wellcare® With delaware first health®

Wellcare With Delaware First Health

Provider Manual

2027

©2027 Wellcare

7292163DE_7PDULPME_WCDE
Internal Approved 09102026

Partners in Quality Care

Dear Provider Partner,

At Wellcare, we deeply value your commitment to delivering compassionate, high-quality care to our members — your patients. Your role is essential in helping us serve individuals who rely on both Medicare and Medicaid, many of whom face complex health and social challenges.

Together, we ensure our members receive the coordinated care they need to live healthier, more fulfilling lives.

We are committed to quality — and that means supporting you with the tools, resources, and programs that help remove barriers to care. Whether it's identifying care gaps, navigating benefits, or addressing social needs, we're here to work alongside you and your team.

As part of our partnership, we also recognize and reward your efforts to close care gaps and improve outcomes. Your dedication makes a meaningful difference.

The enclosed D-SNP Provider Manual is your guide to working with Wellcare. We encourage you to explore the highlighted sections, which reflect our shared goal of delivering integrated, person-centered care.

Thank you for being a trusted Wellcare provider partner.

Sincerely,

Wellcare

©2027 Wellcare

5248563_DE6PDULINSE
Internal Approved 09102026

TABLE OF CONTENTS

2027 D-SNP(Duals) Provider Manual Revision Table 6

Section 1: General Information 7

Background 7

HIDE-SNP Program Commitment and Transition Pillars 7

Integrated Care Transition Pillars 7

Program Launch and Implementation 8

How to Use this Manual 8

Updates and Revisions 9

Key Contact Information 9

Section 2: Member Benefit Information 11

Member Eligibility and Enrollment 11

Exclusions from Enrollment 11

Non-Discrimination Statement 11

Member Rights and Responsibilities 12

Access to Information 12

Language and Disability Services 12

Dignity, Privacy, and Nondiscrimination 12

Participation in Care 13

Grievances, Appeals, and Involvement 13

Final Protections 13

Reasonable Accommodations 13

Member Benefits and Services 14

Additional Notes 14

Non-Covered Services 15

Behavioral Health and Other Services Managed Outside the Plan 15

Member ID Cards 15

Provider Support 16

Special Supplemental Benefits for the Chronically Ill (SSBCI) 17

Pharmacy Benefit Management 18

Member Self-Referrals 19
Family Planning 19
Women's Health 20
Federally Qualified Health Centers (FQHC) 20
Non-Emergency Transportation 20
Accessing Non-Emergent Transportation Services 20
Emergency Services 21
Definitions 22
24 Hour Nurse Advice Line 24
Member Grievance 24
Member Appeals 25
Non-Urgent Pre-Service Appeal 26
Appeals 26
External Review of an Appeal (Expedited) 27
External Review of an Appeal (Non-Expedited) 27
Section 3: Provider Functions and Responsibilities 29
Primary Care/Managed Care Program 29
Primary Care Provider (PCP) Roles and Responsibilities 29
Specialty Care Provider Roles and Responsibilities 29
Hospital Roles and Responsibilities 30
Ancillary/Organization Provider Roles and Responsibilities 30
Appointment Standards 30
Confidentiality and Accuracy of Member Records 33
Obligations of Recipients of Federal Funds 34
Exclusion Screening and Program Integrity 34
Reporting Requirements 35
OSHA Training 35
Provider Credentialing/Re-Credentialing 36
Appeals Process 36
Section 4: Utilization Management 38
UM Decisions 38

Classifying Your Prior Authorization Request 39
Inpatient Review 39
Prior Approval Requirements/ Precertification 40
CMS Interoperability APIs — Provider Overview 41
Prior Authorization API 41
Provider Access API 41
Additional Interoperability APIs 41
Clinical Information 42
Clinical Practice Guidelines 42
Services Requiring Prior Authorization 43
Mental Health Outpatient Visits for Members with MILD-TO-Moderate Behavioral Health Care Needs 44
Specialty Network Access to Care 44
Denials and Reconsiderations 45
Model of Care Overview 45
Care Coordination 45
Evolent 46
Advanced Diagnostic Imaging 46
Cardiac Solutions 47
Program Components 47
Physical Medicine Program 48
Interventional Pain Management 48
Musculoskeletal (MSK) Management Program 49
Medical and Radiation Oncology 49
Cardiology Surgical Procedures 51
Section 5: Billing and Claims Payment 53
Overview 53
Clean Claim Submission 53
Important Steps to Successful Submission of Claims 53
Claims Billing Requirement 55
Taxonomy Codes 56
Federally Qualified Health Center (FQHC)/Freestanding Rural Health Clinic (RHC)/Encounter Rate Clinic (ERC) 56

FQHC, RHC, and ERC Billing Requirements: 56
Billing by Payor Type 56
Electronic Claims Submission 57
Clearinghouses 57
Paper Claims Submission 58
PaySpan® Electronic Payments & Remittance 58
Overview 58
Enrollment 58
How to Access PaySpan 59
Support & Assistance 59
Timely Filing of Claims 59
Corrected Claims 59
Overpayments 60
Retroactive Adjustments 60
Reimbursement Guidelines, Payment Polices and Coding Guidance 60
Member Billing 60
Post-Service Provider Appeals 60
Section 6: Reporting Requirements 64
Mandatory Reporting of Suspected Child and Dependent Adult Abuse 64
Critical Incidents Reporting 64
Incident Reporting 64
Corporate Reporting Requirements 65
Encounter Reporting Requirements 65
Electronic Visit Verification 66
What is Electronic Visit Verification (EVV)? 66
Why was the EVV system implemented? 66
What services require EVV? 66
Services Requiring EVV 66
Required Data Elements 67
EVV System Model 68
Provider Responsibilities 68

Section 7: Compliance and regulatory Requirements 69
FRAUD, WASTE & ABUSE (FWA) Program 69
Purpose and Commitment 69
Definitions (42 CFR §455.2 and HHS Definitions) 69
Examples of FWA and Improper Billing Practices 70
Provider Responsibilities and Cooperation Requirements 70
Reporting 70
Cooperation with Audits and Investigations 71
Documentation Standards 71
Special Investigations Unit (SIU) 71
FWA Detection and Monitoring 71
Post-Payment (Post-Processing) Claims Audits/Investigations 72
Overview 72
Medical Record Requests and Timeframes 72
Failure to Submit Records / Insufficient Documentation 72
Findings Communication, Overpayments, and Recovery 73
Findings Results Letter 73
Overpayment Methodology 73
Appeal of Overpayment 73
Required FWA Training and Screening Requirements 73
Exclusion / Preclusion Screening (Medicare Networks) 74
Reporting Suspected Fraud, Waste, or Abuse 74
False Claims Act (Overview) 74

2027 D-SNP(DUALS) PROVIDER MANUAL REVISION TABLE

Date	Section	Sub-Header	Comments
1/1/2027	2: Member Benefit Information	Sample Member ID Card Special Supplemental Benefits for the Chronically Ill (SSBCI):	Updated member ID card sample; Added section
1/1/2027	3: Provider Functions and Responsibilities	Confidentiality and Accuracy of Member Records Exclusion Screening and Program Integrity Provider Credentialing/Re-Credentialing Appeals Process	Updated list; Updated source list; Updated language; Added section
1/1/2027	4: Utilization Management	UM Decisions CMS Interoperability APIs — Provider Overview Medical and Radiation Oncology Cardiology Surgical Procedures	Updated language; Added section; Added section; Added section
1/1/2027	5: Billing and Claims Payment	Retroactive Adjustments	Added new section
1/1/2027	7: Compliance and Regulatory Requirements	FRAUD, WASTE & ABUSE (FWA) Program	Updated language

SECTION 1: GENERAL INFORMATION

Welcome to the Wellcare With Delaware First Health Provider Manual. This manual is a comprehensive resource for healthcare providers participating in our Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP), administrated by Centene Corporation. Our HIDE-SNP product is designed to deliver seamless, coordinated care to individuals eligible for both Medicare and Medicaid, ensuring access to the full spectrum of covered services.

Within this manual, providers will find essential information on policies, procedures, and best practices that support high-quality, integrated care. Our goal is to empower providers with the tools and guidance needed to improve health outcomes and enhance the member's experience. We value our partnership with you and remain committed to supporting your efforts in delivering exceptional care to our members.

BACKGROUND

In May 2022, the Centers for Medicare & Medicaid Services (CMS) finalized regulatory requirements directing states participating in the Medicare-Medicaid Financial Alignment Initiative to end their demonstration programs by December 31, 2025, or transition to an integrated Dual Eligible Special Needs Plan (D-SNP) model.

In response to this guidance, the Delaware Department of Health and Social Services (DHSS) has transitioned its existing program into a HIDE-SNP. A HIDE-SNP is a type of Medicare Advantage plan specifically designed to serve individuals who are dually eligible for both Medicare and Medicaid. It offers coordinated delivery of Medicare and Medicaid benefits – including long-term services and supports (LTSS) and behavioral health services – through a single managed care organization.

HIDE-SNP Program Commitment and Transition Pillars

Wellcare With Delaware First Health, in partnership with the Delaware Department of Health and Social Services (DHSS), is committed to enhancing care delivery for individuals who are dually eligible for Medicare and Medicaid. This commitment will be upheld through the implementation of a HIDE-SNP, with the primary goal of ensuring continuity of benefits and maintaining high standards of care.

To support a smooth and effective transition, Wellcare With Delaware First Health has adopted the Integrated Care Transition Pillars developed under the CMS Medicare-Medicaid Coordination Office (MMCO) framework, supported by the Resources for Integrated Care (RIC) initiative. These pillars serve as guiding principles for delivering high-quality, person-centered, and equitable care under the HIDE-SNP model.

Integrated Care Transition Pillars

- **Foster Integration and Continuity:** HIDE-SNP program is designed to fully integrate Medicare and Medicaid services, improving access and care quality for dually eligible individuals. The model bridges gaps between physical health, behavioral health, and LTSS. Upon enrollment, members will maintain

access to their existing providers and services – without changes in amount, scope, or duration – until a comprehensive assessment is completed.

- **Reduce Racial and Ethnic Disparities:** The Delaware Department of Health and Social Services (DHSS) will use a data-driven approach to identify and address health disparities. The HIDE-SNP model emphasizes culturally and linguistically appropriate services, ensuring equitable access to care for individuals with limited English proficiency and those from diverse backgrounds. These efforts align with broader state and federal health equity initiatives.
- **Improve Care Delivery:** HIDE-SNPs will implement a person-centered care model that prioritizes the holistic needs of each member. Care coordination will be central, ensuring seamless transitions across care settings and providers. Interdisciplinary care teams will support individualized care planning and service delivery.
- **Promote Self-Determination:** HIDE-SNPs will empower members to take an active role in directing their care, particularly in LTSS. The program supports flexible, enrollee-directed care models that respect individual preferences, values, and goals.
- **Build a Culture of Quality:** Continuous quality improvement will be embedded throughout the HIDE-SNP program. Plans will use integrated data systems to monitor performance, identify gaps, and improve outcomes. Key focus areas include care coordination, person-centered planning, health equity, and value-based payment reform.

Program Launch and Implementation

The HIDE-SNP program launched statewide in Delaware on January 1, 2026, as confirmed by the Delaware Department of Health and Social Services (DHSS). This initiative is designed to provide fully integrated Medicare and Medicaid benefits to dually eligible individuals across the state. While the program will be operational statewide from day one, full integration of LTSS is scheduled to begin in 2027. During the initial implementation phase, certain behavioral health services will remain partially carved out, with coordination maintained between HIDE-SNP plans and state-contracted behavioral health providers to ensure continuity and alignment of care.

HOW TO USE THIS MANUAL

The Wellcare With Delaware First Health Provider Manual is a digital resource designed to provide comprehensive, easy-to-navigate guidance for participating providers. The manual is organized into clearly defined sections, each supported by a master Table of Contents and section-specific Tables of Contents for more precise navigation.

To efficiently locate information:

- Start with the primary Table of Contents to identify the relevant section or topic
- Note the corresponding Section Number
- Navigate to that section and review its section-specific Table of Contents

This manual is available digitally at wellcarede.com. A printed copy may be requested by contacting Provider Services.

Updates and Revisions

The Wellcare With Delaware First Health Provider Manual is a living document, updated regularly to reflect changes in policies, procedures, and program requirements. Minor revisions may be communicated to providers through routine outreach or informational updates.

In the event of significant changes, a revised version of the manual will be issued and will replace any previous editions. Providers are encouraged to reference the most current version, which is always available on the Wellcare With Delaware First Health website at wellcarede.com.

KEY CONTACT INFORMATION

To support providers in delivering high-quality care, Wellcare With Delaware First Health offers dedicated resources for assistance with clinical, administrative, and operational needs. The following contacts are available to help with questions related to claims, authorizations, pharmacy, and more.

Please refer to the table below for the most commonly used contact information:

	Wellcare With Delaware First Health P.O. Box 10420 Van Nuys, CA 91419-0420 Hours of Operation: Monday-Friday, 8am-8pm EST wellcarede.com	
Department	**Phone Number**	**Website**
Member Services	1-844-536-2167 TTY:711	N/A
24-Hour Nurse Advice Line		
Behavioral Health Services		
Provider Services	1-844-536-2169 TTY: 711	
Pharmacy Prior Authorizations		
Express Scripts, Inc. (ESI) Pharmacy Helpdesk	1-833-750-4230	

	Wellcare With Delaware First Health P.O. Box 10420 Van Nuys, CA 91419-0420 Hours of Operation: Monday-Friday, 8am-8pm EST wellcarede.com	
Department	Phone Number	Website
Dental: Centene Dental Services	1-833-236-1886	
Vision: Premier Eye Care	1-866-434-0032	
Non-Emergency Medical Transportation: ModivCare	1-866-393-2166	N/A
PaySpan Support	1-877-371-7154	www.payspanhealth.com
Interpreter Services	1-800-977-7522	N/A
Fraud, Waste, & Abuse	1-866-685-8664	
Ethics & Compliance	1-800-345-1642	

SECTION 2: MEMBER BENEFIT INFORMATION

MEMBER ELIGIBILITY AND ENROLLMENT

To enroll in Wellcare With Delaware First Health, individuals **must:**

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Have full Medicaid benefits (not partial duals)
- Be 21 years of age or older
- Permanently reside in the Wellcare With Delaware First Health service areas
- Not be enrolled in hospice
- Be a U.S. citizen or lawfully present in the United States

EXCLUSIONS FROM ENROLLMENT

The following populations are excluded from enrollment in the program:

- Individuals under the age of 21
- Individuals with partial Medicaid eligibility (e.g., QMB, SLMB, QI, ALMB, QDWI)
- Individuals without full Medicaid coverage (e.g., spend-down status)
- Individuals residing in state psychiatric hospitals
- Individuals with commercial HMO coverage
- Individuals with elected hospice services
- Individuals who are incarcerated
- Individuals with presumptive Medicaid Eligibility
- Individuals disenrolled from Medicaid managed care due to special circumstances

NON-DISCRIMINATION STATEMENT

Wellcare With Delaware First Health will accept all eligible members regardless of:

- Race, color, national origin, sex, religion, age, disability, political affiliations, sexual orientation, or family status.
- Furthermore, we will not limit, or condition coverage of plan benefits based on any factor that is related to the member's health status, including but not limited to:
- Medical condition
- Claims history
- Receipt of healthcare

- Medical history
- Genetic information
- Evidence of insurability or disability

MEMBER RIGHTS AND RESPONSIBILITIES

Members of Wellcare With Delaware First Health may have the following rights and responsibilities, in accordance with applicable federal and state laws, regulations, and the terms of the health plan contract:

Access to Information

1. Members may request and receive information about the health plan, including:
    a. Member rights and responsibilities
    b. Participating providers and their qualifications
    c. Grievance and appeal procedures
    d. Covered benefits and services
2. Provider information – such as location, qualifications, and availability – is accessible via the online provider directory or by contacting the Customer Experience (CE) Department
3. Members may request information about the Plan's structure, operations, and benefits, and can expect responses to reasonable inquiries.
4. Plan rules, benefits, and available options may be explained to Members, with interpreter services made available when needed.

Language and Disability Services

5. Members may access, at no cost:
    a. Language assistance services, including qualified interpreters and translated written materials
    b. Auxiliary aids for effective communication, such as large print documents, audio materials, or accessible electronic formats
6. When available and upon request, the Plan may assist in identifying providers who speak the Member's preferred language

Dignity, Privacy, and Nondiscrimination

7. Members are to be treated with respect and dignity, with consideration for their right to privacy.
8. The Plan is expected to comply with applicable laws regarding the confidentiality of personal health information. Members have the right to authorize or decline the release of their personal health information, consistent with those laws.
9. Members are protected from discrimination based on race, color, national origin, religion, sex, age, marital status, disability, sexual orientation, genetic information, source of payment, and other classifications protected by law.
10. Members may not be subjected to restraint or seclusion as a form of coercion, discipline, convenience, or retaliation.
11. Members should be able to exercise their rights without fear of negative consequences from the Plan, its providers, or the state.

Participation in Care

12. Members are encouraged to participate in decisions about their healthcare, including the right to:
    a. Accept or refuse recommended treatment
    b. Discuss treatment options with their providers, including potential risks, benefits, and alternatives
13. Members may receive healthcare services in accordance with applicable laws and Wellcare With Delaware First Health's agreement with the state.
14. Members may have access to a network of providers, including primary care providers, specialists, hospitals, and American Indian/Alaska Native providers when appropriate.
15. Members may access emergency services when medically necessary, regardless of network status or prior authorization.

Grievances, Appeals, and Involvement

16. Members may voice concerns or submit grievances and appeals regarding their care or plan services.
17. Members may request and review their medical records and request corrections as permitted by law.
18. Members may receive decisions related to service authorization, benefit coverage, and prescription drugs, including notification of appeal rights.
19. Members may recommend improvements to the Plan's policies and procedures.
20. Members may participate in plan governance and operations, consistent with applicable rules and program structure.

Final Protections

21. Members are generally not responsible for bills, cost-sharing, or copayments for services covered by the Plan, including those provided by American Indian/Alaska Native providers, when consistent with applicable program guidelines.

Reasonable Accommodations

22. The Plan and its contracted providers are expected to provide reasonable accommodations for Members with disabilities, as required by law.
    a. Members may be informed annually – and as needed – about their rights to accommodations via the member handbook.
    b. Providers are informed of these requirements through the provider manual.
    c. Members may request accommodations through their care coordinator, who can help assess needs and provide available options.
    d. The Utilization Management team reviews accommodation requests and determines whether they can be provided.
    e. Members may appeal decisions regarding accommodations through the appeals process outlines in plan policy.
23. Receive basic information about the Plan, orally as well as in writing, upon request, about the organization of Wellcare With Delaware First Health including but not limited to Member rights and responsibilities, participating practitioners and providers, grievance and appeal procedures, and covered services. This information is made accessible to all Members including those with limited

English proficiency or reading skills, with diverse cultural ethnic background, and with physical and mental disabilities.

MEMBER BENEFITS AND SERVICES

Wellcare With Delaware First Health offers a comprehensive benefit package to members who are eligible for Medicare and full Medicaid benefits. Covered services are based on medical necessity and must meet professionally accepted standards of care. The Plan integrates Medicare and Medicaid benefits, including LTSS, behavioral health, and preventive care.

Covered services may include:

- Primary and specialty care provider visits
- Hospital inpatient and outpatient services
- Emergency and urgent care services
- Ambulance and emergency medical transportation
- Behavioral health services, including outpatient therapy and psychiatric care
- Prescription drugs
- Dental services
- Vision services, including eye exams and eyeglasses
- Hearing services, including hearing aids
- Durable Medical Equipment (DME) and medical supplies
- Home health care and personal care services
- Skilled nursing facility care
- Rehabilitative therapies (physical, occupational, and speech therapy)
- Preventive services, including immunizations and screenings
- Family planning and reproductive health services
- Podiatry and chiropractic care
- Transportation to medical appointments (non-emergency medical transportation)
- Care coordination and case management
- Second medical opinions, when requested
- LTSS, including in-home and community-based services (phased in by 2027)

Additional Notes

- Members are not responsible for co-pays on Medicaid-covered services.
- Prior authorization may be required for out-of-network services, except in the case of emergencies.
- Members have the right to receive care from Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).
- Interpreter services and materials in alternative formats (e.g., large print, braille, or audio) are available at no cost to members.

- Wellcare With Delaware First Health will implement any changes to covered services as directed by the DHSS and the Delaware Medicaid program.

Non-Covered Services

While Wellcare With Delaware First Health provides a wide range of integrated Medicare and Medicaid benefits, certain services are excluded from coverage under Delaware Medicaid and/or Medicare. These services are not reimbursable and will not be covered by the Plan unless required by law or authorized under special circumstances.

Services Not Covered by the Plan include:

- Elective abortions, except in case of rape, incest, or when the life of the pregnant person is endangered
- Experimental or investigational treatments, drugs, or equipment not approved by CMS of HFS
- Cosmetic surgery or procedures performed solely for aesthetic purposes
- Infertility treatments and related medications
- Erectile dysfunction medications (unless medically necessary and covered under Medicare Part D)
- Services not deemed medically necessary by the Plan or state guidelines

Behavioral Health and Other Services Managed Outside the Plan

Certain services may be administered outside of the HIDE-SNP benefit package by state-contracted providers or waiver programs. These services may include, but are not limited to:

- Certain behavioral health services, such as:
- Inpatient psychiatric care
- Substance use disorder treatment
- Community-based mental health services for individuals with serious mental illness
- Waiver program services, such as:
- Home and Community-Based Services (HCBS) for individuals with developmental disabilities or traumatic brain injuries
- Services provided through the Delaware Department of Human Services (DHHS), including the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)

In these cases, Wellcare With Delaware First Health providers are expected to assist members in obtaining referrals or coordinating care with the appropriate state agency or provider network.

Member ID Cards

Each Wellcare With Delaware First Health member receives a personalized Member ID card upon enrollment. This card serves as proof of coverage and contains essential information that providers should verify prior to delivering services.

Key Information on the Member ID Card

- Member name and identification number
- Plan name and coverage type
- Effective date of coverage
- Contact information for Member Services
- Pharmacy, Vision, and Dental benefit details (if applicable)

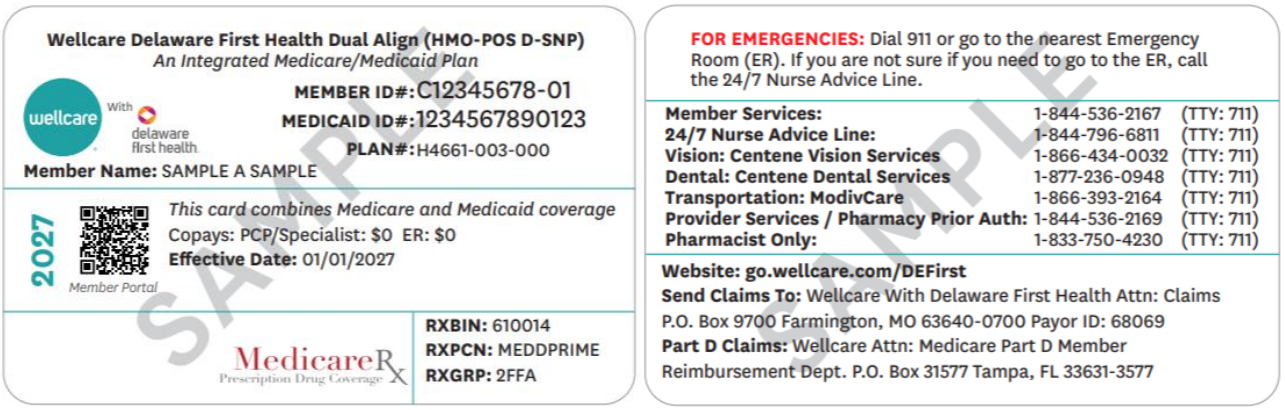
Provider Responsibilities

Providers are expected to:

- Verify member eligibility and benefits using the information on the ID card and the secure Provider Portal.
- Confirm the member's identity at the time of service.
- Use the Member ID number for all claims submissions and prior authorization requests.

Note: Possession of a Member ID card does not guarantee eligibility. Always verify current coverage through the Provider Portal or by contacting Provider Services.

Sample Member ID Card



Provider Support

Providers should contact Member Services at **1-844-536-2167** for assistance with:

- Referrals to state-administered services
- Clarification of benefit coverage
- Coordination with behavioral health or waiver program providers

Special Supplemental Benefits for the Chronically Ill (SSBCI)

Overview

Special Supplemental Benefits for the Chronically Ill (SSBCI) are supplemental benefits available to eligible members enrolled in a Wellcare With Delaware First Health plan that offers SSBCI and who meet CMS-defined eligibility requirements.

Members are continuously reviewed through Wellcare With Delaware First Health's automatic eligibility process using available claims, medical records, clinical assessments, and other approved clinical information. This automated process is the primary pathway used to determine SSBCI eligibility.

Provider Attestation Process

Provider attestation is an alternative qualification pathway for SSBCI benefits primarily intended for newly enrolled members when sufficient claims or clinical data may not yet be available to determine eligibility through the automatic eligibility process.

Members should schedule an in-person office visit or contact their healthcare provider to request that an attestation be submitted. A healthcare provider who is familiar with the member's medical history may attest whether the member meets all required SSBCI eligibility criteria.

Providers should visit the Wellcare With Delaware First Health SSBCI Provider Attestation Portal to complete the online attestation. Providers with questions regarding the attestation process or who may require additional support with submitting an attestation should contact Provider Services using the phone number listed in the applicable Provider Manual or the phone number listed on the back of the member's ID card.

Please note: Provider attestation is for provider use only. Members cannot self-attest for SSBCI eligibility.

SSBCI Eligibility Requirements

To qualify for SSBCI benefits, members must meet **all three** CMS-defined eligibility criteria:

- Has one or more qualifying chronic conditions that is life threatening or significantly limits overall health or function
- Has a high risk of hospitalization or other adverse health outcomes
- Requires intensive care coordination

A diagnosis of a qualifying chronic condition alone does not qualify a member for SSBCI benefits. In addition to having one or more qualifying chronic conditions, eligibility for SSBCI may be demonstrated through one or more of the following:

- History of hospitalization or emergency department visits, and/or
- Frequent use of outpatient services or specialty care, and/or

- Evidence of poor disease control or medication adherence, and/or
- Non-medical social needs that impact health outcomes

Provider Instructions for Submitting an Attestation

Providers should follow these steps to submit an SSBCI attestation:

1. Access the Wellcare With Delaware First Health SSBCI Provider Attestation portal at wellcare.ssbci.rrd.com
2. Review the eligibility criteria and evaluate whether the member meets all required SSBCI eligibility criteria
3. Complete and submit the electronic provider attestation
4. If applicable, submit a claim including the appropriate diagnosis coding consistent with the member's documented chronic condition(s) and services provided

Providers should complete the attestation based on their clinical judgment and evaluation of the member, certifying whether the member meets all required SSBCI eligibility criteria.

Determination Process & Member Notification

Once an attestation is submitted:

- The attestation will be reviewed as part of the SSBCI eligibility determination process
- The member will receive written notification of the determination within 10 business days
- Members determined eligible will receive information regarding available SSBCI benefits and how to access those benefits
- Members not meeting eligibility requirements will receive notification explaining the determination and appeal rights

Submission of a provider attestation does not guarantee approval. Eligibility determinations are based on the member meeting all applicable SSBCI eligibility requirements.

PHARMACY BENEFIT MANAGEMENT

Wellcare With Delaware First Health utilizes a Pharmacy Benefit Manager (PBM) to administer member pharmacy benefits. The PBM provides Wellcare With Delaware First Health with a pharmacy network, pharmacy claims management, and adjudication services. Prior to authorizing any drug benefit, each member's eligibility is determined.

In accordance with the requirements set forth by DHSS, Wellcare With Delaware First Health adopts the State's Health Plan Common formulary for Medicaid. The formulary is designed to cover the vast majority of

therapeutic conditions. However, should a specific medication not listed on the formulary be deemed medically necessary for a member, a medical necessity exception may be requested through the prior authorization (PA) process. Additionally, certain specialized medications on the drug formulary require a PA before they can be dispensed.

The drug formulary is accessible on our website at the Prescriber Portal. This formulary should be consulted when prescribing medications for Wellcare With Delaware First Health members. Medicaid members have coverage for both prescription and specific over-the-counter medication.

While we encourage prescribing within the formulary, we recognize that situations arise where a formulary alternative is not available. Drugs requiring Prior Authorization are identified in the formulary with a PA designation.

Wellcare With Delaware First Health requires adherence to the following Prior Authorization procedures for obtaining medically necessary non-formulary/non-covered drug products:

1. To receive a non-formulary/non-preferred medication, the prescriber must submit a prior authorization request. Using the form on our website through covermymeds.com.
2. The Pharmacy Services reviewer may request that the prescriber submit additional clinical information by fax in order to process the request.
3. If the request is approved, pharmacy services will notify the provider via fax and enter the necessary authorization into the claims processing system for dispensing at a participating pharmacy network provider
4. The prescriber may contact Pharmacy Services by telephone at 1-844-536-2169 with any questions or concerns

MEMBER SELF-REFERRALS

Family Planning

Family planning services include any medically approved method – such as diagnostic evaluation, medications, supplies, devices, and related counseling – used to voluntarily prevent or delaying pregnancy, or to detect and treat sexually transmitted diseases (STDs). These services must be provided continuously to individuals of childbearing age, including sexually active minors, who choose to avoid pregnancy, or wish to manage the number and timing of their children.

Infertility treatment is not covered under the family planning benefit.

All Wellcare With Delaware First Health members have the right to choose any qualified family planning provider, whether in-network or out-of-network. Primary Care Providers (PCPs) should support members by providing family planning services or assisting them in locating and selecting a family planning provider, as requested.

Members seeking additional information or assistance with family planning referrals may contact Member Services at 1-844-536-2167.

Women's Health

Female members aged 21 and older may self-refer to any in-network OB/GYN for routine annual examinations and preventive screenings, including Pap smears, chlamydia testing, and mammograms. Members may also self-refer to an in-network OB/GYN of their choice for prenatal and perinatal care.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

FQHCs are essential community-based providers that deliver comprehensive healthcare services. All Wellcare With Delaware First Health members have access to FQHCs when these services are available within their community. The Member Handbook outlines each member's right to seek care from an FQHC within their service area.

For more information or assistance accessing an FQHC, members may contact Member Services at **1-844-536-2167**.

NON-EMERGENCY TRANSPORTATION

Wellcare With Delaware First Health ensures that non-emergency transportation and travel expenses are readily available and accessible for members requiring medically necessary care. This service supports access to medical appointments, examinations, and treatments as determined necessary by the member's primary care provider.

Non-emergency transportation is available to support members' access to medically necessary care. Covered services include, but not limited to:

- End Stage Renal Disease treatment (hemodialysis)
- Prenatal and preventive care
- Mental health services
- Prescription pickup
- Durable Medical Equipment (DME) supplies

Wellcare With Delaware First Health partners with a transportation agency that maintains a provider network capable of servicing the entire geographic area in which members reside.

Accessing Non-Emergent Transportation Services

To schedule non-emergent transportation, the member, their primary care provider (PCP), or a Wellcare With Delaware First Health representative may call the transportation vendor at **1-866-393-2166** or contact Member Services at **1-844-536-2167** for assistance.

The non-emergent transportation vendor will provide services for the following individuals:

- **Members:** All Wellcare With Delaware First Health members for covered outpatient services.
- **Parents or Legal Guardians:** May accompany minor or legally incapacitated members to appointments.

- **Other Family Members:** Transportation for additional individuals (e.g., siblings) may be permitted, depending on circumstances and vendor policies.

Transportation is provided to and from participating providers. In cases where medically necessary services are only available from a non-participating provider, transportation may be arranged as directed by Wellcare With Delaware First Health.

For more information on how to access non-emergent transportation services, members should consult their Member Handbook or contact Member Services at **1-844-536-2167**.

EMERGENCY SERVICES

Wellcare With Delaware First Health provides coverage for emergency services in accordance with applicable Medicare and Medicaid requirements. Emergency services are covered without prior authorization and are available not included under Medicare – or covers them at a greater amount, duration, or scope – Wellcare With Delaware First Health will provide those services through Medicaid as outlined in our contract.

- **Emergency Care Access**: Emergency services are available to members 24 hours a day, 7 days a week. Members will be screened and stabilized without prior authorization in accordance with the Emergency Medical Treatment and Labor Act (EMTALA), using the prudent layperson standard.
- **Medicare-Covered Emergency Services**: Wellcare With Delaware First Health covers appropriate cost sharing for emergency services and medical screenings provided under Medicare, including:
    - Out-of-network or out-of-area emergency services delivered in a hospital emergency department.
    - Emergency care received without prior notice to the PCP or plan.
    - Emergency transportation and professional services necessary to evaluate or stabilize an emergency medical condition.
- **Post-Stabilization Care**: Wellcare With Delaware First Health ensures coverage for post-stabilization services in alignment with 42 CFR §422.214 and §422.113. Cost-sharing coverage is provided under the following conditions:
- Services are pre-approved by a plan provider or representative.
- Services are delivered within one hour of a pre-approval request to maintain the members' stabilized condition without explicit prior approval.
- Wellcare With Delaware First Health fails to respond within the regulatory timeframe (1 hour) to a request for authorization.
- No plan representative is available at the time of the authorization request.
- A disagreement occurs between the treating provider and the Plan representative, and the provider cannot consult with a plan provider in a timely manner.
- **Medical Screening and Stabilization**: Hospitals providing emergency services must conduct a medical screening exam to determine if an emergency condition exists. If one is found, the provider must

stabilize the member before discharge or transfer. Emergency services must continue until the member is clinically stabilized.

- Medicaid Coverage: For services not covered under Medicare but included under Medicaid, Wellcare With Delaware First Health will ensure those services are provided as part of the member's benefits.
- Authorization Requirements After Stabilization: If additional care (e.g., hospitalization or specialty services) is needed following an emergency room visit, prior authorization may be required unless the circumstances meet any of the above exceptions.

Coverage Ends When:

- A Wellcare With Delaware First Health provider assumes responsibility for the member's care.
- The member is transferred under the care of a plan-approved provider.
- An agreement is reached between the treating provider and the Plan.
- The member is discharged.

Definitions

Emergency Medical Condition

An emergency medical condition is defined as a medical condition manifesting acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, with average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in one or more of the following:

- Placing the health of the individual (or a pregnant woman and her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services

Emergency services are defined as covered inpatient and outpatient services that:

- Are provided by a qualified provider in accordance with federal requirements under Title 42; and
- Are necessary to evaluate or stabilize an emergency medical condition.

Post-stabilization Care Services

Post-stabilization care services are defined as medically necessary services provided after a Member has been stabilized, and are intended to:

- Maintain the stabilized condition; or
- Improve or resolve the Member's condition, consistent with 42 CFR §438.114(e).

Plan Coverage and Financial Responsibility

The Plan covers and reimburses for emergency services regardless of whether the provider is contracted with the Plan.

The Plan will not deny coverage for emergency services under the following circumstances:

- The Member experienced an emergency medical condition, even if the absence of immediate medical attention would not have led to the outcomes described above; or
- A Plan representative directed the Member to seek emergency care.

The Plan does not:

- Restrict what qualifies as an emergency condition based solely on diagnosis or symptom lists;
- Deny emergency service claims due to lack of notification to the Member's Primary Care Provider, the Plan, or the DHSS within 10 calendar days of treatment.

Members cannot be held financially liable for any screening or treatment needed to diagnose or stabilize an emergency medical condition.

The attending emergency provider, or the provider treating the Member, is solely responsible for determining when the Member is stabilized for discharge or transfer. This determination is binding on the Plan if:

- It adheres to generally accepted medical standards; and
- The services are covered under the Plan's contract.

Post-stabilization Authorization and Coverage

The Plan is financially responsible for post-stabilization services provided by contracted or non-contracted providers when:

- Services are pre-approved by a Plan provider or representative;
- Services are initiated within one hour of a request for pre-authorization, even if pre-approval is not yet obtained;
- The Plan fails to respond within one hour, cannot be reached, or if the Plan and the treating provider cannot reach agreement on care and no Plan provider is available for consultation.

In such cases, the treating provider must be given the opportunity to consult with a Plan provider, and care may proceed until such consultation occurs or until one of the criteria outlined in 42 CFR §422.113(c)(3) is met.

Cost Sharing

Members may not be charged more for post-stabilization services than they would have paid had the services been obtained through a contracted provider. For the purposes of cost-sharing, post-stabilization services begin upon inpatient admission.

End of Plan Financial Responsibility

Wellcare With Delaware First Health's financial responsibility for post-stabilization care services ends when any of the following occurs:

- A Plan-affiliated provider with hospital privileges assumes responsibility for the Member's care
- A Plan-affiliated provider assumes care through transfer

- The Plan and the treating provider reach agreement on care
- The Member is discharged

Wellcare With Delaware First Health will not deny coverage of medically necessary post-stabilization care solely because notification was not received within the required timeframe when the member's condition meets the criteria outlined above. Coverage decisions will not be based on any of the following prohibited factors, including:

- Failure to provide timely notification alone
- Existence of another EMC (Emergency Medical Condition) determination
- Holding the member financially liable for covered post-stabilization services
- Overriding the treating physician's determination that the member remains unstable
- Limiting coverage based on a diagnosis list

24 HOUR NURSE ADVICE LINE

Wellcare With Delaware First Health offers a 24-Hour Nurse Advice Line as a resource to support members in making informed healthcare decisions. This service is intended to supplement, not replace, the care and guidance of the members' PCP.

The Nurse Advice Line offers:

- General health information
- Guidance on appropriate levels of care
- Assistance understanding health care benefits
- Information on treatment options and available resources

This service is available at no cost to members, 24 hours a day, 7 days a week, 365 days a year.

Nurse Advice Line Phone Number: 1-855-323-4578 TTY: 711

Providers should encourage members to utilize the Nurse Advice Line for non-emergency medical questions or concerns, especially outside of regular office hours.

Wellcare With Delaware First Health monitors member grievances and appeals as part of its quality oversight and compliance responsibilities. The grievance and appeal processes outlined below are in accordance with state and federal regulations and apply to all Wellcare With Delaware First Health members.

MEMBER GRIEVANCE

A grievance is defined as any expression of dissatisfaction about matters other than an "action" (i.e., a denial, reduction, or termination of a service), which would be subject to the appeal process. Examples of grievances may include:

- Delays in obtaining timely appointments or referrals

- Concerns regarding provider or staff behavior
- Alleged violations of member rights
- Issues related to the quality of care or services received

Grievances may be submitted by the member, their authorized representative, or a provider acting on the member's behalf. Members may contact Wellcare With Delaware First Health Member Services at 1-844-536-2167 to file a grievance. Member grievances may be filed verbally by contacting Customer Service or submitted in writing. Providers may also file a grievance on behalf of the member with the member's written consent, AOR forms are available on the Plan website, under Forms.

Wellcare With Delaware First Health offers both informal and formal grievance processes. Informal grievances are typically resolved during the initial interaction with Member Services.

Formal grievances should be submitted to:

Wellcare With Delaware First Health
Appeals & Grievances Medicare Operations
P.O. Box 10052
Van Nuys, CA 91410

Upon receipt of a formal grievance, Wellcare With Delaware First Health will send written acknowledgment within five (5) business days and issue a resolution within 30 calendar days of receipt. In cases involving clinical urgency, Wellcare With Delaware First Health will request a response from the provider or facility within 24 hours. For standard grievances, provider responses are expected within seven (7) calendar days to support timely resolution.

Providers are expected to cooperate fully with Wellcare With Delaware First Health in the investigation and resolution of member grievances, including responding to information requests within designated timeframes. Failure to respond may impact the resolution process or be escalated for contractual review.

Members will receive written notification of the grievance outcome, which will include the resolution determination and any next steps, if applicable.

Member Appeals

An appeal is a formal request from the member, their authorized representative, or provider to review a decision made by Wellcare With Delaware First Health to deny, reduce, delay, or terminate a requested service or payment. Examples include:

- Denial of a service based on medical necessity
- Denial of payment for a service already received
- Termination or reduction of a previously authorized service

Non-Urgent Pre-Service Appeal

Members have 60 calendar days to file an appeal from the date of the denied service. All written or verbal communication by a member regarding dissatisfaction with a decision to deny, reduce, delay, or terminate a clinical service based on medical necessity or on benefit determination is to be considered an appeal.

A provider or other authorized representative of the member such as family member, friend, or attorney may file an appeal on the member's behalf with the member's written permission. The member must submit written permission to Wellcare With Delaware First Health for an authorized representative to appeal on their behalf.

Members have the right to appeal an adverse benefit determination. Appeals may be submitted to the Wellcare With Delaware First Health Appeals Department or by phone through Member Services at **1-844-536-2167**. If submitted in writing, the appeal should include a valid phone number for follow-up and confirmation of receipt.

Appeals should be mailed to:

Wellcare With Delaware First Health
Appeals & Grievances Medicare Operations
P.O. Box 10052
Van Nuys, CA 91410

Within three business days of receiving a member's appeal, Wellcare With Delaware First Health will notify the member of all the information that is required to process the request. Appeals are reviewed and resolved within 30 calendar days from the date of receipt. For members enrolled in the Children's Special Health Care Service program, appeals will be resolved within 10 calendar days.

Appeals are reviewed by a qualified clinical peer reviewer holding the same or similar specialty as the treating provider. The reviewer will not be the same individual who made the initial determination to deny, reduce, or terminate services.

Wellcare With Delaware First Health will provide written notification of the appeal decision to the member, the PCP, and any other provider directly involved in the appeal.

Appeals

A member or their provider may call Member Services at **1-844-536-2167** to file an expedited appeal if they think that their situation is clinically urgent and reviewing the appeal in the standard timeframe 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 or in the opinion of a practitioner with knowledge of the member's medical condition
- Would subject the member to severe pain that cannot be adequately managed without the care or treatment

If an appeal is deemed urgent, the member must obtain written confirmation from their provider attesting that the standard appeal timeframe could seriously jeopardize the member's life, health, or ability to regain maximum function.

Upon receipt of the expedited appeal, Wellcare With Delaware First Health will notify the member within 24 hours if additional information is required. A decision will be rendered within 72 hours of receiving the expedited request.

The outcome will be communicated verbally to the member, their PCP, and any other provider involved in the appeal, followed by written notification.

Note: Wellcare With Delaware First Health prohibits any punitive action against a provider who requests an expedited resolution or supports a member's appeal.

External Review of an Appeal (Expedited)

Members have the right to request a determination by the Insurance Director or his/her designee, or by an independent review organization under the Patient's Right to Independent Review Act.

An expedited external appeal may be submitted by the member and/or the member's authorized representative within 10 days after the member receives an adverse determination from the health plan only if the following are met:

- A provider must substantiate, either orally or in writing, that the standard timeframe for review of the grievance/appeal would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function; and
- The member has already filed a request for an expedited internal appeal with the health plan.

The request for external review should be submitted to the following address:

MAXIMUS Federal Services, Inc.
Medicare Managed Care & PACE Reconsideration Project
3750 Monroe Avenue, Suite 702
Pittsford, NY 14534-1302
Phone: 1-585-348-3300
Fax: 1- 585-425-5292

External Review of an Appeal (Non-Expedited)

Members have the right to request a determination by the Director or his/her designee, or by an independent review organization under the Patient's Right to Independent Review Act. Members must first exhaust the internal appeal process through the health plan before filing a request for an external review with the Department of Insurance and Financial Services (DIFS).

A request for an external review of a grievance/appeal may be submitted by the member and/or the member's authorized representative within 127 days after the Member receives an adverse determination or final adverse determination from the health plan.

The request for external review should be submitted to the following address:

MAXIMUS Federal Services, Inc.
Medicare Managed Care & PACE Reconsideration Project
3750 Monroe Avenue, Suite 702
Pittsford, NY 14534-1302
Phone: 585-348-3300
Fax: 585-425-5292

SECTION 3: PROVIDER FUNCTIONS AND RESPONSIBILITIES

PRIMARY CARE/MANAGED CARE PROGRAM

Wellcare With Delaware First Health utilizes a PCP Member-Centered Medical Home system. In this system, the PCP is responsible for the comprehensive management of each member's health care. This may include, but is not limited to, ensuring that all medically necessary care is made available and delivered, facilitating the continuity of member health care, promoting, and delivering the highest quality health care per Wellcare With Delaware First Health standards.

Wellcare With Delaware First Health providers are responsible for knowing and complying with all Wellcare With Delaware First Health network policies and procedures. Implementation of Wellcare With Delaware First Health policies will facilitate the Plan's periodic reporting of HMO data to DHSS, the State, and the Federal agencies.

Primary Care Provider (PCP) Roles and Responsibilities

Each Wellcare With Delaware First Health member selects a PCP who is responsible for coordinating the member's total healthcare. PCPs are required to work 20 hours per week per location, and be available 24 hours a day, seven days a week.

Female members will have direct access to women's health specialists to provide women's routine and preventative health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

Except for required direct access benefits or self-referral services, all covered health services are either delivered by the PCP or are referred/approved by the PCP and/or Wellcare With Delaware First Health.

All providers must offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service (FFS) if the provider serves only Medicaid members.

Specialty Care Provider Roles and Responsibilities

Wellcare With Delaware First Health recognizes that the specialty provider is a valuable team member in delivering care to Wellcare With Delaware First Health Medicare members. Key specialty provider roles and responsibilities include, but are not limited to:

- Rendering services requested by the PCP by referral
- Communicating with the PCP regarding the findings in writing
- Obtaining prior authorization from the PCP and plan before rendering any additional services not specified on the original referral form
- Confirming member eligibility and benefit level prior to rendering services

- Providing the consultation report to the PCP within 60 days of the consultation date
- Providing the lab or radiology provider with:
- The PCP and/or corporate prior authorization number
- The member's ID number

Hospital Roles and Responsibilities

Wellcare With Delaware First Health recognizes that the hospital is a valuable team member in delivering care to Wellcare With Delaware First Health Medicare members. Essential hospital responsibilities include, but are not limited to:

- Coordination of discharge planning with Wellcare With Delaware First Health Medicare Utilization Management staff
- Coordination of mental health/substance abuse care with the appropriate state agency or provider
- Obtaining the required prior authorization from the Plan before rendering services
- Communication of all pertinent patient information to Wellcare With Delaware First Health and to the PCP
- Communication of all hospital admissions to the Wellcare With Delaware First Health Medicare Utilization Management staff within one business day of admission
- Issuing all appropriate service denial letters to identified members

Ancillary/Organization Provider Roles and Responsibilities

Wellcare With Delaware First Health recognizes that the ancillary provider is another valuable team member in delivering care to Wellcare With Delaware First Health Medicare members. Critical ancillary provider responsibilities include, but are not limited to:

- Confirming member eligibility and benefit level before rendering services
- Being aware of any limitations, exceptions, and/or benefit extensions applicable to Wellcare With Delaware First Health Medicare members
- Obtaining the required prior authorization from the Plan before rendering services
- Communication of all pertinent patient information to Wellcare With Delaware First Health and to the PCP

APPOINTMENT STANDARDS

All participating providers are required to comply with Wellcare With Delaware First Health's standards for appointment availability and in-office wait times. These standards are established to ensure that Members receive timely access to medically necessary services based on the urgency of their clinical needs.

Wellcare With Delaware First Health continuously monitors provider adherence to these standards through various oversight mechanisms. Providers found to be out of compliance may be subject to corrective action plans, up to and including contract review.

Type of Appointment	Access Standard
Specialty Care	
Routine specialty care (e.g., vision, hearing)	Within 6 weeks of request
Acute specialty care (e.g., vision, hearing)	Within 5 business days of request
Dental Services	
Emergency dental services	Available immediately, 24 hours/day, 7 days/week
Urgent dental care	Within 48 hours
Routine dental care	Within 21 business days of request
Preventive dental services	Within 6 weeks of request
Initial dental appointment	Within 8 weeks of request
Durable Medical Equipment (DME)	
Adaptive/enhanced DME and supplies	Within 21 calendar days (large metro, metro, micro areas) Within 28 calendar days (rural/extreme access areas)
Assistive Technology Devices	Within 21 calendar days (large metro, metro, micro areas) Within 28 calendar days (rural/extreme access areas)
Home and Community-Based Services (HCBS)	
Chore services	Within 14 calendar days (large metro, metro, micro areas) Within 21 calendar days (rural/extreme access areas)
Community living supports	Within 7 calendar days (large metro, metro, micro areas)

Type of Appointment	Access Standard
	Within 14 calendar days (rural/extreme access areas)
Home-delivered meals	Within 14 calendar days (large metro, metro, micro areas) Within 21 calendar days (rural/extreme access areas)
Personal care services (non-waiver)	Within 7 calendar days (large metro, metro, micro areas) Within 14 calendar days (rural/extreme access areas)
Personal emergency response systems	Within 30 calendar days (all geographic areas)
Preventive nursing services (agency and non-agency)	Within 7 calendar days (large metro, metro, micro areas) Within 14 calendar days (rural/extreme access areas)
Private duty nursing services (agency and non-agency)	Within 7 calendar days (large metro, metro, micro areas) Within 14 calendar days (rural/extreme access areas)
Respite services	Within 7 calendar days (large metro, metro, micro areas) Within 14 calendar days (rural/extreme access areas)
Respite services – non-waiver (in-home)	Within 7 calendar days (large metro, metro, micro areas) Within 14 calendar days (rural/extreme access areas)
Vehicle modifications	Within 90 calendar days (large metro, metro, micro areas)

Type of Appointment	Access Standard
	Within 120 calendar days (rural/extreme access areas)
Non-Emergency Medical Transportation (NEMT)	
Regularly scheduled services	48–72 hours advance notice required
Urgent services	Same-day or next-day availability
NEMT wait and transport times	- Pickup must not occur more than 15 minutes after scheduled time - Drivers must wait 15 minutes before leaving - Members must not arrive >1 hour early - Drop-off must not occur before the facility opens unless requested - Pickup after appointment must occur within 1 hour of notice if there is no prearranged time - Pickup must not occur >15 minutes after facility closes unless requested

CONFIDENTIALITY AND ACCURACY OF MEMBER RECORDS

Medical records and other health and enrollment information of a member must be managed under established procedures that:

- Safeguard the privacy of any information that identifies a particular member
- Respect member rights to access, amend errors in, request confidentiality for, or an accounting of disclosures of the member's health information
- Identify when and to whom member information may be disclosed
- Safeguard the privacy of any information that identifies a particular member
- Secure information through robust controls designed to maintain the confidentiality, integrity, and availability of medical records and to protect against threats or hazards to the security or integrity of such information and any uses or disclosures of such information that could violate the law.
- Maintain such records and information in a manner that is accurate and timely, ensure timely access by Members to the records and information that pertain to them for what purpose(s) the information will be used within the organization, and identify when and to whom member information may be disclosed

In addition to the obligation to safeguard the privacy and security of any information that identifies a particular member, the health plan and all participating providers are each obligated to abide by all federal and state laws regarding confidentiality and disclosure for mental health records, medical health records, and member information. First tier and downstream providers must comply with Medicare laws, regulations, and CMS instructions (422.504(i)(4)(v)) and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, within requested time frames, and maintain records a minimum of 10 years.

OBLIGATIONS OF RECIPIENTS OF FEDERAL FUNDS

Providers participating in Wellcare With Delaware First Health Medicare plans are reimbursed with federal funds and must comply with all applicable laws and regulations governing recipients of those funds. These include, but are not limited to:

- Title VI of the Civil Rights Act of 1964
- Rehabilitation Act of 1973
- Age Discrimination Act of 1975
- Americans with Disabilities Act of 1990
- False Claims Act
- Anti-Kickback Statute
- Health Insurance Portability and Accountability Act (HIPAA)

Exclusion Screening and Program Integrity

To ensure program integrity, Wellcare With Delaware First Health conducts monthly exclusion checks using the following sources:

- Delaware DHSS Website
- Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
- Medicare Exclusion Database (MED)
- System for Award Management (SAM)
- CMS Preclusion List

These checks are performed prior to contracting, during credentialing and recredentialing, and monthly thereafter. If a provider is excluded, suspended, or terminated from the Delaware Medicaid Program, Medicare, or another state's Medicaid program – or is subject to a state or federal licensing action – Wellcare With Delaware First Health will take appropriate action, including termination or suspension from the provider network.

Upon notification from DHSS or CMS, Wellcare With Delaware First Health is prohibited from authorizing services or issuing payment to any provider who is excluded from participation in Medicaid or Medicare, except under limited circumstances such as emergency services.

Reporting Requirements

Wellcare With Delaware First Health is required to notify CMS and DHSS on a quarterly basis when a provider fails credentialing or recredentialing due to:

- Program integrity concerns
- Adverse actions
- Adverse benefit determinations (effective January 1, 2018)

All related documentation must be submitted in accordance with applicable federal and state laws, regulations, and contractual obligations.

OSHA TRAINING

Employee training and annual in-service education must include:

- Universal precautions
- Proper handling of blood spills
- HBV and HIV transmission and prevention protocol
- Needle stick exposure and management protocol
- Bloodborne pathogen training
- Sharps handling
- Proper disposal of contaminated materials
- Information concerning each employee's at-risk status

At-risk employees must be offered the Hepatitis B vaccination free of charge. Each employee file of an at-risk employee must contain informed consent or informed refusals for Hepatitis B vaccines. Personal protective equipment must be provided to each at-risk employee.

Necessary equipment must be provided for the administration of mouth-to-mouth resuscitation.

Documents to be posted in the facility are:

- Pharmacy Drug Control license issued by the State of Delaware if dispensing drugs other than samples
- Section 17757a from the Board of Pharmacy (if dispensing drugs other than samples)
- Controlled Substances License from State of Delaware and the Federal DEA
- CLIA certificate or waiver
- Medical Waste Management certificate
- X-ray equipment registration
- R-H 100 notice
- Radiology protection rules

PROVIDER CREDENTIALING/RE-CREDENTIALING

The provider's credentialing and re-credentialing processes require that all providers keep the Wellcare With Delaware First Health Credentialing Coordinator updated with changes in credentials. In conjunction with this, providers should respond promptly to any requests to update information so that all credentialing files can be maintained appropriately.

Providers have the following rights during the credentialing process: All information received during the credentialing process that is not peer protected can be forwarded to the applicant upon written request to the credentialing department. The notification will include the time frame and the contact information to respond in writing with a correction or explanation. Wellcare With Delaware First Health is not required to reveal the source of the information if the information is not obtained to meet the credentialing verification requirements or if disclosure is prohibited by law. Upon written request to the credentialing department, any practitioner has the right to be informed in writing or verbally of their credentialing status.

Wellcare With Delaware First Health will make at least three (3) outreach attempts to notify providers of any material discrepancies between credentialing verification data and the information submitted by the provider during the credentialing process, giving them the opportunity to correct erroneous information. Notifications will include the time frame for making the correction and includes the contact information for submitting the correction/explanation which must be submitted in writing before the due date stated on the notification. The provider must inform Wellcare With Delaware First Health in writing of their intent to correct any erroneous information.

Wellcare With Delaware First Health re-credentials each provider in the network at least every three years. Approximately six months prior to the provider's three-year anniversary date, the provider will be notified of the intent to re-credential. All necessary forms will be sent for completion. In certain instances, a site visit will also be scheduled.

Additionally, the provider re-credentialing process includes the review of quality improvement studies, member surveys, complaints and grievances, utilization data, and member transfer rates.

All individuals or entities that furnish services to, or order, refer, or certify the need for services provided to individuals eligible under the Delaware Medicaid State Plan must be screened and enrolled in the Delaware Medicaid program. To receive reimbursement for Medicaid-covered services rendered to eligible beneficiaries, providers must complete the enrollment process and obtain approval through the Delaware Medicaid Management Information System.

Please note: Enrollment is required for participation in a managed care network but does not obligate providers to accept Medicaid fee-for-service beneficiaries. For additional information regarding enrollment requirements, providers are encouraged to consult relevant guidance issued by the DHSS and review applicable policy communications.

Appeals Process

Wellcare With Delaware First Health maintains a formal appeal process for any provider or applicant who is denied new or continued participation in the provider network.

When an Applicant receives a non-approval notice, the affected practitioner has 30 calendar days from receipt of the notice to file a written request for reconsideration. The request must include additional supporting documentation in favor of the applicant's consideration for network participation and should be directed to the Wellcare With Delaware First Health Quality Medical Director via Provider Services. To submit a reconsideration request or obtain further instructions, please contact Provider Services at 1-844-536-2169.

Failure to deliver the request within 30 calendar days constitutes a waiver of reconsideration rights by the affected practitioner.

The request is presented to the Credentialing Committee at the next regularly scheduled meeting but in no case later than sixty (60) calendar days from the receipt of additional information. The Committee may recommend:

- Support of the original denial recommendation by the Credentialing Committee and closure of the file; OR
- Support of the applicant's ability to meet the plan minimum participation criteria and approval of the applicant for inclusion in the plan practitioner network.

The Medical Director/Credentialing Committee Chair, or designee, notifies the applicant in writing within thirty (30) calendar days of the Credentialing Committee decision.

When a practitioner's current participation status is being suspended, restricted or terminated based on issue of quality of care or service, the plan offers and informs the practitioner of their right to a formal appeal hearing. Information about the appeal process and where to submit the request is included within the notification letter. The request for the appeal hearing must be submitted in writing to the Credentialing contact listed on the notification letter within thirty (30) calendar days of the date of the notice. Failure to deliver the request within 30 calendar days constitutes a waiver of hearing rights and the Credentialing Committee's proposed decision becomes final.

In the event a practitioner requests a hearing pursuant to this Policy and Procedure, the plan appoints an Appeals Committee on an ad hoc basis. The Appeals Committee conducts hearings regarding proposed decisions from the Credentialing Committee to suspend, restrict or terminate the network participation of practitioners. The Appeals Committee is comprised of a minimum of three (3) network practitioners, including at least one who is in the same specialty as the practitioner under review.

SECTION 4: UTILIZATION MANAGEMENT

The objective of Wellcare With Delaware First Health's Utilization Management program is to ensure that the medical services provided to members are medically necessary and/or appropriate and are in conformance with the health plan benefits. To guide the decision-making process, UM applies systematic evaluations to appropriate medical necessity criteria and considers circumstances unique to the member.

Access to the Utilization Management Staff

For Utilization Management inquiries, you may call during normal business hours Monday-Friday, 8 a.m. to 5 p.m. at 1-844-536-2169. The provider portal is available 24/7 to status authorization requests and submit new requests

UM DECISIONS

Utilization decisions are based on appropriateness of care and service, as well as the member's eligibility. Wellcare With Delaware First Health does not specifically reward our providers, associates, consultants, or other individuals for any denials of coverage or care issued, nor do we use incentives to encourage denial of care or service.

Utilization management clinical staff uses plan documents for benefit determination and Medical Necessity Coverage Guidelines to support Utilization Management decision-making. All utilization review decisions to deny coverage are made by Wellcare With Delaware First Health Medicare medical directors. In certain circumstances, external review of service requests is conducted by qualified, licensed providers with the appropriate clinical expertise.

Providers should refer directly to Medicare coverage policies for information on Medicare coverage policies and determinations. The two most common types of Medicare coverage policies are National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

NCDs and The Centers for Medicare and Medicaid Services (CMS) explain NCDs through program manuals, which are located on the CMS website under Regulations & Guidance/Guidance/Manuals.

LCDs provide guidance to the public and provider community within a specific geographical area. LCDs supplement an NCD or explain when an item or service will be considered covered if there is no NCD. An LCD cannot contradict an NCD.

In situations where neither NCDs, LCDs nor guidance in Medicare manuals exist, Wellcare With Delaware First Health may reference current literature reviews and Optum, Inc.'s InterQual criteria to inform coverage decisions. When appropriate, Wellcare With Delaware First Health consults with practicing providers and medical experts within the relevant field. Additionally, Wellcare With Delaware First Health considers government agency policies, standards set by nationally recognized accreditation organizations, and Wellcare With Delaware First Health Medical Management policies in its clinical decision-making process.

Wellcare With Delaware First Health may also align its coverage policies with those of other Medicare-Advantage (MA) Organizations within its service area when applicable.

Wellcare With Delaware First Health's Medical Necessity Guidelines are based on current literature review, consultation with practicing providers and medical experts in their particular field, government agency policies, and standards adopted by national accreditation organizations. It is the responsibility of the attending provider to make all clinical decisions regarding medical treatment. These decisions should be made consistently with accepted principles of professional medical practice and in consultation with the member.

Copies of the criteria utilized in decision-making are available free of charge upon request by calling the Utilization Management department at **1-844-536-2169**. In certain circumstances, an external review of service requests is conducted by qualified, licensed providers with the appropriate clinical expertise.

Utilization management decisions determine the medical necessity of a service and are not a guarantee of payment. Claims payment is determined by the member's eligibility and benefits at the time the services are rendered.

Previously approved prior authorizations can be updated for changes in dates of service, CPT/HCPCS codes, or provider within 30 days of the original date of service prior to claim denial.

Classifying Your Prior Authorization Request

Standard Organization Determination (Non-urgent Preservice Request): Standard organization determinations are made as expeditiously as the member's health condition requires, but no later than 7 calendar days after Wellcare With Delaware First Health receives the request for service.

Expedited Organization Determination (Urgent/Expedited Preservice Request): Expedited organization determinations are service requests are made when the member or the provider believes that waiting for a decision under the standard timeframe could place the member's life, health, or ability to regain maximum function in serious jeopardy. The determination will be made as expeditiously as the Member's health condition requires, but no later than 72 hours After receiving the Member's or Provider's request. An extension may be granted for an additional 14 calendar days if the Member requests an extension or if Wellcare With Delaware First Health justifies a need for additional information and documents how the delay is in the interest of the Member.

Requests for expedited review will require provider attestation confirming the clinical urgency of the request.

Inpatient Review

Our nurse reviewers are assigned to follow members at specific acute care facilities to promote collaboration with the facility's review staff and management of the member across the continuum of care. Wellcare With Delaware First Health's nurse reviewers assess the care and services provided in an inpatient setting and the member's response to the care by applying InterQual® criteria together, with the facility's staff, Utilization Management's clinical staff coordinates the members' discharge needs.

Wellcare With Delaware First Health's nurse reviewers' interface with the hospital/facility discharge planners to:

- Obtain and identify the member's discharge planning needs
- Facilitate the transition of the member from one level of care to another level of care
- Obtain clinical information and facilitates the authorization of post discharge services, such as DME, home health services, and outpatient services

Providers must notify Wellcare With Delaware First Health within one business day of admission.

Prior Approval Requirements/ Precertification

Wellcare With Delaware First Health offers multiple methods to submit authorization requests. For the most efficient and timely service use of Wellcare With Delaware First Health's Online Prior Authorization (PA) Form is the preferred method of submitting requests.

1. **Online Submission:** The Wellcare With Delaware First Health Online PA Form can be accessed by visiting the secure Provider Portal
2. **Fax Submission**: Refer to Utilization Management's referral type fax numbers. Please include pertinent clinical documentation with the request if indicated
3. **Phone Submission**: Many authorizations cannot be processed via phone, as clinical review and supporting documentation are required. Requests should only be submitted via the phone for services related to pending hospital discharges or expedited pre-certification requests.

Wellcare With Delaware First Health	
Type of Request	Fax Number
Inpatient Admissions	1-855-581-2251
Post-Acute Admissions	1-844-409-5557
Pre-Service Standard Requests	1-844-409-5557
Pre-Service Expedited Requests (Toll Free)	1-855-581-2251
Part B	1-844-409-5557
Part D (prescription drugs)	1-866-388-1767
Behavioral Health Inpatient Admissions	1-833-967-0499
Behavioral Health Outpatient Services	1-833-967-0498

When submitting a Prior Authorization request, please include the following information:

- Member's name and date of birth
- Member's identification number
- Requesting Provider & NPI Number
- Servicing Provider & NPI Number
- Servicing Facility & NPI Number
- Place of Service
- Date(s) of service

- Procedure Code(s)
- ICD-10 Diagnosis Code(s)

Decision Timeframes – Prior Authorizations			
Review Type	Make Decision	Written/Verbal Notification	Written Notification (Denials)
Pre-Service Non-urgent	Within 7 days of receipt of the request	Within 7 days of receipt of the request	Within 7 days of receipt of the request
Pre-Service Urgent	Within 72 hours of receipt of the request	Within 72 hours of receipt of the request	Within 72 hours of receipt of the request
Urgent Concurrent	Within 24 hours of receipt of the request, 72 hours if clinical is not included with initial request	Within 24 hours of receipt of the request, 72 hours if clinical is not included with initial request	Within 72 hours of the decision

CMS INTEROPERABILITY APIS — PROVIDER OVERVIEW

In support of federal CMS interoperability requirements, Wellcare With Delaware First Health offers a set of standardized application programming interfaces (APIs) that support improved data sharing between providers, health plans, and members. Two of these - the **Prior Authorization API** and the **Provider Access API** - are designed specifically to reduce administrative burden, streamline clinical workflows, and strengthen care coordination through the secure, electronic exchange of information within participating EHR/EMR systems.

Prior Authorization API

Providers whose EHR/EMR vendor has connected to the Prior Authorization API may be able to check authorization requirements, identify required documentation, submit prior authorization requests, and receive status updates and decisions electronically within their existing clinical workflow. These capabilities bring greater transparency to the process and support more efficient prior authorization processing for medical items and services.

Provider Access API

Providers whose EHR/EMR vendor has connected to the Provider Access API may be able to retrieve eligible patient claims, clinical, and prior authorization information to support treatment and care coordination. Access is generally limited to providers with an active treatment relationship and remains subject to applicable member consent and privacy requirements.

Additional Interoperability APIs

CMS interoperability requirements also include the **Patient Access API**, which allows members to share their health information with third-party applications; the **Payer-to-Payer API**, which supports electronic data

exchange when members change plans or are covered by more than one health plan; and the **Provider Directory API**, which makes provider directory information available to third-party applications.

For detailed educational materials, implementation guidance, a list of connected EHR/EMR vendors, and frequently asked questions, providers are encouraged to visit the wellcarede.com.

CLINICAL INFORMATION

Clinical information should be provided at the time of submission of the request. The provider or facility is responsible for ensuring services are authorized prior to service delivery authorization. Wellcare With Delaware First Health provides a reference number on all authorizations. To ensure a timely decision, make sure all supporting clinical information is included with the initial request:

Clinical information includes relevant and current information regarding the members:

- History of presenting problem
- Physical assessment
- Diagnostic results
- Photographs
- Consultations
- Previous and current treatment
- Member's response to treatment

Clinical Practice Guidelines

Wellcare With Delaware First Health encourages the use of evidence-based Clinical Practice Guidelines (CPGs) by all participating providers. These guidelines are available under the Provider section of our website at wellcarede.com.

Whenever possible, Wellcare With Delaware First Health adopts preventive and clinical practice guidelines that are:

- Published by nationally recognized organizations (e.g., CDC, USPSTF, AHRQ),
- Endorsed by government institutions, or
- Developed through statewide collaboratives or consensus among healthcare professionals in the relevant field.

These guidelines are reviewed and selected with the needs of the Delaware HIDE-SNP population in mind. This includes individuals who are dually eligible for Medicare and Medicaid, and who may require:

- Home and community-based services (HCBS),
- Behavioral health support, and
- Management of chronic and complex conditions.

The goal is to support whole-person, integrated care that improves health outcomes, promotes independence, and aligns with the principles of the Model of Care for HIDE-SNPs.

SERVICES REQUIRING PRIOR AUTHORIZATION

The list below provides Wellcare With Delaware First Health's general Prior Authorization requirements. This list is not all inclusive and is subject to change. Providers will be given 60-day advance notice to additions to the Prior Authorization list. Please verify requirements at the time of the request.

Wellcare With Delaware First Health Utilization Management verifies benefit eligibility and medical necessity for select services at the time of the request and is not a guarantee of coverage or payment. Payment is determined by the members' eligibility and benefits at the time of service.

Claims payment is also based on the appropriateness, accuracy, and presence of codes submitted on the claim as determined by Centers for Medicare and Medicaid Services (CMS). You can check the requirements for any code on our website at wellcarede.com. Codes that are not listed on the applicable Medicaid fee schedule may not be payable by Wellcare With Delaware First Health.

Inpatient Services

- All inpatient admissions (Emergent and Elective)
- Long-Term Acute Care (LTACH) admissions
- Acute Rehabilitation admissions
- Skilled nursing facilities (SNF) admissions

Durable Medical Equipment (DME)[1]

- DME items are covered according to the Delaware Department of Healthcare and Family Services (HFS) Medicaid Fee Schedule and are subject to applicable prior authorization requirements
- Insulin pumps for DM type 1
- Hearing aids

Certain Outpatient Services/Treatments/Procedures

- Chiropractic Services
- Nutritional Counseling
- Hyperbaric oxygen therapy
- Genetic Testing
- Home Health/Skilled Nursing Visits
- Back Surgeries

[1] *This list is not all inclusive and is subject to change.*

- Ambulance Transportation Non-Emergent
- Dental Anesthesia in Facility
- Hysterectomy
- Spinal Surgeries
- Varicose Vein Surgery
- Breast Reduction
- Septoplasty
- Rhinoplasty
- Experimental and Investigational procedures

MENTAL HEALTH OUTPATIENT VISITS FOR MEMBERS WITH MILD-TO-MODERATE BEHAVIORAL HEALTH CARE NEEDS

Wellcare With Delaware First Health covers mental health outpatient services for members with mild to moderate behavioral health conditions. Members with severe mental illness conditions as defined by the state, receive mental health outpatient services through the PIHPs. You may contact our Behavioral Health staff at **1-844-536-2167** to assist a member with the following services:

- Locating a behavioral health provider
- Scheduling behavioral health appointments
- Locating community groups and self-help groups

SPECIALTY NETWORK ACCESS TO CARE

Referrals to Specialists may be considered when an appropriate in-network specialist is not available, or when a second opinion is requested following consultation or treatment by an in-network specialist. Specialist referrals may be utilized when an in-network specialist is not available, or to seek another opinion subsequent to consultation/treatment with an in-network specialist.

As a PCP, you may request a referral to one of the health care public entities via Wellcare With Delaware First Health's Provider Portal at www.wellcarede.com/for-providers, fax or by calling Wellcare With Delaware First Health at **1-844-536-2169**. Wellcare With Delaware First Health's staff will forward the information and authorization to the central referral office of the public entities. Wellcare With Delaware First Health will fax you a copy of the approved referral notification form along with contact information to the public entity.

Services that DO NOT require prior authorization (regardless of contract status) include:

- Emergency services
- Post stabilization services
- Women's Health
- Long-Acting Reversible Contraception (LARCs)
- Other services based on state requirements

You may access the most recent Authorization Requirements on the Prior Authorization Requirements tool.

DENIALS AND RECONSIDERATIONS

Denials based on medical necessity may only be issued by a Wellcare With Delaware First Health Medical Director. When a denial occurs, the requesting provider will be notified via phone to discuss the decision.

In addition to verbal communication, a written denial notice is:

- Faxed to the requesting provider, and
- Mailed to the member.

The denial notice includes the following:

- The specific reason(s) for the denial,
- A reference to the applicable benefit provision and/or clinical guideline used to make the decision,
- Instructions on how to request a free copy of the benefit provision and/or guideline,
- A clear description of the members' appeal rights, and
- Step-by-step instructions for submitting an appeal.

MODEL OF CARE OVERVIEW

Wellcare With Delaware First Health's Model of Care is designed to support a complex population with diverse medical, behavioral, and social needs. The Care Coordination model integrates medical, hospital, behavioral health, and LTSS, along with community-based resources, to promote independent and healthy living.

This whole-person approach emphasizes not only the management of chronic conditions but also recovery, wellness, and member autonomy. Central to this model is the Interdisciplinary Care Team (ICT), which may include the member, their chosen supports, primary care provider (PCP), care manager, LTSS coordinator, and other clinical or social service specialists, as appropriate.

The provider network reflects this integrated philosophy, consisting of medical professionals, behavioral health specialists, LTSS providers, and community-based organizations committed to evidence-based, collaborative, and person-centered care.

Wellcare With Delaware First Health continuously refines its Model of Care through quality improvement initiatives, incorporating data-driven insights and member feedback to ensure it meets the evolving needs of the dual-eligible population. These efforts have been recognized at both the state and national levels.

Care Coordination

Wellcare With Delaware First Health's Care Coordination program offers personalized case management for members with complex or high-risk conditions. The program is designed to improve health outcomes through proactive care planning and service coordination.

Eligible members include those with:

- Asthma
- Diabetes
- Congestive heart failure
- Cardiovascular disease
- Complex or catastrophic illness
- High emergency room utilization
- Maternity care needs

Care Coordinators may contact providers to:

- Participate in members' ICT meeting
- Coordinate and/or update a member's plan of care
- Confirm diagnoses or test results
- Identify care gaps or non-compliance issues
- Address behavioral health needs or social determinants of health

Referrals to Care Coordination may be submitted via the secure Wellcare With Delaware First Health Provider Portal using the "Notify CM" button, or by calling **1-844-536-2169**.

Integrated Care Team (ICT)

Providers identified as part of a member's ICT are encouraged to actively participate in the care planning process. The ICT collaborates with the member and their supports to ensure care is coordinated, person-centered, and aligned with the member's unique goals, preferences, and needs.

EVOLENT

Advanced Diagnostic Imaging

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

Prior authorization is required for the following outpatient radiology procedures:

- CT/CTA/CCTA
- MRI/MRA
- PET

Key Provisions:

- Emergency room, observation, and inpatient imaging procedures do not require authorization;
- It is the responsibility of the ordering provider to obtain authorization; and

- Providers rendering the above services should verify that the necessary authorization has been obtained; failure to do so may result in denial of all or a portion of the claim.

To reach Evolent and obtain authorization, please call **1-866-510-4470** and follow the prompt for radiology authorizations. Evolent also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information or call our Provider Services department.

Cardiac Solutions

Wellcare With Delaware First Health in collaboration with Evolent, launched a cardiac imaging program to promote healthcare quality for members with possible cardiac disease.

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

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

How does this program improve member health?

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

Program Components

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

How the Program Works

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

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

The following services do not require authorization through Evolent:

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

To reach Evolent and obtain authorization, please call **1-866-510-4470** and follow the prompt for radiology and cardiac authorizations. Evolent also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information.

Physical Medicine Program

To help ensure that physical medicine services (physical, speech, l and occupational therapy) provided to our members are consistent with nationally recognized clinical guidelines, Wellcare With Delaware First Health has partnered with Evolent to implement a prior authorization program for physical medicine services. Evolent provides utilization management services for outpatient physical, occupational and speech therapy services on behalf of Wellcare With Delaware First Health members.

How the Program Works

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

Under the agreement between Wellcare With Delaware First Health and Evolent, Wellcare With Delaware First Health oversees the Evolent Therapy Management program and continues to be responsible for claims adjudication. If Evolent therapy peer reviewers determine that the care provided fails to meet our criteria for covered therapy services, you and the member will receive notice of the coverage decision.

Should you have questions, please contact Wellcare With Delaware First Health Provider Services at **1-844-536-2169**.

Interventional Pain Management

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

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

Note: A separate prior authorization number is required for each procedure ordered. Prior authorization is not required through Evolent for services performed in the emergency department, on an inpatient basis or in conjunction with a surgery. Prior authorization and/or notification of admission is still required through Wellcare With Delaware First Health. To obtain authorization through Evolent, visit RadMD.com. or call 1-866-510-4470.

Musculoskeletal (MSK) Management Program

The MSK program currently requires prior authorization for non-emergent outpatient, interventional spine pain management services (IPM), and will be expanded to include spinal cord stimulators, and inpatient and outpatient hip, knee, shoulder, lumbar, and cervical spine surgeries for our members. The decision to implement this latest program is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

Under the terms of this agreement:

- We will oversee the MSK program and continue to be responsible for claims adjudication and medical policies.
- Evolent will manage IPM services, and inpatient and outpatient MSK surgeries through the existing contractual relationships with us.

It is the responsibility of the ordering provider to obtain prior authorization for all IPM procedures and MSK surgeries managed by Evolent. Evolent does not manage prior authorization for emergency MSK surgery cases that are admitted through the emergency room or for MSK surgery procedures outside of those procedures listed above. The ordering provider must obtain prior authorization with Evolent prior to performing the surgery/procedure. Facility admissions do not require a separate prior authorization. However, the facility should ensure that an Evolent prior authorization has been obtained prior to scheduling the surgery/procedure.

MSK surgeries other than those outlined above will continue to follow prior authorization requirements for hospital admissions and elective surgeries as outlined for the Wellcare With Delaware First Health HIDE-SNP line of business.

Medical and Radiation Oncology

Wellcare With Delaware First Health has partnered with Evolent to administer the Medical Oncology and Radiation Therapy Utilization Management Program. This program is designed to ensure that selected oncology and radiation therapy services are clinically appropriate, evidence-based, and delivered in accordance with nationally recognized guidelines and medical necessity criteria.

Coverage and authorization requirements may vary by product and market. Services subject to prior authorization are identified in the Health Plan's current Prior Authorization List and applicable medical policies, which are updated periodically.

Providers are required to submit all applicable prior authorization requests through the https://www.evolent.com/provider-portal. The portal is used for submission of clinical documentation, authorization determination, and related inquiries.

How the Program Works

Medical and Radiation Oncology Services: Prior authorization will be required for outpatient settings:

Medical Oncology

These are drug-based cancer treatments, including:

- **Chemotherapy regimens** (IV and oral, when covered under medical benefit)
- **Immunotherapy** (e.g., checkpoint inhibitors)
- **Targeted therapy** (precision oncology drugs based on biomarkers)
- **Combination cancer regimens** (chemo + immunotherapy or targeted agents)
- **Supportive oncology drugs** when they require authorization

Radiation Oncology

- Treatment planning and simulation
- Conventional external beam radiation therapy (EBRT)
- Intensity-Modulated Radiation Therapy (IMRT)
- Stereotactic Body Radiation Therapy (SBRT)
- Stereotactic Radiosurgery (SRS) (brain and spine-focused treatments)
- Image-Guided Radiation Therapy (IGRT)
- **Brachytherapy** (internal radiation in certain cases)
- **Specialized radiation treatment planning services** and physics/technical components tied to treatment delivery

Program functions

- Review of dose, frequency, and treatment duration
- Validation against oncology clinical pathways and guidelines
- Monitoring for appropriate sequencing of therapies (especially multi-line treatment)

Cardiology Surgical Procedures

Wellcare With Delaware First Health has partnered with Evolent to launch an innovative Cardiac Surgical Quality and Safety Management Program. The program is designed to work collaboratively with providers to promote patient safety through the practice of high quality and cost-effective care for Ambetter Health members undergoing cardiac surgical procedures.

How the Program Works

Cardiology surgical procedures: Prior authorization will be required for the following non-emergent inpatient and outpatient surgeries:

CARDIAC SURGERIES & PROCEDURES

Including all associated partial, total, and revision surgeries

- Coronary Angioplasty/Stenting
- Internal Cardiac Monitoring
- Implantable Cardioverter Defibrillator
- Leadless Pacemaker
- ICD Revision or Removal
- Left Atrial Appendage (LAA) Occluders
- Non-Coronary Angioplasty/Stenting
- Pacemaker
- Pacemaker Revision or Removal
- Peripheral Revascularization
- Percutaneous Transcatheter Closure
- WCD - Wearable Cardiac Defibrillator
- Cardiac Ablation
- Coronary Artery Bypass Grafting

KEY PROVISIONS:

- Emergency related procedures do not require authorization
- It is the responsibility of the ordering provider to obtain authorization
- Providers rendering the above services should verify that the necessary authorization has been obtained; failure to do so may result in non-payment of your claims.

To submit authorizations, please contact Evolent at https://www.evolent.com/provider-portal

SECTION 5: BILLING AND CLAIMS PAYMENT

OVERVIEW

Wellcare With Delaware First Health's Claims Department is structured to ensure accurate and timely processing of provider claims. A dedicated toll-free telephone number, **1-844-536-2169**, is available for providers to contact a representative with claim-related inquiries.

CLEAN CLAIM SUBMISSION

Wellcare **With** Delaware First Health only accepts the CMS 1500 (02/12) and CMS 1450 (UB-04) Claim Forms whether filing on paper or electronically. Other claim form types will be rejected and returned to the provider.

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

IMPORTANT STEPS TO SUCCESSFUL SUBMISSION OF CLAIMS

The following information must be included on every claim, paper or electronic:

1. Providers must file claims using standard claims forms (CMS 1450 (UB-04) for hospitals and facilities; CMS 1500 for providers or practitioners).
2. Complete all required fields on an original, red CMS 1500 (Version 02/12) or CMS 1450 (UB-04) Claim Form. NOTE: Non-red, nonstandard, and handwritten claim forms will be rejected back to the provider.
3. Enter the provider's NPI number in the "Rendering Provider ID#" section of the CMS 1500 form (see box 24J).
4. Providers must include their taxonomy code (e.g., 207Q00000X for Family Practice) and corresponding ID qualifier in this section for correct processing of claims.
5. Ensure all Diagnosis Codes, Procedure Codes, Modifier, Locations (Place of Service); Type of Bill, Type of Admission, and Source of Admission Codes are valid for the date of service.
6. Ensure all Diagnosis and Procedure Codes are appropriate for the age and sex of the member.

7. Ensure all Diagnosis Codes are coded to their highest number of digits available.
8. Principal diagnosis billed reflects an allowed principal diagnosis as defined in the volume of ICD-10-CM for the date of service billed. Ensure member is eligible for services during the time which services are provided.
9. Ensure provider receives authorization to provide services to the eligible member, when appropriate.
10. Ensure an authorization is given for services that require prior authorization by Wellcare With Delaware First Health.
11. National Drug Code (NDC) is billed in the appropriate field on all claim forms when applicable. This includes the quantity and type. Type is limited to the list below:

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

12. For a CMS 1500 Claim Form, this criteria looks at all procedure codes billed and the diagnosis they are pointing to. If a procedure points to the diagnosis as primary, and that code is not valid as a primary diagnosis code, that service line will deny.
13. All inpatient facilities are required to submit a Present on Admission (POA) Indicator. Claims will be denied (or rejected) if the POA indicator is missing. Please reference the CMS Billing Guidelines regarding POA for more information and for excluded facility types. Valid 5010 POA codes are:

    - N – No
    - U – Unknown
    - W – Not Applicable
    - Y – Yes

14. Claims must contain the CLIA number when CLIA waived or CLIA certified services are provided. Paper claims must include the CLIA certification in Box 23 when CLIA waived or CLIA certified services are billed. For EDI submitted claims, the CLIA certification number must be placed in: X12N 837 (5010 HIPAA version) loop 2300 (single submission) REF segment with X4 qualifier or X12N 837 (5010 HIPAA version) loop 2400 REF segment with X4 qualifier, (both laboratory services for which CLIA certification is required and non-CLIA covered laboratory tests); and DME Claims require Referring Provider.

All claim submissions will be subject to 5010 validation procedures based on CMS Industry Standards.

If electronic Claim submission is not possible, all hard copy (CMS-1500, CMS-1450 {UB-04}) claims must be submitted by mail to:

Wellcare With Delaware First Health
Attn: Claims Department
P.O. Box 9700
Farmington, MO 63640-0700

CLAIMS BILLING REQUIREMENT

In order to receive reimbursement in a timely manner, please ensure each claim:

1. Uses the data elements of UB-04 (UB-04 Version 050) or CMS 1500 as appropriate http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf
2. If the facility is Medicaid-enrolled ASC, bill using the ASC X12 837 5010 professional claim format when submitting electronic claims. Paper claims must be billed on CMS 1500 paper form.
3. It is submitted within 365 days of the date the service was performed
4. Identifies the member (Member ID assigned by Wellcare With Delaware First Health address, and date of birth)
5. Identify the Plan (Plan name and/or member ID number)
6. Lists the date (mm/dd/yyyy) and place of service
7. If necessary, substantiates the medical necessity and appropriateness of the care or services provided, that includes any applicable authorization number if Wellcare With Delaware First Health requires prior authorization
8. Includes additional documentation based upon services rendered as reasonably required by Wellcare With Delaware First Health Medical Policies
9. Is certified by provider that claim:
    a. Is true, accurate, prepared with the knowledge and consent of provider
    b. Does not contain untrue, misleading, or deceptive information
    c. Identifies each attending, referring, or prescribing provider, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim
10. Is a claim for which the provider has verified the member's eligibility and enrollment in Wellcare With Delaware First Health before the claim was submitted
11. Is not a duplicate of a claim submitted within 45 days of the previous submission
12. Is submitted in compliance with all of Wellcare With Delaware First Health's prior authorization and claims submission guidelines and procedures
13. Is a claim for which the provider has exhausted all known other insurance resources for the Medicaid line of business (Medicaid is the payer of last resort)
14. Is submitted electronically if the provider has the ability to submit claims electronically

Providers may submit and check the status of claims electronically via the secure Wellcare With Delaware First Health Provider Portal.

Submit claims via the Provider Portal: www.wellcarede.com/for-providers

Note: For fastest, most accurate processing, EDI is the preferred method.

Submit all initial claims for payment to:

Wellcare With Delaware First Health
Attn: Claims Department
P.O. Box 9700
Farmington, MO 63640-0700

TAXONOMY CODES

Taxonomy Codes are designed to categorize the type, classification, and/or specialization of healthcare providers. Wellcare With Delaware First Health requires all claims, both paper and electronic, to include the taxonomy code of the rendering provider. The taxonomy code included on the claim must also match the taxonomy code Wellcare With Delaware First Health has on file for the rendering provider. To submit or update this information, please complete the provider enrollment form located on our website.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC)/FREESTANDING RURAL HEALTH CLINIC (RHC)/ENCOUNTER RATE CLINIC (ERC)

FQHCs are important community providers, and all Wellcare With Delaware First Health members have access to them if the member resides in a community where FQHC services are available. The Member Handbook outlines the member's rights to access a FQHC in their service area. Billing requirements for FQHC/RHC for Medicaid is fee-for-service.

FQHC, RHC, and ERC Billing Requirements:

- Claims must be billed using the group National Provider Identifier (NPI).
- Behavioral health (BH) claims must include the appropriate BH modifier.
- All claims must be submitted on a UB-04 claim form.

Billing by Payor Type

Billing by Payor Type		
Payor Type	Claim Form	Reimbursement Method
Wellcare With Delaware First Health– Medicare Primary	UB-04	Paid at CMS Federal Encounter Rate or Fee Schedule based on services rendered

Billing by Payor Type		
Payor Type	Claim Form	Reimbursement Method
Wellcare With Delaware First Health– Medicaid Primary	UB-04	Paid based on the Delaware Medicaid provider fee schedule
Dual-Eligible Members	UB-04	Medicare pays primary claim; Medicaid processes coinsurance and remaining balance, as applicable

ELECTRONIC CLAIMS SUBMISSION

Providers using electronic submission shall submit all claims to Wellcare With Delaware First Health or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 837 electronic format, or a CMS 1500 and/or UB-04, or their successors. Claims shall include the provider's NPI, tax ID and the valid taxonomy code that most accurately describes the services reported on the claim. The provider acknowledges and agrees that no reimbursement is due for a covered service and/or no claim is complete for a covered service unless performance of that covered service is fully and accurately documented in the member's medical record prior to the initial submission of any claim.

In-network providers may submit claims through Wellcare With Delaware First Health Provider Portal at www.wellcarede.com/for-providers.

Clearinghouses

The preferred method for submitting claims is electronically. This can be done through clearinghouses or via the online Provider Portal.

If you are re-submitting a claim for a status or a correction, please indicate "Status" or "Claims Correction" on the claim.

Wellcare With Delaware First Health is currently accepting electronic claims from the following clearinghouses:

Availity Essentials

- Customer Support: 1-800-282-4548
- **Claim Types:** Professional/Facility
- Payer ID: 68069

Providers are responsible for ensuring they receive a confirmation file for claims submitted via EDI.

Wellcare With Delaware First Health may add new clearinghouses partners periodically. Providers should contact Provider Services at **1-844-536-2169** to verify whether their current clearinghouse is included in the

approved list. It is the providers' responsibility to ensure receipt of a confirmation file for all claims submitted via EDI.

PAPER CLAIMS SUBMISSION

To facilitate processing and to minimize chances for rejection or error in payment, it is required that paper claims be typewritten or computer printed. The recommended font to use for computer generated claims is 12-point Times New Roman font. Do not print in italics, bold or script. Handwritten claims and photocopied claims are not accepted. Paper claims information must be submitted within the confines of each item box.

Claims must be legibly signed and dated in ink by the provider or his or her authorized representative. Any claim that is not properly signed or that has the certification statement altered will be rejected. A rubber signature stamp or other substitute is not acceptable. An authorized representative may only be a trusted employee over whom the provider has direct supervision on a daily basis and who is personally responsible on a daily basis to the provider. Such a representative must be designated specifically and must sign the provider's name and his or her own initials on each certification statement. This responsibility cannot be delegated to a billing service. It is mandatory that claims for services be submitted only on original billing forms. Photocopies or other facsimile copies cannot be accepted for payment purposes.

PAYSPAN® ELECTRONIC PAYMENTS & REMITTANCE

Overview

PaySpan® is Wellcare With Delaware First Health's preferred secure electronic payment solution that allows providers to receive claim payments and remittance information electronically. Through PaySpan, providers can access payment details quickly, streamline reimbursement processes, and reduce administrative burden associated with paper checks and mailed EOBs.

Benefits to Providers

- **Faster Payments:** Receive claim payments via EFT (Electronic Funds Transfer), reducing delays associated with paper checks.
- **Convenient Online Access:** View remittance information (835s/EOBs) online, download reports, and reconcile payments in real time.
- **Customizable Preferences:** Choose how and when payments are received, including grouping, notification settings, and reporting formats.
- **Enhanced Security:** EFT reduces risk of lost, stolen, or misdirected checks.
- **Improved Administrative Efficiency:** Streamlined payment workflows allow billing teams to reduce manual posting and improve cash flow management.

Enrollment

Providers who have not yet enrolled in PaySpan must complete the online registration process. During enrollment, providers will:

- Verify TIN/NPI credentials
- Provide banking information for EFT
- Set up user accounts and security preferences

Providers should have their most recent payment or provider information available to complete registration.

Existing PaySpan providers will be required to add the Wellcare With Delaware First Health's line of business to their existing account using their TIN. Failure to register the new line of business may result in providers receiving paper checks.

How to Access PaySpan

Providers may log in to PaySpan's secure portal at www.payspanhealth.com.

Support & Assistance

For enrollment assistance, password resets, or technical questions, providers may contact PaySpan Customer Service:

- **PaySpan Support: 1-877-331-7154**
- **Email:** providersupport@payspanhealth.com
- **Hours:** Monday–Friday, 8 a.m. to 8 p.m. EST

For questions related to claim payment amounts or adjudication decisions (not system access), providers should contact Provider Services at **1-844-536-2169**.

TIMELY FILING OF CLAIMS

A claim must be submitted within 180 days from the date of service.

CORRECTED CLAIMS

A corrected claim should be submitted when a provider needs to change information on a previously submitted initial claim. All requests for corrected claims or reconsiderations/claim disputes must be received within 90 days from the date of the original explanation of payment or denial.

If you are replacing or voiding/cancelling a UB-04 claim, please use appropriate bill type of 137 or 138. If you are replacing or voiding/cancelling a CMS 1500 claim, please complete box 22. For replacement or corrected claim, enter resubmission code 7 on the left side of item 22 and enter the original claim number of the claim you are replacing on the right side of item 22. If submitting a void/cancel claim, enter resubmission code 8 on the left side of item 22 and enter the original claim number of the paid claim you are voiding/cancelling on the right side of item 22. If you do not follow these corrected claim form submission processes the claim will deny for a duplicate claim submission.

OVERPAYMENTS

Providers are required to promptly notify Wellcare With Delaware First Health upon identification of any overpayment. Identified overpayments must be returned to the Plan within sixty (60) calendar days, accompanied by written documentation detailing the reason for the overpayment.

RETROACTIVE ADJUSTMENTS

Should CMS Risk Adjustment activity retroactively increase or decrease payments, including Risk Adjustment Data Validation (RADV), and for adjustments made by CMS to Health Plan's monthly payments based upon changes in eligibility, capitation payments to Providers shall be retroactively adjusted on a proportional basis.

Wellcare may contract with a vendor to conduct premium enhancing activities. Any fees resulting from premium enhancing activities conducted by Wellcare With Delaware First Health's vendor will be charged back to Provider during the period when the premium changes are realized. The vendor will sign a HIPAA compliant Business Associate Agreement with Wellcare that allows it to collect PHI on our behalf.

REIMBURSEMENT GUIDELINES, PAYMENT POLICES AND CODING GUIDANCE

Member Billing

Pursuant to Law, Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the State or another payor is responsible for paying such amounts. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization. Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Wellcare With Delaware First Health to the Provider. Providers may not bill Wellcare With Delaware First Health DSNP members for covered services, also known as "balance billing," regardless of whether they believe the amount they were paid or will be paid by Wellcare With Delaware First Health is appropriate or sufficient. Balance billing a Member for Covered Services is prohibited, except for the Member's applicable Patient Liability towards covered Medicaid services such as Nursing Facility.

Post-Service Provider Appeals

Wellcare With Delaware First Health offers a Post-Service claim appeal process for disputes related to denial of payment for services rendered to Wellcare With Delaware First Health members. This process is available to all providers, regardless of whether they are in or out of network.

What Types of Issues Can Providers Appeal?

The appeals process is in place for two main types of issues:

- Post-Service Provider Appeal: An appeal of services that were denied or reduced because they did not meet a specific criteria, policy or guideline and have a denied authorization on file. For example, the provider disagrees with a determination made by Wellcare With Delaware First Health, such as

combining two stays as a 15-day readmission. In this case, the provider should send additional information (such as medical records) that support the provider's position.

- Administrative Appeal: An appeal by a provider of a claim/service denied for failure to authorize services according to timeframe requirements. In this case, the provider must explain the circumstances and why the provider feels an exception is warranted in that specific case.

A provider's lack of knowledge of a member's eligibility or insurance coverage is not a valid basis for an appeal. Providers cannot appeal denials due to a member being ineligible on the date of service or due to non-covered benefits.

How to File a Post-Service Provider Appeal

Providers may submit a post-service appeal in one of three ways:

1. Login to the Provider Portal to submit an appeal. This is the preferred method for a quicker turnaround time.
2. Via mail by filling out the Appeal Cover Letter form and sending documentation to support your position, such as medical records, to the following address:

Wellcare With Delaware First Health
Attn: Appeals Department
P.O Box 9700
Farmington, MO 63640-0700

Timeframe for Filing a Post-Service Provider Appeal

Provider appeals must be submitted within 180 days from the date of the EOP.

Response to Post-Service Provider Appeals

Wellcare With Delaware First Health typically responds to a Post-Service Provider Appeal within 30 calendar days from the date of receipt. Providers will receive a letter with the decision and rationale.

For Medicare-covered services, there is one level of provider appeal, and all determinations are final.

For Medicaid-covered services, providers may have additional appeal rights, including the option to request a State Fair Hearing or review by a Medicaid Independent Review Entity (IRE), depending on the nature of the service and the appeal.

Medical Records

All medical records requested by Wellcare With Delaware First Health are to be provided at no cost from the Provider. This includes administrative fees, copying fees, paper fees, and fees delegated from a third-party vendor.

Medical records should be provided to Wellcare With Delaware First Health within 10 business days of request, unless otherwise agreed. To help ease the burden on providers, accommodations can be arranged

for individuals designated by Wellcare With Delaware First Health to assist in extracting medical records for this request. Electronic access to medical records should be arranged wherever possible.

Procedure

All practitioners in the network must comply with the following:

1. Medical record documentation must include at least the following elements:
    a. All services provided directly by the practitioner
    b. All ancillary services and diagnostic tests ordered by the practitioner
    c. All diagnostic and therapeutic services for which the member was referred to by the practitioner (e.g., home health nursing reports, specialty provider reports, hospital discharge reports, and physical therapy reports)
2. The essential documentation elements for the medical record include:
    a. History and physicals
    b. Allergies and adverse reactions, or NKDA, are prominently noted
    c. Problem lists of significant illnesses and medical conditions, with date of onset
    d. Medications (current medications, changes, discontinuation, and reported reactions)
    e. Working diagnoses are consistent with findings
    f. Treatment plans are consistent with diagnoses
    g. Preventive services/risk screenings
    h. There is no evidence that the member is placed at inappropriate risk by a diagnostic or therapeutic procedure
3. The Medical Record Keeping standard checks for the following:
    a. Presence of an organized medical record system (i.e., dividers by type of service such as lab reports/test, consults, etc.)
    b. The medical record is a unit record (bound and organized)
    c. Entries in the medical record are legible, signed and dated
    d. The medical record is available to the practitioner (attending and covering) at every visit and retrievable for review for ten years
    e. Member information is kept confidential by ensuring that the records are stored securely, and only authorized personnel have access to the records. Fax machines should be in an area that is not accessible by other members to ensure confidentiality

f. Acknowledgement of receipt of privacy notice in record (If not in individual records, there is a central file with acknowledgement of receipt of notice)

Note: Corrective action plans are requested of all providers whose compliance falls below stated levels (80%). Reassessment is subsequently completed within 6 months to verify improved performance and compliance.

A focused medical record review is performed annually as part of the continuous quality improvement activities of Wellcare With Delaware First Health. In addition, an individual practitioner medical record review may be performed, when the apparent lack of compliance with the above standards is discovered during a utilization management or QI activity.

SECTION 6: REPORTING REQUIREMENTS

MANDATORY REPORTING OF SUSPECTED CHILD AND DEPENDENT ADULT ABUSE

Delaware First Health providers who are mandatory reporters under Delaware law have a responsibility to report known suspected child or dependent adult abuse in accordance with all applicable laws.

If you suspect a child under the age of 18 is abused or neglected, call Child Abuse Hotline at **1-800-292-9582** More information is available at dhss.delaware.gov/dhss/dmma/medicaid.html.

To report abuse, neglect, exploitation, or self-neglect of a dependent adult, call **1-800-223-9074**.

CRITICAL INCIDENTS REPORTING

Delaware First Health Providers shall report critical incidents to Delaware First Health immediately upon occurrence and no later than within twenty-four (24) hours after detection or notification. The Incident Report Form can be found at DelawareFirstHealth.com. Delaware First Health shall ensure suspected cases of abuse, neglect and/or exploitation are reported to DSAMH Risk Management. Critical incidents include but are not limited to the following incidents:

- Unexpected death of a member
- Suspected physical, mental, or sexual mistreatment, abuse, and/or neglect of a member
- Suspected theft or financial exploitation of a member
- Severe injury sustained by a member when source of injury is unknown, and injury is suspicious, or injury requires transfer to acute care
- Medication or treatment error or omission that jeopardizes a member's health or safety
- Inappropriate/unprofessional conduct by a provider involving a member

Incident Reporting

If Wellcare With Delaware First Health or a provider perceives an immediate threat to the member's life or safety, contact **911**.

Incident Involves	Contact	Timeframe
All adults (including those with disabilities), ages 18–59, living in an institutional setting Cases of suicidal ideation for members with developmental disabilities (DD) or mental health concerns residing in an institutional setting	Delaware Department of Health and Social Services (DHSS): **1-866-833-9718**	Immediately

Incident Involves	Contact	Timeframe
Adults with disabilities, ages 18-59, living in a community setting Older adults (60 years of age and older) regardless of residence	Adult Protective Services Hotline: 1-888-277-4302 (1-888-APS-4302)	Immediately
All adults, ages 18–59, living in a community setting	Local Police Department	Immediately

CORPORATE REPORTING REQUIREMENTS

Member encounter information should be reported on submitted claims forms (CMS 1500; UB-04) by stamping or clearly designating on the claims form "ENCOUNTER."

Practices will be monitored for accurate and complete encounter reporting. The data that Wellcare With Delaware First Health submits to the State of Delaware requires your compliance with this requirement.

Other reporting requirements or data collection may be added, as data collection requirements are dynamic. PCP offices will be notified in writing of any additional reporting requirements.

ENCOUNTER REPORTING REQUIREMENTS

To support regulatory compliance and ensure accurate reporting of healthcare utilization, Centene – on behalf of Wellcare With Delaware First Health – is responsible for submitting encounter data to both federal and state agencies. This includes:

- CMS (Centers for Medicare & Medicaid Services) for Medicare-covered services
- Delaware Department of Health and Social Services (DHSS) for Medicaid-covered services

For members dually eligible for Medicare and Medicaid, Centene must submit two separate encounter records – one to CMS and one to DHSS.

Providers play a critical role in this process by submitting complete and accurate claims that include all required data elements. These claims serve as the foundation for encounter records and must reflect all services rendered to members. Claims should follow standard formatting conventions using CMS 1500 or UB-04 forms, as applicable.

To ensure compliance with Centene's government contracts, providers must:

- Submit claims timely and accurately
- Include all necessary coding and documentation
- Adhere to Centene's data integrity standards

Incomplete or inaccurate encounter data may result in regulatory penalties for Centene. Therefore, providers are expected to maintain high standards in documentation and claim submission.

Additionally, as part of the provider contract, Provider Preventable Conditions (PPCs) must be reported. PPCs include:

- **Health Care-Acquired Conditions (HCACs)** – conditions not present at the time of inpatient admission
- **Other Provider Preventable Conditions (OPPCs)** – conditions that could have been avoided through adherence to evidence-based clinical guidelines

All delegated vendors, delegated providers, and capitated providers are required to submit encounter data to Centene, regardless of reimbursement arrangements.

ELECTRONIC VISIT VERIFICATION

What is Electronic Visit Verification (EVV)?

Electronic Visit Verification (EVV) is a validation of the date, time, location, type of Personal Care Services (PCS) or Home Health (HH) Care Services provided, and the individual(s) providing and receiving services. The EVV system will electronically capture:

- The type of service performed
- Beneficiary, client, or participant receiving the service
- Date of the service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends

Why was the EVV system implemented?

The 21st Century Cures Act (the Cures Act), enacted by the U.S. Congress in December 2016, added Section 1903(l) to the Social Security Act to require all states to use Electronic Visit Verification (EVV) for Personal Care Services (PCS) and Home Health Care Services (HHCS) provided under a Medicaid State Plan of the Social Security Act or under a waiver of the State Plan.

What services require EVV?

In accordance with the 21st Century Cures Act and guidance from the Centers for Medicare & Medicaid Services (CMS), the State of Delaware requires the use of Electronic Visit Verification (EVV) for specific Medicaid-funded services that involve in-home care. EVV is a system that electronically captures key data about service delivery to ensure compliance, accuracy, and accountability.

Services Requiring EVV

Effective **December 30, 2022**, EVV is mandatory for the following services:

Personal Care Services (PCS)

CMS defines personal care services as assistance with:

- Activities of Daily Living (ADLs): bathing, dressing, toileting, mobility, and grooming

- Instrumental Activities of Daily Living (IADLs): meal preparation, shopping, laundry, and housekeeping

In Delaware, EVV is required for Medicaid-funded PCS such as:

- Personal Care
- Attendant Care (including self-directed)
- Companion Services
- Respite Services (including self-directed)
- Chore Services
- Homemaker Services
- Supported Living

Home Health Services (HHCS)

EVV is also required for:

- Home Health Aide
- Home Health Nursing
- Physical Therapy
- Occupational Therapy
- Speech Therapy

Other Services

- Private Duty Nursing (PDN) – only when provided in the home

Excluded Services

EVV is **not required** for:

- Applied Behavior Analysis (ABA)
- Social work and dietetic services
- PDN provided in school settings
- Early Intervention (Part C) program visits

Required Data Elements

EVV systems must capture the following six data points:

1. Type of service performed
2. Individual receiving the service
3. Date of service
4. Location of service delivery
5. Individual providing the service

6. Time the service begins and ends

EVV System Model

Delaware has adopted an Open EVV Model, allowing providers to:

- Use the state-selected EVV vendor, HHAeXchange
- Use an alternative EVV system, provided it meets all state and federal requirements

Provider Responsibilities

Providers delivering EVV-required services must:

- Ensure timely and accurate EVV data submission
- Maintain compliance with Delaware Medicaid and CMS standards
- Coordinate with the EVV vendor for onboarding, training, and system access

To complete onboarding with HHAeXchange (HHAX), providers must:

- Have a valid National Provider Identifier (NPI)
- Be enrolled in CHAMPS, Delaware's Medicaid provider enrollment system

For more information on Delaware's EVV program, including onboarding and technical requirements, visit the Delaware Medicaid EVV Information Page.

SECTION 7: COMPLIANCE AND REGULATORY REQUIREMENTS

FRAUD, WASTE & ABUSE (FWA) PROGRAM

Purpose and Commitment

Wellcare With Delaware First Health is committed to the prevention, detection, investigation, and reporting of suspected **fraud, waste, and abuse (FWA)** in accordance with applicable **federal and state laws, regulations, and contractual requirements**. FWA impacts the healthcare system broadly and may result in significant and unnecessary costs to publicly funded programs.

Wellcare With Delaware First Health has developed an aggressive, proactive fraud waste and abuse ("FWA") program designed to collect, analyze and evaluate data in order to identify suspected fraud, waste and abuse.

Detection tools have been developed to identify patterns of health care service use, including over utilization, unbundling, up-coding, misuse of modifiers, services not rendered and other common schemes

Through its parent company, **Centene Corporation (Centene)**, Wellcare With Delaware First Health maintains a dedicated **Special Investigations Unit (SIU)** and an established FWA program designed to:

- Collect, analyze, and evaluate data to identify potential FWA patterns
- Conduct audits and investigations to assess billing and documentation compliance
- Implement corrective actions, recover overpayments when appropriate, and refer matters to regulatory or law enforcement agencies as required

Definitions (42 CFR §455.2 and HHS Definitions)

For purposes of this manual:

- **Fraud**: An intentional deception or misrepresentation made with knowledge that the deception could result in an unauthorized benefit to the individual or another party. This includes any act that constitutes fraud under applicable federal or state law.
- **Waste**: The overutilization of services or practices that result in unnecessary costs, including consumption or expenditures without adequate return.
- **Abuse**: Provider practices inconsistent with sound fiscal, business, or medical practices that result in unnecessary costs to Medicare and/or Medicaid, reimbursement for services not medically necessary, or services that fail to meet professionally recognized standards of care. Abuse also includes member practices that result in unnecessary program costs.

Examples of FWA and Improper Billing Practices

Common FWA and improper billing practices may include, but are not limited to:

- Billing for services **not rendered**
- **Duplicate billing** (billing the same service more than once)
- **Unbundling** or fragmenting codes
- **Upcoding** services
- Billing **add-on codes without required primary CPT codes**
- Use of **exclusion codes**
- Misuse of modifiers
- Diagnosis and/or procedure codes **inconsistent with the member's age**
- **Excessive units** or frequency
- **Overutilization** or medically unnecessary services
- Misuse of benefits (including inappropriate use of identification cards)

Providers are cautioned that unbundling, upcoding and other activities designed to manipulate codes contained in the International Classification of Diseases (ICD-CM), Providers' Current Procedural Terminology (CPT) Health Care Common Procedure Coding System, (HCPCS) and/or Universal Billing Revenue Coding Manual as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

In addition, providers are reminded that medical records and other documentation must be maintained consistent with contractual and regulatory obligations.

Federal and state regulatory agencies, law enforcement and Wellcare With Delaware First Health vigorously investigate incidents of suspected FWA. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized Provider, loss of licensure and/or civil and/or criminal prosecution, fines and other penalties.

PROVIDER RESPONSIBILITIES AND COOPERATION REQUIREMENTS

Reporting

Providers, including Provider employees and /or Provider sub-contractors, must report to Wellcare With Delaware First Health any suspected fraud, waste or abuse, misconduct or criminal acts by any Provider, including Provider employees and/or Provider sub-contractors, or by Wellcare With Delaware First Health Members. If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the

member may be involuntarily disenrolled from Wellcare With Delaware First Health, with appropriate state and regulatory approval.

Cooperation with Audits and Investigations

Participating providers are obligated to cooperate fully with Centene SIU, and applicable oversight agencies. This includes, as required:

- Producing requested medical records and related documentation timely
- Making staff and/or subcontractor personnel available for interviews and consultation
- Making offices and facilities available for onsite visits
- Cooperating with investigative processes, including hearings, trials, and other proceedings when applicable

Documentation Standards

Quality care and appropriate payment depend on **accurate, complete, and legible medical record documentation**. Documentation must support:

- The service(s) billed
- The level of service reported
- Medical necessity, where applicable
- Compliance with all relevant CMS, state, contractual and Wellcare With Delaware First Health documentation and billing requirements

SPECIAL INVESTIGATIONS UNIT (SIU)

Our Special Investigations Unit (SIU) proactively monitors for potential FWA and investigates allegations of fraud, waste, and abuse. Staff includes full-time investigators, clinical investigators, data analysts, management support, administrative staff, and legal personnel.

FWA DETECTION AND MONITORING

Wellcare With Delaware First Health uses multiple methods to identify potential billing irregularities, including:

- Claims analytics and code editing tools during claims processing
- Pattern recognition for potential overutilization, unbundling, upcoding, and modifier misuse
- Retrospective audits and investigations
- Prepayment Reviews

Reviews may incorporate, as applicable:

- CMS guidelines
- Federal and state regulations/guidance
- Local Coverage Determinations (LCDs)
- National Coverage Determinations (NCDs)
- Specialty-specific billing and coding guidance
- Wellcare With Delaware First Health clinical and billing policies
- Contractual requirements

When clinically appropriate, review may include assessment by a clinician of like specialty.

POST-PAYMENT (POST-PROCESSING) CLAIMS AUDITS/INVESTIGATIONS

Overview

A post-payment audit/investigation is a review of clinical documentation for claims previously submitted. Reviews are conducted to ensure payment is supported by proper documentation, consistent with the services rendered.

Medical Record Requests and Timeframes

Wellcare With Delaware First Health will request medical, behavioral health, dental, vision, or pharmacy records to initiate an investigation:

- Medical records will be requested for a defined review period.
- Providers must submit requested records within the timeframe stated in the request.
- If no response is received, a **second and final request** may be issued.
- Records must be received within the timeframe specified in the second request.

As a reminder, HIPAA permits the use or disclosure of protected health information (PHI) for treatment, payment, and health care operations (TPO) without the member's or patient's consent or authorization. See 45 C.F.R. § 164.506.

Failure to Submit Records / Insufficient Documentation

If a provider:

- Fails to respond to the second and final request, **or**
- Submits records that do not document the services billed,

Consistent with applicable law, regulation, and provider agreement terms, Wellcare With Delaware First Health may recover all amounts paid for the services in question.

FINDINGS COMMUNICATION, OVERPAYMENTS, AND RECOVERY

Findings Results Letter

Upon completion of an investigation, Wellcare With Delaware First Health may issue a Proposed Action Letter (PAL) that includes:

- A summary of the review findings and outcome.
- A complete list of the claims reviewed, including the determination for each claim line.
- Documentation of the sources used to make claim-line determinations.
- Any applicable recovery amount and the basis for it.
- Notice of appeal rights

Overpayment Methodology

If documentation does not support the payment, Wellcare With Delaware First Health will seek recovery of identified claim payments. Depending on the scope of review, overpayments may be calculated using:

- Claim-by-claim review, and/or
- Extrapolation methodology may be used to estimate overpayment amounts through statistical sampling, consistent with program integrity methods used in Medicare and Medicaid oversight.

Appeal of Overpayment

Providers may contest the findings, the amount of the overpayment, or the methodology used to identify the overpayment by filing an appeal within 120 calendar days of the date of receipt of the PAL with supporting documentation.

Instructions for filing an appeal are provided in the initial PAL and include:

- A complete and accurate explanation of the issues being refuted. Supporting materials, medical records, or other documentation to challenge the findings.
- An appeal letter as necessary outlining any contractual, regulatory, factual or other basis of disagreement with the findings and/or overpayment amount.

If the provider does not contest the overpayment, repay the amount due, or contact Wellcare With Delaware First Health within thirty calendar days of receiving the PAL to arrange payment, Wellcare With Delaware First Health will offset the overpayment against future claims submitted by the provider.

Required FWA Training and Screening Requirements

Providers and their employees/contractors must comply with applicable CMS rules and regulations related to compliance training and education, including FWA training requirements. Providers and their employees must complete FWA training:

- Within 90 days of contracting, and
- Annually thereafter, as applicable (e.g., consistent with requirements referenced under § 423.504).

Exclusion / Preclusion Screening (Medicare Networks)

For Medicare lines of business, providers are required to check:

- OIG/GSA Exclusion lists, and
- The CMS Preclusion List

Prior to hiring/contracting and monthly thereafter for staff, volunteers, temporary employees, consultants, directors, and contractors who meet applicable requirements, consistent with references including:

- The Act §1862(e)(1)(B)
- 42 C.F.R. §§ 422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6)
- 1001.1901

Medicare payment may not be made for items or services furnished or prescribed by a precluded or excluded provider/entity.

Reporting Suspected Fraud, Waste, or Abuse

Wellcare With Delaware First Health encourages prompt reporting of suspected FWA. Reports may be made anonymously and are treated as confidential to the extent permitted by law.

Fraud, Waste, and Abuse Hotline: 1-866-685-8664
Corporate Compliance/Ethics Hotline (as applicable): 1-800-345-1642
Email (if applicable): Special_Investigations_Unit@centene.com

All reports are reviewed and investigated as appropriate.

False Claims Act (Overview)

The False Claims Act establishes liability when a person or entity improperly receives or avoids payment to the federal government. Prohibited conduct includes, but is not limited to:

- Knowingly presenting (or causing to be presented) a false claim for payment or approval
- Knowingly making or using a false record or statement material to a false or fraudulent claim
- Conspiring to violate the False Claims Act
- Knowingly making or using false statements to avoid or decrease an obligation to pay the government

For additional information, providers may reference CMS resources (e.g., www.cms.hhs.gov).

wellcarede.com