines for adequate supervision. All supervising providers must follow state licensing and certification requirements.

Open clinical dialogue and affirmative statement

Nothing within the Provider Agreement or this manual should be construed as encouraging providers to restrict medically necessary, covered services or to limit clinical dialog between providers and their patients. Providers may communicate freely with members regarding the available treatment options, including medications, regardless of benefit coverage limitations.

We will not prohibit or otherwise restrict practitioners acting within the lawful scope of practice from advising or advocating on behalf of their patients about their health status, medical care or treatment options.

Provider contract termination

A terminated provider who is actively treating members must continue treatment until the termination date. The termination date is the end of the 90-day period following written notice of termination, or according to a timeline determined by the contract.

After we receive a provider's notice to terminate a contract, we notify members impacted by the termination. Wellpoint sends a letter to inform affected members about:

- The impending termination of the provider
- The member's right to request continued access to care
- The Customer Care Center phone number to request PCP changes
- Referrals to the UM department for continued access to care consideration

Members under the care of specialists may submit requests for continued access to care, including after the transition period, by calling the Customer Care Center at **800-782-0095**.

Wellpoint may terminate the Provider Agreement if we determine that the quality of care or services given by a healthcare provider is not satisfactory. We make this determination by reviewing member satisfaction surveys, utilization management data, member complaints or grievances, other complaints or lawsuits alleging professional negligence and quality of care indicators.

Termination of the ancillary provider/patient relationship

Under certain circumstances, an ancillary provider may terminate the professional relationship with a member, as provided for and in accordance with the provisions of this manual. However, ancillary providers may not terminate the relationship because of the member's medical condition or the amount, type or cost of covered services required by the member.

Member disenrollment

When a member disenrolls and requests a transfer to another health plan, providers are expected to work with the Wellpoint case managers responsible for helping the member make the transition. This transition must occur without disruption of any regimen of care that qualifies as a continuity of care condition. The case manager will coordinate with the member, the member's providers and the case manager at the new health plan to ensure an orderly transition.

Provider rights

Providers, acting within the lawful scope of practice, shall not be prohibited from advising a member or advocating on behalf of a member for any of the following:

- The member's health status, medical care or treatment options, including any alternative, self-administered treatment
- Any information the member needs to decide among all relevant treatment options
- The risks, benefits and consequences of treatment or non-treatment
- The member's right to participate in decisions regarding his/her healthcare, including the right to refuse treatment and to express preferences about future treatment decisions
- To receive information on the grievances and appeals and state fair hearing procedures
- To have access to policies and procedures covering authorization of services
- To be notified of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested
- To challenge, on behalf of our members, the denial of coverage or payment for medical assistance
- To be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable law based solely on that license or certification

Wellpoint's provider selection policies and procedures do not discriminate against particular providers who serve high-risk populations or specialize in conditions requiring costly treatment.

Prohibited activities

All providers are prohibited from:

- Billing eligible members for covered services
- Segregating members in any way from other persons receiving similar services, supplies or equipment
- Discriminating against Wellpoint members or Mountain Health Trust participants

CHAPTER 17: CLINICAL PRACTICE AND PREVENTIVE HEALTHCARE GUIDELINES

Customer Care Center phone: 800-782-0095
Customer Care Center fax: 888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Overview

At Wellpoint, we believe that providing quality healthcare should not be limited to the treatment of injury or illness. We are committed to helping providers and members become more proactive in the quest for better overall health. To accomplish this goal, we offer tools for providers to find the best, most cost-effective ways to:

- Provide member treatment
- Empower members through education
- Encourage member lifestyle changes, when possible

We want providers to have access to the most up-to-date clinical practice and preventive healthcare guidelines that are offered by nationally recognized healthcare organizations and based on extensive research. These guidelines include the latest standards for treating the most common and serious illnesses, such as diabetes and hypertension. These guidelines also include recommendations for preventive screenings, immunizations, and member counseling based on age and gender.

Preventive healthcare guidelines

Wellpoint considers preventive health guidelines to be an important component of healthcare. Wellpoint develops preventive health guidelines in accordance with recommendations made by nationally recognized organizations such as the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Advisory Committee on Immunizations Practices (ACIP), the American College of Obstetrics and Gynecology (ACOG) and the United States Preventive Services Task Force (USPSTF). These organizations make recommendations based on reasonable medical evidence. We review the guidelines annually for content accuracy, current primary sources, new technological advances and recent medical research. We make appropriate changes based on this review of the recommendations and/or preventive health mandates. We encourage providers to utilize these guidelines to improve the health of our members.

Locate the guidelines, educational materials and health management programs on our website at provider.wellpoint.com/wv. For directions on how to access the *Provider Resources* page of our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**. The preventive healthcare guidelines available include the following:

- Medical Policy Preventive Health Guidelines
- United States Health and Human Services Administration for Children and Families Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- In the *Member Preventive Health Care Guidelines* section: Preventive Health Care Guidelines

The Wellpoint website offers the most up-to-date clinical resources for preventive screenings, immunizations, and counseling for our members. If you do not have Internet access, request a hard copy of the preventive healthcare guidelines by calling our Customer Care Center at **800-782-0095**.

Please note: Our recommendation of these guidelines is not an authorization, certification, explanation of benefits or a contract. Actual member benefits and eligibility are determined in accordance with the requirements set forth by the state and as set forth in the member's Evidence of Coverage and Member Handbook.

Behavioral health clinical practice guidelines

All providers have access to evidence-based *Clinical Practice Guidelines* for a variety of behavioral health disorders commonly seen in primary care including attention deficit hyperactivity disorder, bipolar disorder for children and adults, major depressive disorder, schizophrenia and substance use disorders. These clinical practice guidelines are located online at provider.wellpoint.com/wv. For directions on how to access the *Provider Resources* page of our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

Clinical practice guidelines

Wellpoint considers clinical practice guidelines to be an important component of healthcare. Wellpoint adopts nationally recognized clinical practice guidelines and encourages physicians to utilize these guidelines to improve the health of our members. Several national organizations produce guidelines for asthma, diabetes, hypertension and other conditions. The guidelines, which Wellpoint uses for quality and condition care programs, are based on reasonable medical evidence. We review the guidelines at least every two years, or when changes are made to national guidelines, for content accuracy, current primary sources, new technological advances and recent medical research.

Providers may access the up-to-date listing of the clinical practice guidelines on the provider website at provider.wellpoint.com/wv. For directions on how to access the *Provider Resources* page of our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

The Wellpoint website offers the most up-to-date clinical resources and guidelines. If you do not have Internet access, request a hard copy of the clinical practice guidelines by calling our Customer Care Center at **800-782-0095**.

Please note: Our recommendation of these guidelines is not an authorization, certification, explanation of benefits or a contract. Actual member benefits and eligibility for services are determined in accordance with the requirements set forth by the state and as set forth in the member's Evidence of Coverage and Member Handbook.

CHAPTER 18: CASE MANAGEMENT

Case Management phone: 304-347-2475
Case Management email: wvcmreferrals@wellpoint.com
Hours of operation: Monday to Friday, 8 a.m. to 5 p.m.

Overview

Case Management is a process that emphasizes teamwork to assess, develop, implement, coordinate and monitor treatment plans in order to optimize our members' healthcare benefits and promote quality outcomes.

Wellpoint's Case Management program, provided at no cost to our members, offers expert assistance in the coordination of complex healthcare. The Case Manager, through interaction with the member, the member's representative and/or providers, collects data and analyzes information about actual and potential care needs for the purpose of developing a treatment plan. Cases referred to the Case Management department may be identified by disease or condition, dollars spent or high utilization of services.

Please note: The Wellpoint Case Management department is sensitive to the impact cultural diversity has on our members and their interaction within the healthcare system. We encourage providers to become familiar with our cultural and linguistic training materials, available on the provider website at provider.wellpoint.com/wv. For directions on how to access the *Provider Resources* page of our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

Role of the case manager

The case manager's role is to assess the member's healthcare status, develop a healthcare plan and:

- Facilitate communication and coordination within the healthcare team.
- Facilitate communication with the member and his or her representative in the decision-making process.
- Educate the providers on the healthcare team and the member about case management, community resources, benefits, cost factors and all related topics to assist in making informed decisions.
- Encourage appropriate use of medical facilities and services, with the goal of improving quality of care and maintaining cost-effectiveness on a case-by-case basis.

The Case Management department includes experienced and credentialed registered nurses, LCSWs and LPCs, some of whom are also certified case managers. The team also includes social workers, who add valuable skills that allow us to address our members' medical needs, as well as psychological, social and financial issues.

Provider responsibilities

PCPs have the responsibility of participating in case management, sharing information and facilitating the process by:

- Referring members who could benefit from case management.
- Sharing information as soon as the PCP identifies complex healthcare needs.
- Collaborating with Case Management staff on an ongoing basis.
- Referring members to specialists, as required.
- Monitoring and updating the care plan to promote healthcare goals.
- Notifying Case Management if members are referred to services provided by the state or some other institution not covered by the Wellpoint agreement.
- Coordinating county- or state-linked services such as public health, behavioral health, schools and waiver programs. The provider may call Case Management for additional assistance.

Case management procedure

When a member has been identified as having a condition that may require case management, the case manager contacts the member and the referring provider (if the referral was from a provider) for an initial assessment. Then, with the involvement of the member, the member's representative and the provider, the case manager develops an individualized care plan. This plan may involve coordinating services with public and behavioral health departments, schools, and other community health resources.

The case manager periodically re-assesses the care plan to monitor the following:

- Progress toward goals
- Necessary revisions
- New issues to be addressed to ensure the member receives the support necessary to achieve care plan goals

After goals are met or case management can no longer impact the case, the case manager closes the case.

Potential referrals

Providers, nurses, social workers and members or their representatives may request Case Management services. Examples of cases appropriate for referral include:

- Children or adults with special healthcare needs requiring coordination of care
- HIV/AIDS
- Chronic illness such as asthma, diabetes and heart failure
- Complex or multiple-care needs such as multiple trauma or cancer

- Frequent hospitalizations or emergency room utilization
- Hemophilia, sickle cell anemia, cystic fibrosis or cerebral palsy
- High-risk or teen pregnancies
- Potential transplants
- Preterm births

Referral process

To request case management services, providers, nurses, social workers, and members or their representatives may call **304-347-2475** or send a *Care Management Referral Form* by email to **wvcmreferrals@wellpoint.com**. A case manager will respond to a request within three business days. Download the *Care Management Referral Form* on the provider website at provider.wellpoint.com/wv. For directions on how to access our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

Behavioral health case management

Wellpoint's behavioral health case management programs are designed to improve member health outcomes by integrating with our medical care programs and making reliable and proven protocols available to providers. Wellpoint's case management is complimentary to and coordinates with any other case management services provided by a provider.

Wellpoint views case management as a continuum of services and supports that are matched on an individualized basis to the needs of the member. Members who are identified as at-risk for hospitalization due to behavioral health or substance use disorders are offered ongoing case management support. Wellpoint's case management services are primarily provided telephonically but can be field based in specific situations.

Wellpoint provides clinical teams staffed with West Virginia-based behavioral health and medical case managers working in close collaboration with community and provider-based case managers. The main functions of the Wellpoint behavioral health case managers include, but are not limited to:

- Use health risk assessment data gathered by Wellpoint from members to identify members who will benefit from engagement in individualized care coordination and case management.
- Use "trigger report data" based upon medical and behavioral health claims to identify members at risk.
- Consult and collaborate with our medical case managers and condition care clinicians regarding members who present with comorbid conditions.

Comorbid is either the presence of one or more disorders (or diseases) in addition to a primary disease or disorder, or the effect of such additional disorders or diseases.

- Refer members to provider-based case management, as clinically appropriate, for ongoing intensive case management and then continue involvement with the member and the provider to coordinate care, when needed, among different agencies, medical providers, etc.
- Work directly with the member and provider based upon the severity of the member's condition.
- Document all actions taken and outcomes achieved for members in Wellpoint's information system to ensure accurate and complete reporting.

Behavioral health case management provider responsibilities

Behavioral Health providers have the responsibility of participating in Case Management, sharing information, and facilitating the process by:

- Referring members who could benefit from Case Management.
- Sharing information as soon as the provider identifies complex healthcare needs.
- Collaborating with Case Management staff on an ongoing basis.
- Referring members to Specialists, as required.
- Monitoring and updating the care plan to promote healthcare goals.
- Notifying Case Management if members are referred to services provided by the state or some other institution not covered by the Wellpoint agreement.

Coordinating county- or state-linked services such as public health, behavioral health, schools, and waiver programs. The provider may call Case Management for additional assistance.

CHAPTER 19: Condition Care Program

Population Health phone: 888-830-4300
Population Health fax: 888-762-3199
Hours of operation: Monday to Friday, 8:30am to 5:30pm.

Overview

Our Condition Care (CNDC) Program is based on a system of coordinated care management interventions and communications designed to assist physicians and other healthcare professionals manage members with chronic conditions.

Condition care services focus on the needs of the member through telephonic and community-based resources. Our team utilizes motivational interviewing techniques in conjunction with member self-empowerment to enhance the member's ability to manage more than one disease and meet their changing healthcare needs.

Who is eligible?

Members diagnosed with one or more of the conditions listed below are eligible for CNDC services:

- Asthma
- Bipolar disorder
- Chronic obstructive disorder (COPD)
- Congestive health failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder — adult and child/adolescent
- Schizophrenia
- Substance use disorder

In addition to our condition-specific condition care programs, our member-centric, holistic approach also allows us to assist members with smoking and weight management education.

Program features

- Proactive population identification process
- Program content is based on evidence-based clinical practice guidelines
- Collaborative practice models that include the physician and support providers in treatment planning

- Continuous self-management education
- Ongoing communication with primary and ancillary providers regarding patient status
- Nine of our Condition Care programs are National Committee for Quality Assurance accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care

Programs are based on nationally recognized approved clinical practice guidelines which are located at provider.wellpoint.com/wv. A copy of the guidelines can be printed from the website.

As a valued provider, we welcome your referrals of patients who can benefit from additional education and case management support. Our case managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk stratified based on the severity of their disease. They are provided with continuous education on self -management concepts, which include primary prevention, coaching related to healthy behaviors and compliance/monitoring as well as case/care management for high-risk members. Providers are given telephonic and/or written updates regarding patient status and progress.

Provider rights and responsibilities

You have the right to:

- Have information about Wellpoint, including:
  - Provided program and services
  - Our staff
  - Our staff's qualifications
  - Any contractual relationships
- Decline to participate in or work with any of our programs and services for your patients
- Be informed of how we coordinate our interventions with your patient's treatment plans
- Know how to contact the person who manages and communicates with your patients
- Be supported by our organization when interacting with patients to make decisions about their healthcare
- Receive courteous and respectful treatment from our staff
- Communicate complaints about CNDC as outlined in the Wellpoint provider complaint and Grievance procedure

Contact information

You can call a Condition Care Team Member at **888-830-4300** or email us at **Condition-Care-Provider-Referrals@wellpoint**. Additional information about CNDC program content is located at provider.wellpoint.com/wv.

CHAPTER 20: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Customer Care Center phone: 800-782-0095
Customer Care Center fax: 888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Overview

Wellpoint operates with an unyielding commitment to meeting our diverse customers' needs. Our vision statement is "Be the most innovative, valuable and inclusive partner."

The plan is committed to excellence in the quality of care and services provided to members, and to the provider networks competency. The plan is dedicated to improving member satisfaction, improving the health status and quality of care for our members and the public, providing value added services, improving member safety, and maintaining member access to medical and behavioral health services.

The plan's QM Program is an ongoing, comprehensive, and integrated system which defines how departments support quality objectively and systematically monitors and evaluates the quality, safety and appropriateness of medical and behavioral healthcare and service the health network offers and identifies and acts on opportunities for improvement. We are evolving and building upon our culture with a focus on continuous improvement. Our values provide an overall foundation for success, helping define what we do and how we do it. The plan lives these values, drive to deliver winning results and raise the bar through continuous improvement. The plan values are:

Leadership – Redefine what's possible
Community – Committed, connected, invested
Integrity – Do the right thing, with a spirit of excellence
Agility – Deliver today – transform tomorrow
Diversity – Open your hearts and minds

Quality improvement program

The QM Program's overall goal is to improve the quality and safety of clinical care and services provided to members through Wellpoint's network of providers and its programs and services. Specific goals are established to support the QM Program purpose. All goals are reviewed annually and revised as needed.

The QM Program goals are to:

- Develop and maintain QM resources, structure and processes that support the organization's commitment to quality healthcare for our members.
- Continuously improve the quality of care and service provided to members.
- Improve or maintain positive member and provider experiences through data analysis and implementing effective interventions.

- Monitor and maintain full compliance with all applicable state, federal and accreditation requirements.
- Implement and oversee a comprehensive Population Health Strategy that addresses:
  - Keeping members healthy.
  - Managing members with emerging risk.
  - Patient safety or outcomes across settings.
- Managing chronic illness.
- Monitor for and maintain patient safety and promote safe clinical practices.
- Determine if vulnerable and special needs populations have adequate access and maintain that access to appropriate care management programs, including Complex Case Management, Case Management and Condition Care and if available LTSS Programs
- Maintain compliance with the Cultural and Linguistically Appropriate Services (CLAS) standards through a Health Disparities Program
- Establish and maintain effective credentialing and re-credentialing processes for providers that comply with state, federal and accreditation requirements
- Provide appropriate access to care by monitoring practitioner and provider access and availability reports
- Provide oversight for all delegated activities to maintain compliance with all state, federal and accrediting organizations

Annually, specific activities and objectives are identified and recorded in the QM Work Plan document along with responsible staff members to monitor the progress to achieving the goals of newly and previously identified issues. Specific time frames for completion of each activity are established.

Healthcare effectiveness data and information set

HEDIS is a national evaluation and a core set of performance measurements gauging the effectiveness of Wellpoint and the network providers in delivering quality care. We are ready to help when the providers and their office staff need training to participate in required HEDIS evaluations. Providers can request consultations and training in the following areas:

- Information about the year's selected HEDIS studies
- How data for those measures will be collected
- Codes associated with each measure
- Tips for smooth coordination of medical record data collection

Wellpoint's QI staff will contact the provider's office when we need to review or copy any medical records required for HEDIS or QI studies. Wellpoint requests that records be returned within five

business days to allow time to abstract the records and request additional information from other providers, if needed. Office staff must provide access to medical records for review and copy, if necessary.

Practitioner/Provider performance data

Practitioners and providers must allow Wellpoint to use performance data in cooperation with our quality improvement program and activities.

Practitioner/provider performance data means compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual healthcare practitioner such as a physician, or a healthcare organization such as a hospital. Common examples of performance data include the HEDIS quality of care measures maintained by NCQA and the comprehensive set of measures maintained by the National Quality Forum (NQF). Practitioner/provider performance data may be used for multiple plan programs and initiatives including but not limited to:

- Reward programs — pay for performance (P4P), pay for value (PFV) and other results-based reimbursement programs that tie provider or facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include but are not limited to shared savings programs, enhanced fee schedules and bundled payment arrangements.
- Recognition programs — programs designed to transparently identify high value providers and facilities and make that information available to consumers, employers, peer practitioners and other healthcare stakeholders.

Quality management

Annually, and in accordance with NCQA standards, Wellpoint analyzes relevant utilization data against established thresholds for each health plan to detect current utilization levels. If our findings fall outside specified target ranges and indicate potential under-utilization or over-utilization, further analysis will occur based on the recommendation of Wellpoint's Quality Management Committee (QMC). The follow-up analysis may include gathering the following data from specific provider and practice sites:

- Case management services needed by members
- Claims payments for covered services
- Coordination with other providers and agencies
- Focus studies
- Investigation and resolution of member and provider complaints and appeals within established time frames
- Retrospective reviews of services provided without authorization

Best practice methods

Best practice methods are Wellpoint's most up-to-date compilation of effective strategies for quality healthcare delivery. We share best practice methods during site visits to provider offices. The Network Management teams offer Wellpoint policies, procedures, and educational toolkits to help guide improvements. Toolkits may include examples of best practices from other offices, including:

- Resources for improving compliance with preventive health services
- Clinical practice guidelines
- Care for members with special or chronic care needs

Member satisfaction surveys

Member satisfaction with our health plan services is measured every year by NCQA. NCQA conducts a member satisfaction survey called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The survey is designed to measure member satisfaction with Wellpoint services, including:

- Access to care
- Physician care and communication with members
- Wellpoint customer service

Each year, Wellpoint shares the results of the CAHPS survey with providers in the Wellpoint network. Providers should review and share the results with office staff and incorporate appropriate changes to their offices in an effort to improve scores.

Provider satisfaction surveys

Wellpoint shall conduct provider surveys to monitor and measure provider satisfaction with Wellpoint's services and to identify areas for improvement. Provider participation in these surveys is highly encouraged and your feedback is very important. We inform providers of the results and plans for improvement through provider bulletins, newsletters, meetings or training sessions.

Facility site and medical record reviews

Wellpoint conducts facility site and medical record reviews to determine provider:

- Compliance with standards for providing and documenting healthcare.
- Compliance with standards for storing medical records.
- Compliance with processes that maintain safety standards and practices.
- Involvement in the continuity and coordination of member care.

Please note: BMS and Wellpoint have the right to enter the premises of providers to inspect, monitor, audit or otherwise evaluate the work performed. We perform all inspections and evaluations in such a manner as to not unduly delay work, in accordance with the provider contract.

Medical record documentation standards

Wellpoint requires providers to maintain medical records in a manner that is current, organized, and permits effective and confidential member care and quality review. We perform medical record reviews of all providers upon signing of a contract and, at a minimum, every three years thereafter to ensure that network providers are in compliance with these standards.

Providers must agree to maintain the confidentiality of member information and other information contained in a member's medical record according to HIPAA standards and HITECH act. The Confidentiality of Medical Information Act prohibits a provider of healthcare from disclosing any individually identifiable information regarding a patient's medical history, mental and physical condition, or treatment without the patient's or legal representative's consent or specific legal authority. The provider will release such information only as permitted by applicable federal, state and local laws. Any information released must be necessary to other providers and the health plan, related to treatment, payment, or healthcare operations. In addition, information must be released upon the member's signed and written consent. Consent forms must be signed by the member and are required each year. The forms will expire one year from the signature date.

Medical record security

Medical records must be secure and inaccessible to unauthorized persons to prevent loss, tampering, disclosure of information, alteration or destruction of the records. Information must be accessible only to authorized personnel within the provider's office, Wellpoint, BMS or to persons authorized through a legal instrument. Records must be made available to Wellpoint for purposes of quality review, HEDIS and other studies. Office personnel will ensure that individual patient conditions or information is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas.

Medical record storage and maintenance

Active medical records must be secured and inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed and organized, permitting effective patient care and quality review while maintaining confidentiality. Inactive records are to remain accessible for a period of time that meets state and federal guidelines.

Electronic record-keeping system procedures must be in place to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures and maintain upkeep of computer systems. Security systems must be in place to provide back-up storage and file recovery, to provide a mechanism to copy documents and to ensure that record input is unalterable.

Availability of medical records

The medical record system must allow for prompt retrieval of each record when the member comes in for a visit. Providers must maintain members' medical records in a detailed and comprehensive manner that accomplishes the following:

- Conforms to good professional medical practice
- Facilitates an accurate system for follow-up treatment

- Permits effective, professional medical review and medical audit processes

Medical records must be legible, signed and dated, and maintained for at least seven years as required by state and federal regulations.

Providers must supply a copy of a member's medical record upon reasonable request by the member at no charge. The provider must facilitate the transfer of the member's medical record to another provider at the member's request. Access to medical records and confidentiality must be provided in accordance with the standards mandated in HIPAA, the HITECH act, and all other state and federal requirements.

Providers must permit Wellpoint and representatives of BMS to review members' medical records for the purposes of monitoring the provider's compliance with the medical record standards, capturing information for clinical studies, monitoring quality, or any other reason. BMS encourages providers to use technology, such as health information exchanges, to transmit and store medical record data.

Medical record requirements

At a minimum, every medical record must include:

- The patient's name or identification (ID) number on each page in the record
- Personal biographical data, including home address, employer, emergency contact name and telephone number, home and work telephone numbers and marital status
- Entries dated with the month, day and year
- Entries containing the author's identification and title. For example, handwritten signature, unique electronic identifier or initials
- Identification of all providers participating in the member's care
- Information on the services furnished by all providers
- List of problems, including significant illnesses, medical conditions and psychological conditions
- Presenting complaints, diagnoses, and treatment plans, including the services to be delivered
- Physical findings relevant to the visit, including vital signs, normal and abnormal findings, and appropriate subjective and objective information
- Information on allergies and adverse reactions, or a notation that the patient has no known allergies or history of adverse reactions
- Information on advance directives
- Past medical history, including serious accidents, operations and illnesses. In addition:
  - For patients 14 years old and older, the record must include information about substance abuse
  - For children and adolescents, the record must include past medical history as relates to prenatal care, birth, operations, and childhood illnesses

- Notations concerning the use of cigarettes, alcohol and substance abuse for patients 14 years and older, including anticipatory guidance and health education
- Physical examinations, treatment required and possible risk factors relevant to the treatment
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Information about the individuals who have been instructed in assisting the patient
- Medical records must be legible, dated, and signed by the provider, physician assistant, nurse practitioner or nurse midwife providing patient care
- Up-to-date immunization records for children, or an appropriate history for adults
- Documentation of attempts to provide immunizations. If the member refuses immunization, document proof of voluntary refusal of the immunization in the form of a signed statement by the member or guardian
- Evidence of preventive screening and services in accordance with Wellpoint's preventive health practice guidelines
- Documentation of referrals, consultations, diagnostic test results and inpatient records. Evidence of the provider's review may include the provider's initials or signature and notation in the patient's medical record. The provider may indicate review and patient contact, follow-up treatment, instructions, return office visits, referrals and other patient information
- Notations of appointment cancellations or No Shows and the attempts to contact the member to reschedule
- No indication or implication that the patient was placed at inappropriate risk by a diagnostic test or therapeutic procedure
- Documentation on whether an interpreter was used in any visit (initial or follow-up)

Misrouted protected health information

Providers and facilities are required to review all member information received from Wellpoint to ensure no misrouted protected health information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email or electronic remittance advice (RA). Providers and facilities are required to destroy immediately any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please contact the Customer Care Center at **800-782-0095**.

Advance directives

Recognizing a person's right to dignity and privacy, our members have the right to execute an advance directive, also known as a living will, to identify their wishes concerning healthcare services should they become incapacitated. Providers may be asked to assist members in procuring and completing the necessary forms. For more information, go provider.wellpoint.com/wv. For directions

on how to access the *Provider Resources* page of our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

Ready access to Advance Directive documents is recommended in the event a member requests this information. Advance Directive documents should be properly noted in the member's medical record, when applicable.

Medical record review process

Wellpoint's QI team will call the provider's office to schedule a medical record review on a date and time that will occur within 30 days. On the day of the review, the QI staff will:

1. Request the number and type of medical records required.
2. Review the appropriate number and type of medical records per provider.
3. Complete the medical record review.
4. Meet with the provider or office manager to review and discuss the results of the medical record review.
5. Provide a copy of the medical record review results to the office manager or provider or send a final copy within 10 days of the review.
6. Schedule follow-up reviews for any corrective actions identified.

Providers must attain a score of 80% or greater to pass the medical record review.

Facility site review process

An initial facility site review and inspection is required for all PCP sites, OB/GYNs and high volume specialists participating in the Wellpoint program.
A facility site review inspection consists of 13 elements, including the following:

1. Accessibility
2. Appearance
3. Safety and infectious waste disposal
4. Office policies
5. Provider availability
6. Treatment areas
7. Patient services
8. Process of documentation
9. Personnel
10. Medications, including emergency supplies
11. Referral process
12. Medical records elements and organization
13. Appointment accessibility

A facility site review is required if the site has not been previously reviewed and accepted as part of Wellpoint's credentialing process. In addition:

- Facility site reviews are required as part of the initial credentialing process for new providers, as well as every three years. In addition, if a provider reaches a threshold of three complaints in a rolling twelve months, a facility site review will be conducted.

- OB/GYN specialty sites and high volume specialists participating in the Wellpoint program and not serving as PCPs must undergo an initial site inspection.
- Practitioners must notify Wellpoint when relocating to a new site or when adding a new site. If a review has not been previously performed at the new site, Wellpoint will perform a facility site review prior to members being seen.

A Wellpoint department associate will call the provider's office to schedule an appointment date and time before the facility site review due date. The associate will fax or mail a confirmation letter with an explanation of the audit process and required documentation. During the facility site review, the QI associate will:

1. Lead a pre-review conference with the provider or office manager to review and discuss the facility review process and answer any questions.
2. Conduct the facility site review.
3. Complete the facility site review.
4. Develop a corrective action plan, if applicable.

After the facility site review is completed, Wellpoint's associate will meet with the provider or office manager to:

1. Review and discuss the results of the facility site review and explain any required corrective actions.
2. Provide a copy of the facility site review results and the corrective action plan to the office manager or provider. Or the QI associate may send a final copy within 10 days of the review.
3. Educate the provider and office staff about Wellpoint standards and policies.
4. Schedule a follow-up review for any corrective actions identified.

Providers must attain a score of 80% or greater with no deficiencies in critical elements to pass the facility site review.

Critical Elements: Critical elements include making sure sharps containers are present, autoclave spore testing*, universal precautions, medication storage, and availability of emergency equipment*. Full compliance with critical elements must be attained.

* When applicable.

Facility site review: corrective actions

If the facility site review results in a non passing score, Wellpoint will notify providers immediately of the non passing score, all cited deficiencies and corrective action requirements. The provider office will develop and submit a corrective action plan. Wellpoint will conduct follow-up visits every six months until the site complies with Wellpoint standards.
The provider and office staff will:

- Submit a corrective action plan with verification for all critical elements and/or other survey deficiencies requiring immediate correction within 10 business days of the survey. Critical element deficiencies will be re-evaluated within 30 days of the site visit. Additional time may be granted, if necessary.

- Submit a corrective action plan for all other deficiencies within 30 days of the survey.

If deficiencies (other than critical) are not closed within 60 days of the date of the written corrective action plan request, or if the provider is otherwise uncooperative with resolving outstanding issues with the facility site review, the provider will be considered noncompliant.

Preventable adverse events

Providers and healthcare systems, as advocates for our members, are responsible for the continuous monitoring, implementation, and enforcement of applicable healthcare standards. We strive and reinforce efforts to build a safer, equitable, high-quality healthcare system and decrease the occurrence of patient safety events, provider preventable conditions (PPCs), and hospital-acquired conditions (both referred to as HCACs). We advocate for a safety culture that improves the delivery of healthcare, health outcomes, and alignment with national patient safety efforts. In doing so, we are committed to working collaboratively with network providers and hospitals to promote safe practices and to identify and implement appropriate strategies, processes, and technologies to address and avoid PPCs and HCACs, including as it applies to health disparities. Our goal is to enhance the quality of care received not only by our members, but by all patients receiving care within individual practices, in these facilities, and across the healthcare continuum.

The breadth and complexity of today's healthcare system means there are inherent risks, many of which can be neither predicted nor prevented. However, when there are preventable adverse events, they should be tracked and reduced, with the ultimate goal of elimination.

Prevention of adverse events may require the disclosure of PHI. HIPAA specifies that PHI may be disclosed for the purpose of healthcare operations in relation to quality assessment and improvement activities. The information shared with us is legally protected through the peer review process and will be maintained in a strictly confidential manner. If you receive a request for medical records, please provide the records within 10 days of the date of the request.

We will continue to monitor activities related to the list of adverse events from federal, state and private payers, including Never Events.

Never Events: As defined by the National Quality Forum (NQF), Never Events are adverse events that are serious, but largely preventable, and of concern to both the public and healthcare providers.

Provider preventable adverse conditions and HCACs should not occur. When they do, we firmly support the concept that a health plan and its members should not pay for resultant services, remaining consistent with CMS payment policy and as stated in Wellpoint's reimbursement policy/contracts.

Section 2702(a) of the Affordable Care Act prohibits Federal financial participation (FFP) payments to states for any amounts expended for providing medical assistance for provider preventable conditions (PPCs), including healthcare-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs). PPCs are hospital-acquired conditions not present on hospital admission, the

wrong procedure performed on a patient, and procedures performed on a wrong patient or body part.

The MCO may not make payments for PPCs as defined by the federal regulations and BMS policy in accordance with 42 CFR 438.6. The MCO will track PPC data and make it available to BMS upon request.

Please note: Medicaid is prohibited from paying for certain healthcare acquired conditions (HCAC). This applies to all hospitals.

Practitioner/Provider performance data

Practitioner/Provider performance data means compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual healthcare practitioner, such as a physician, or a healthcare organization, such as a hospital.

Common examples of performance data would include the HEDIS quality of care measures maintained by the National Committee for Quality Assurance (NCQA) and the comprehensive set of measures maintained by the National Quality Forum (NQF).

Practitioner/provider performance data may be used for multiple plan programs and initiatives, including but not limited to:

- Reward programs — pay for performance (P4P), pay for value (PFV) and other results-based reimbursement programs that tie provider or facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include but are not limited to shared savings programs, enhanced fee schedules and bundled payment arrangements.
- Recognition programs — programs designed to transparently identify high value providers and facilities and make that information available to consumers, employers, peer practitioners and other healthcare stakeholders.

CHAPTER 21: ENROLLMENT AND MARKETING RULES

Customer Care Center phone: 800-782-0095
Customer Care Center fax: 888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Overview

The delivery of quality healthcare poses numerous challenges, not the least of which is the commitment shared by Wellpoint and providers to protect our members. We want our members to make the best healthcare decisions possible. And when members ask for our assistance, we want to provide that assistance so they make those decisions without undue influence.

Wellpoint recognizes that providers occupy a unique, trusted and respected part of people's lives. Given the complexity of modern-day healthcare and the inherent difficulties communicating with some of the populations we serve, there are potential pitfalls when Wellpoint or providers try to assist in the decision-making process. Sometimes, even though the intent is to help make our members' lives better, we may overstep.

For that reason, we are committed to following the enrollment and marketing guidelines created by the West Virginia Bureau for Medical Services (BMS), and to honoring the rules for all state healthcare programs.

Marketing policies

Providers serving members enrolled in Medicaid Managed Care are required to comply with the federal marketing regulations in 42 CFR 438.104, as well as marketing policies set forth by BMS in its contract with MCOs. Under these regulations both MCOs and providers are prohibited from the following activities:

- Engaging in direct marketing to enrollees that is designed to increase enrollment in a particular MCO
- Distributing marketing materials written above the 6th grade reading level, unless approved by the department
- Distributing gifts from MCOs directly to the MCO's potential members or currently enrolled members
- Distributing directly or through any agent or independent contractor marketing materials that contain false or misleading information
- Making any assertion or statement (orally or in writing) that the any MCO is endorsed by CMS, a federal or state government agency, or similar entity
- Using terms that would influence, mislead, or cause potential members to contact an MCO, rather than the enrollment broker, for enrollment
- Making any written or oral statements containing material misrepresentations of fact or law relating to an MCO's plan or the Medicaid program, services, or benefits

- Making potential member gifts conditional based on enrollment with the MCO
- Posting MCO-specific, non-health related materials or banners in provider offices
- Conducting potential member orientation in common areas of providers' offices
- Soliciting enrollment or disenrollment in any MCO, or distributing MCO-specific materials at a marketing activity (This does not apply to health fairs where providers do immunizations, blood pressure checks, etc. as long as the provider is not soliciting enrollment or distributing plan specific MCO materials.)
- Discriminating against a member or potential member because of race, age, color, religion, natural origin, ancestry, marital status, gender, gender identity, sexual orientation, physical or mental disability, health status or existing need for medical care, with the following exception: certain gifts and services may be made available to members with certain diagnoses
- Assisting with Medicaid or CHIP MCO enrollment form
- Making false, misleading or inaccurate statements relating to services or benefits of the MCO or Medicaid program, or relating to the providers or potential providers contracting with the MCO
- Using social media as a means to:
- Post or send protected private information
- Advertise via direct communication with potential members
  - Directly respond to any members for anything other than a general response (such as MCO phone number or website links)
  - Partake in individual communication
  - Request or add followers or friends
  - Tag individuals

Enrollment process

BMS determines the eligibility and enrollment for Wellpoint members. The enrollment process is as follows:

- The enrollment broker presents managed healthcare plan options to individuals and families eligible for Wellpoint.
- Eligible members enroll in the plan of their choice and select a PCP; or, Wellpoint assigns a PCP to the member. The head-of-household completes applications and makes selections on behalf of children eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.
- The enrollment broker informs Wellpoint of new member enrollment. After enrollment, the broker updates Wellpoint about any changes in member eligibility, status, or contact information, such as change of address.

- Wellpoint notifies providers about newly assigned members through monthly enrollment rosters. Providers also have access to these rosters by logging into our secure provider website at provider.wellpoint.com/wv.
- Wellpoint sends each new member a New Member Kit within one week of receiving the BMS monthly enrollment roster. This kit includes a Quick Start Guide, a letter, and the Evidence of Coverage.
- Wellpoint sends the member ID card within five days of receiving the monthly enrollment roster. The ID card includes the PCP contact information.

Please note: BMS will re-enroll any member automatically who loses Wellpoint eligibility but becomes eligible again within one year or less. Members will return to the same healthcare plan and PCP they had prior to disenrollment, if available. Members also may choose to switch plans at the time of re-enrollment.

Please note: To support the member enrollment process, PCPs are encouraged to maintain open panels.

Open panels: The commitment by Wellpoint-contracted providers to accept new Wellpoint members.

Enrolling newborns

Initially, a newborn is covered under the mother's plan. Newborn delivery notification is required using the *Newborn Enrollment Notification Report*. Complete the entire form and include the newborn's name, date of birth and other pertinent information. Fax the completed form to **855-402-6983**.

To prevent delay in Wellpoint coverage for newborns, submit the *Newborn Enrollment Notification Report* to notify Wellpoint about delivery within three days of the delivery.

Request that your patients take these steps as soon as their babies are born:

- Immediately contact BMS or their social worker to request the required paperwork
- Fill out and return the required paperwork to the state to enroll their newborn in Medicaid or CHIP

The *Newborn Enrollment Notification Report* is located at provider.wellpoint.com/wv > **Resources > Forms**. For directions on how to our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

Please note: To admit a baby for health reasons beyond a normal nursery admission, complete the *Request for Preservice Review* form in addition to the *Newborn Enrollment Notification Report*. The *Request for Preservice Review* form is located at provider.wellpoint.com/wv.

For directions on how to access our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

CHAPTER 22: FRAUD, WASTE AND ABUSE

Customer Care Center phone: 800-782-0095
Customer Care Center fax: 888-438-5209
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

We are committed to protecting the integrity of our healthcare program and the effectiveness of our operations by preventing, detecting and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

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

To help prevent fraud, waste and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Learn more at www.fighthealthcarefraud.com.

For samples of the member ID card, refer to the **Member Identification Cards** section.
Presentation of a member identification card does not guarantee eligibility; providers should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries on the website and telephonic verification may be obtained through the automated Customer Care Center at **800-782-0095**.

Providers should encourage members to protect their identification cards as they would a credit card, to carry their health benefits card at all times, and report any lost or stolen cards to our company as soon as possible. Understanding the various opportunities for fraud and working with members to protect their health benefit ID card can help prevent fraudulent activities. Providers should instruct their patients who have lost their member ID card or found errors on their explanation of benefits (EOB), to contact Customer Care, **800-782-0095**.

Reporting fraud, waste and abuse

If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste or abuse, you have the right to report it. No individual who reports violations or suspected fraud and

abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her callback number is kept in strict confidence by the Special Investigations Unit (SIU).

Report your concerns by:

- Visiting our website and completing the *Report Waste, Fraud and Abuse* form at www.fighthealthcarefraud.com and then select **Report It**.
- Calling the SIU hotline, **866-847-8247**

Any incident of fraud, waste, or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of provider fraud, waste and abuse

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

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

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

Examples of member fraud, waste and abuse

- Forging, altering, or selling prescriptions
- Letting someone else use the member's identification card
- Relocating to out-of-service plan area and not notifying us
- Using someone else's identification card

When reporting concerns involving a member include:

- The member's name
- The member's date of birth, member ID, or case number if you have it
- The city where the member resides
- Specific details describing the fraud, waste, or abuse

Investigation process

Our Special Investigations Unit (SIU) reviews all reports of provider or member fraud, waste, and abuse for all services. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste, or abuse, which may include but is not limited to:

- *Written warning and/or education*: We send secure/trackable communications to the provider documenting the issues and the need for improvement. Correspondence may include education or requests for recoveries, or may advise of further action.
- *Medical record review*: We review medical records in context to previously submitted claims and/or to substantiate allegations.
- *Prepayment Review*: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- *Recoveries*: We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment on future claims or further legal action.

If you are working with the SIU all checks and postal correspondence should be sent to:
Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Instructions for sending paper medical records and/or claims when working with the SIU is found in correspondence from the SIU. If you have questions, contact your investigator. Delays for claim and/or medical record review, and ultimately resolution of an investigation may be delayed if SIU-supplied instructions are not followed. An opportunity to submit claims and medical records

electronically is an option if you register for an Availity account. Contact Availity Client Services at 800-AVAILITY (282-4548) for more information.

About prepayment review

One method we use to detect FWA is through prepayment claim review. Through a variety of means, certain providers (facilities or professionals), or certain claims submitted by providers, may come to our attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or claims activity that indicates the provider is an outlier compared to his/her/its peers.

Once a claim, or a provider, is identified as an outlier or has otherwise come to our attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination the provider's action(s) may involve FWA, unless exigent circumstances exist, the provider is notified of their placement on prepayment review and given an opportunity to respond.

When a provider is on prepayment review, the provider will be required to submit medical records and any other supporting documentation with each claim so the SIU can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation in accordance with this requirement will result in a denial of the claim under review. The provider will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, we may review coding, documentation, and other billing issues. In addition, one or more clinical utilization management guidelines may be used in the review of claims submitted by the provider, even if those guidelines are not used for all providers delivering services to plan members.

The provider will remain subject to the prepayment review process until the health plan is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the provider could face corrective measures, up to and including termination from the network at the direction of the State.

Providers are prohibited from billing a member for services the health plan has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers whose claims are determined to be not payable may make appropriate corrections and resubmit such claims in accordance with the terms of their Provider Agreement, proper billing procedures and state law. Providers also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Acting on Investigative Findings

If, after investigation, the SIU determines a provider appears to have committed fraud, waste, or abuse the provider:

- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination
- Will be referred to other authorities as applicable and/or designated by the State
- The SIU will refer all suspected criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily disenrolled from our healthcare plan with state approval.

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

Relevant legislation

False Claims Act

We are committed to complying with all applicable federal and state laws, including the Federal *False Claims Act (FCA)*. The *FCA* is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the *FCA*, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of $5,500 to $11,000 per false claim. The *FCA* also contains *qui tam* or whistleblower provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under *qui tam* provisions in the *FCA* and may be entitled to a percentage of the funds recovered by the government.

HIPAA

The *Health Insurance Portability and Accountability Act (HIPAA)* was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of healthcare fraud and simplifies the administration of health insurance.

- Our company recognizes its responsibility under *HIPAA* privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose; conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting us; however, privacy regulations allow the transfer or sharing of member information. Our company may request information to conduct business and make decisions about care such as a member's medical record, authorization determinations or payment appeal resolutions. Such requests are considered part of the HIPAA definition of treatment, payment or healthcare operations.
- Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to us, verify the receiving fax number is correct, notify the appropriate staff at our company and verify the fax was received.
- Email (unless encrypted and/or transferred by another secure service) should not be used to transfer files containing member information (e.g., Excel spreadsheets with claim information; such information should be mailed or faxed.)
- Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked "confidential" and addressed to a specific individual, P.O. Box or department at our company.
- Our company voicemail system is secure and password protected. When leaving messages for any of our associates, leave only the minimum amount of member information required to accomplish the intended purpose.
- When contacting us, please be prepared to verify the provider's name, address and tax identification number (TIN) or member's provider number.
- All laws regarding the privacy, security and confidentiality of healthcare information and a patient's rights to his or her medical information and personal information shall apply to Telehealth interactions. This section shall not be construed to alter the scope of practice of any healthcare provider or authorize the delivery of healthcare services in a setting, or in a manner, not otherwise authorized by law. Telehealth services are used to support healthcare when the provider and patient are physically separated. Typically, the patient communicates with the provider via interactive means i.e. live audio/video feed. Participating providers and facilities shall be solely responsible for ensuring the security and privacy of their interactive audio/video platform. Such platform must at a minimum include technical, administrative and physical safeguards to ensure that all information pertaining to covered members is protected in accordance with applicable law utilizing controls equivalent to those necessary for compliance with the Health Insurance Portability and Accountability Act ("HIPAA").

Employee education about the *False Claims Act*

As a requirement of the *Deficit Reduction Act of 2005*, contracted providers who receive Medicaid payments of at least $5 million (cumulative from all sources), must comply with the following:

- Establish written policies for all employees, managers, officers, contractors, subcontractors and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in section *1902(a)(68)(A)*.
- Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, waste and abuse. Include in any employee handbook a specific discussion of the laws described in *Section 1902(a) (68) (A)*, the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, waste and abuse.

HITECH

To comply with *HIPAA Public Law 104-191* and the *Health Information Technology for Economic and Clinical Health Act (HITECH Act)* at *42 U.S.C. 17931 et.seq.* the *Contract* (and addenda) must explain that the provider must treat all information that is obtained through the performance of the services included in the provider *Contract* as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes, but is not limited to, information relating to applicants or enrollees of BMS programs.

CHAPTER 23: MEMBER RIGHTS AND RESPONSIBILITIES

Customer Care Center phone: 800-782-0095
Customer Care Center fax: 800-438-5209
Availity Chat with Payer: https://Availity.com
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Overview

Members should be clearly informed about their rights and responsibilities so they can make the best healthcare decisions. Members also have the right to ask questions about the way we conduct business, as well as the responsibility to learn about their healthcare coverage.

The member rights and responsibilities in this chapter are defined by the state of West Virginia and appear in the Wellpoint member welcome packets. You may view the Member Rights and Responsibilities in the *Join Our Network* section of the *Our Network* page at provider.wellpoint.com/wv > **Our Network > Member Rights and Responsibilities**. For directions on how to access the *Provider Resources* page of our website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

Members have certain rights and responsibilities when receiving their healthcare. They have a responsibility to take an active role in their care. We are committed to making sure members' rights are respected while providing their health benefits. This also means providing access to Wellpoint network providers and the information members need to make the best decisions for their health and welfare. Each member is free to exercise their rights, and the exercise of those rights does not adversely affect the way Wellpoint, Wellpoint's network providers, or the State agency treats the member.

Member rights

Members have the right to:

- Learn about their rights and responsibilities.
- Get the help they need to understand the Evidence of Coverage and Member Handbook.
- Learn about us, our services, doctors, and other healthcare providers.
- See their medical records as allowed by law.
- Have their medical records kept private unless they tell us in writing that it's OK for us to share them or it is allowed by law.
- Be part of candid discussions about appropriate or medically necessary treatment options for their conditions, healthcare needs, and treatment options no matter the cost and whether their benefits cover them.
- Be part of decisions that are made by their doctors and other providers about their healthcare needs.
- Be told about other treatment choices or plans for care in a way that fits their condition.

- Get news about how doctors are paid.
- Find out how we decide if new technology or treatment should be part of a benefit.
- Be treated with respect, dignity, and the right to privacy all the time.
- Know that we, their doctors, and their other healthcare providers cannot treat them in a different way because of their age, gender, gender identity, sexual orientation, race, national origin, language needs, or degree of illness or health condition.
- Talk to their doctor about things that are private.
- Have problems taken care of fast, including things they think are wrong, as well as issues about getting an OK from us, their coverage, or payment of service.
- Be treated the same as others.
- Get care that should be done for medical reasons.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Choose their PCP from the PCPs in our provider directory that are taking new patients.
- Use providers who are in our network.
- Get medical care in a timely manner.
- Get services from providers outside our network in an emergency.
- Refuse care from their PCP or other caregivers.
- Be able to make choices about their healthcare.
- Make an advance directive (also called a living will).
- Tell us their concerns about Wellpoint and the healthcare services they get.
- Question a decision we make about coverage for care they got from their doctor.
- File a complaint or an appeal about Wellpoint, any care they get or if their language needs are not met.
- Ask how many grievances and appeals have been filed and why.
- Tell us what they think about their rights and responsibilities and suggest changes.
- Ask us about our Quality Improvement (QI) program and tell us how they would like to see changes made.
- Ask us about our utilization review process and give us ideas on how to change it.
- Know that the date they joined our health plan is used to decide their benefits.
- Know that we only cover healthcare services that are part of their plan.
- Know that we can make changes to their health plan benefits as long as we tell them about those changes in writing.

- Ask for their Evidence of Coverage and Member Handbook and other member materials in other formats such as large print, audio CD, or Braille at no charge to them.
- Ask for an oral Interpreter and translation services at no cost to them.
- Use interpreters who are not their family members or friends.
- Know they will not be held liable if their health plan becomes bankrupt (insolvent).
- Know their provider can challenge the denial of service with their OK.

Member responsibilities

Members have the responsibility to:

- Supply information (to the extent possible) that Wellpoint and its
- practitioners and providers need in order to provide care. Learn as much as they can about their health issue and work with their provider to set up treatment goals they agree on.
- Ask questions about any medical issue and make sure they understand what their provider tells them.
- Follow the care plan and instructions, to the best of their ability, that they have agreed on with their provider or other healthcare professionals.
- Do the things that keep them from getting sick.
- Make and keep medical appointments and tell their provider at least 24 hours in advance when they cannot make it.
- Always show their member identification (ID) card when they get healthcare services.
- Use the emergency room only in cases of an emergency or as their provider tells them.
- Tell us right away if they get a bill that they should not have gotten or if they have a complaint.
- Treat all Wellpoint staff and doctors with respect and courtesy.
- Know and follow the rules of their health plan.
- Know that laws guide their health plan and the services they get.
- Know that we do not take the place of workers' compensation insurance.
- Tell us and their Department of Human Services (DoHS) case worker when they change their address, family status or other healthcare coverage.

Availity Chat with Payer is available during normal business hours. Get answers to your questions about eligibility, benefits, authorizations, claims status, and more. To access Availity Essentials, go to https://Availity.com and select the appropriate payer space tile from the drop-down. Then, select Chat with Payer and complete the pre-chat form to start your chat.

CHAPTER 24: CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES, IMPLICIT BIAS, AND SOCIAL DETERMINATS OF HEALTH

Customer Care Center phone: 800-782-0095
Customer Care Center fax: 888-438-5209
Availity Chat with Payer: https://Availity.com
Hours of operation: Monday to Friday, 8 a.m. to 6 p.m.

Patient panels are increasingly diverse and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. In addition to Cultural Competency training, Wellpoint offers Social Determinants of Health (SDoH) training, Screening, Brief Intervention, and Referral to Treatment (SBIRT) trainings and more via the Wellpoint provider portal under the Provider Training Academy (**provider.wellpoint.com/wv > Resources > Provider Training Academy**). Wellpoint wants to help, as we all work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed, how symptoms are described,
- Expectations of care and treatment options,
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine. Providers should develop training program(s) for staff, including but not limited to, member needs to help address physical, behavioral, and environmental health (for example, Adverse Childhood Experiences and motivational interviewing). Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values and preferred means of having those needs met
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for limited English proficient patients.

- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

Wellpoint ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. Wellpoint encourages providers to access and utilize MyDiversePatients.com.

MyDiversePatients.com: The My Diverse Patient website offers resources, information, and techniques, to help provide the individualized care every patient deserves regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD**: Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **My Inclusive Practice - Improving Care for LGBTQIA+ Patients:** Helps providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients, & develop strategies for providing effective healthcare to LGBTQIA+ patients.
- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a healthcare encounter.
- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations & learn techniques to improve patient-centered communication to support needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- **Reducing Health Care Stereotype Threat (HCST):** Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

Cultural Competency Training (Cultural Competency and Patient Engagement): A training resource to increase cultural and disability competency to help effectively support the health and healthcare needs of your diverse patients.

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients.

Wellpoint appreciates the shared commitment to ensuring members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

Language capability of providers and office staff

Wellpoint strives to have a provider network that can meet the linguistic needs of our members. An important component is being aware of the language capabilities of you and your office staff. Use the Employee Language Prescreening Tool, found in the *Caring for Diverse Populations* toolkit, to help begin assessing the level of proficiency with non-English languages. Please provide updates on the language capabilities of your office staff annually and at least every three years for yourself. In addition to meeting the linguistic needs of our members, Wellpoint strives to meet the ethnic and cultural preference of our members. An important component of this is capturing ethnicity data during the credentialing process. Language capability and provider ethnicity information will be reported in the provider directory to help members find a provider and/or office that can communicate in their preferred language and meets their cultural preferences.

Provide these updates using the *Provider Maintenance Form* by navigating to provider.wellpoint.com/wv and selecting **Forms**.

Interpreter services

For those instances when you cannot communicate with a member due to language barriers, interpreter services are available at no cost to you or the member. Wellpoint provides over-the-phone and face-to-face Interpreters. Providers must notify members of the availability of interpreter services and strongly discourage the use of friends and family, particularly minors, to act as Interpreters. You or your office staff should document the member's preferred language other than English in the member's medical record, any refusal of interpreter services, and requests to use a family member or friend as an Interpreter.

Face-to-face interpreters for members needing language assistance, including American Sign Language, are available by placing a request at least 72 hours in advance. A 24-hour cancellation notice is required. Over-the-phone interpreters are available 24 hours a day, 7 days a week.

To request interpreter services, providers and members should call Wellpoint's Customer Care Center at **800-782-0095**. For after-hours nurse services, call the 24/7 NurseLine at **888-850-1108**. Take the following steps to initiate interpreter services when a member is on the phone line with you:

1. Give the member's identification (ID) number to the Customer Care or 24/7 NurseLine associate.
2. Explain the need for an interpreter and state the language required.
3. Wait on the line while the connection is made.
4. Once connected to the interpreter, the Customer Care or 24/7 NurseLine associate introduces the Wellpoint member, explains the reason for the call, and begins the dialogue.

For members with hearing or speech loss, West Virginia Relay Service is a toll-free TDD service. Call **711** or the following numbers:

- For voice to TDD: **866-368-1634**
- For TDD to voice: **800-982-8771**

For additional information on interpreter services, access the *Interpreter services* section of the *Provider Training Academy* page at provider.wellpoint.com/wv > **Resources > Provider Training Academy**. For directions on how to access the provider website, please see **Chapter 1: Accessing Information, Forms and Tools on Our Website**.

Americans with Disabilities Act

Providers must comply with all applicable federal and state laws in assuring accessibility to all services for members with disabilities, pursuant to the *Americans with Disabilities Act (ADA)* and the *Rehabilitation Act of 1973,* maintaining the capacity to deliver services in a manner that accommodates the needs of its members. Providers contracted with Wellpoint are required by law to provide disabled persons full and equal access to medical services.

Although a review of the requirements of the law and implementing regulations can be daunting, providing full and equal access to persons with disabilities can be achieved by:

- Removing physical barriers.
- Providing means for effective communication with people who have vision, hearing or speech disabilities, including providing auxiliary aids as needed.
- Providing flexibility in scheduling to accommodate people with disabilities.
- Allowing extra time for members with disabilities to dress and undress, transfer to examination tables, and extra time with the provider in order to ensure the individual is fully participating and understands the information.
- Making reasonable modifications to policies, practices, and procedures.

For more information on making changes to a practice to ensure ADA compliance, providers can refer to these additional resources:

- https://www.ada.gov
- https://www.ada.gov/medcare_mobility_ta/medcare_ta.htm

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WVWP-CD-062747-24