

Overview Outpatient Services	<p>The focus of Outpatient Utilization Management (UM) is to provide our members access to quality care and monitor the appropriate utilization of services. The Utilization Management Plan defines quality care as:</p> <ul style="list-style-type: none">• treatment that improves the member's physical and emotional status• promotes health and early treatment• involves members in the decision making process• decisions based on accepted medical principles and practices• effective and efficient use of technology and other resources and• accurate and appropriate documentation within the medical records.
Criteria Used	<p>The UM department utilizes the following criteria when making determinations:</p> <ul style="list-style-type: none">• InterQual• CMS Medicare Guidelines• St. Anthony's Guidelines• Local and Federal statutes and laws• Member benefits• ECRI Health Technology Assessment Information Service <p>Please contact your local Provider Relations Representative to request additional information about the Plan's clinical criteria.</p>
Hours of Availability	<p>The Plan's Utilization Management Department is available Monday through Friday 8:00 A.M. to 5:00 P.M. Please refer to your Quick Reference Guide for telephone numbers.</p>
Emergency Care	<p>The Primary Care Physician is responsible for the care of the patient twenty-four hours a day, seven days a week. The Primary Care Physician or designated covering physician must be available via phone or answering service to appropriately triage and evaluate all non-emergent care.</p>

WellCare members with an Emergency indicating the need for medical or behavioral care should call 911 or a local emergency number and/or go to the nearest qualified provider for care. For Child Health Plus and Healthy Choice the Member Contract requires members to notify their PCP within 48 hours of receiving care for an emergency.

Per the directive of CMS letter dated 8/18/2000, an emergency medical condition is:

a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or any serious dysfunction of a bodily organ.

A condition cannot be classified as an Emergency if:

- The onset is not sudden or unexpected; or
- A prudent layperson with an average knowledge of medicine and health would not expect the consequences listed in paragraph above.
- The WellCare Medical Director will determine whether a condition can be classed as a Medical Emergency, and will state reasons in writing whenever this classification is denied.

For Healthy Choice, Medicare, Child Health Plus and Family Health Plus, the PCP should notify WellCare of an Emergency Department (ER) visit using the Primary Care Physician Provider Referral Form. The request should be submitted to WellCare within 48 hours of the Emergency Department (ER) visit.

Referrals**Specialty Referrals**

The WellCare Specialty Referral Process gives Primary Care Physicians (PCPs) a great deal of control over the process by which their patients receive care from specialists. PCPs are responsible to identify the need for a referral, and may authorize up to three (3) specialty visits to an individual participating specialists for a member. These visits will be valid for sixty (60) days. To receive a supply of referral forms call WellCare Customer Service at 1-800-288-5441.

The Primary Care Physician can issue a referral to a participating specialist. The referral will be inclusive of diagnostic testing and office procedures, if required. In turn, the specialist will assume the sole responsibility for the authorization requirement, if the procedure requires authorization. Please refer to the list of procedures/services requiring prior authorization. These are identified in the Quick Reference Guide

Referrals for visits for the following outpatient services: dialysis, chemotherapy, radiation therapy and allergy are also done using a referral form. There is no predetermined limit on the number of visits that can be requested on one referral for these services. These visits are valid over a sixty (60) day period.

WellCare establishes coverage determination guidelines and benefits clarifications through Medical Management. Specific criteria used on reviews are available upon request.

**Procedures &
Services Requiring
Prior Authorization****AUTHORIZATION REQUIRED**

- Hospital observation and admissions
- Hospital-based outpatient services
- Hospital-based diagnostic laboratory services (except designated hospitals)
- Ambulance transportation in non-emergent situations
- Domiciliary, rest home and custodial care admissions
- Rehabilitation facility admissions

- Skilled nursing facility admissions
- Surgical procedures (including but not limited to ambulatory surgery, cosmetic surgery, orthopedic surgery, bariatric surgery, plastic surgery, caesarean-section, organ and tissue transplants, penile implants, circumcision and elective surgery) performed at network hospital, free-standing or other non-hospital network facilities
- Inpatient Mental Health and Alcohol/Substance abuse
- Cardiac/pulmonary rehabilitation programs
- Durable Medical Equipment, orthotics, prosthetics
- Home Health Care Services
- Respite Care Services
- Hospice Care Services
- Health Education Programs
- Outpatient alcohol and substance abuse
- Court ordered services
- Physical therapy services-after initial 3 visits
- Occupational therapy services-after initial 3 visits
- Speech therapy services-after initial 3 visits
- Respiratory therapy services
- Sterilization procedures
- Termination of pregnancy
- Hearing services
- Dental services
- New technology and experimental procedures

**NO REFERRAL OR AUTHORIZATION FORM
REQUIRED**

- Emergent transportation services
- Emergent care services
- Primary care provider office visits, including preventive medicine services
- Immunizations (as medically indicated), except those required for employment or travel
- Outpatient OB/GYN services
- Mammograms
- Family planning services (except sterilization and termination of pregnancy)

- Diagnosis and treatment of sexually transmitted and communicable diseases

Authorization Request Form

Please refer to the Authorization Form and Referral Form included in the Forms Section (16). These forms must be filled out completely and legibly. You must include an operating fax number with area code in order to receive an authorization number. If your office does not have a fax machine, please contact Referral/Auth Services at the telephone number listed in your Quick Reference Contact Guide

Authorization Time Frames

All routine requests must be faxed to the Plan. Only STAT authorizations, those that are emergent/urgent in nature, may be obtained by a telephone call to Outpatient Services. Emergent/Urgent is defined as any service that if delayed could effect the member's health or functional capabilities and must be performed immediately. This definition does not include services that the provider office failed to include in an initial authorization request. Please note the word "STAT" on the fax.

Requests should be submitted as soon as possible, preferably at least ten (10) days prior to the start of service or procedure. If all medical information necessary to make the final determination is attached to the request, Outpatient Services will respond within two (2) business days of receipt for urgent authorization request. Routine outpatient authorization requests may take up to 14 days in which to make a final determination. It is the provider's responsibility to respond as quickly as possible to any requests for further information from UM.

For recipients voluntarily enrolling, the Plan will honor any written documentation of prior authorization of ongoing covered services for a period of ten (10) calendar days after the effective date of enrollment or until the plan's primary care physician assigned to that member reviews the member's treatment plan, whichever comes first.

For recipients that the state has assigned, the Plan will

honor any written documentation of prior authorization of ongoing covered services for a period of one month after the effective date of enrollment or until the Plan's primary care physician assigned to that member reviews the member's treatment plan, whichever comes first.

Status Requests

If you have not received a request for further information or an authorization number via fax within 72 hours of the request, you may call the Referral/Auth Department at the toll-free telephone listed on the Quick Reference Guide. Please have the member's name and ID number available when calling.

Notification and Authorization Process for Medicare Patients

The Quick Reference Guide identifies the services that require a notification and those which require an authorization.

Notifications are requests for participating specialty consultations and/or PT/OT/Speech Therapy services. WellCare tracks these requests in order to provide you and the Plan with a summary of your referral and practice patterns. NOTE: Routine office-based services (e.g. lab, x-rays, immunizations, EKG's) do not require notification or authorization.

Authorizations are required for service requests that the Plan will review for medical necessity. Once approved, an authorization number will be faxed to your office. Authorization requiring activities include: facility-based (inpatient acute and sub-acute care, and outpatient) services, DME, home health care, as well as specialized laboratory and imaging services.

The **Notification/Authorization Form** is the document that you must fill out and fax to the Plan for the requested services. Please note that region-specific WellCare fax numbers are at the top of the form. Once the demographic information and service request portion of the document has been completed:

If the request is a **notification**, only a check in the appropriate box is needed. If the request is for an

authorization, then a clinical note delineating the reason(s) for the service is necessary. (e.g. pre-op inpatient day for patient with poorly controlled diabetes). Then simply sign and fax the form back to the Plan.

Ancillary Services

All Ancillary service requests require a complete Authorization Form and medical information necessary to make the final determination. The additional information needed specific to each service is noted as follows.

Home Health Care

1. Initial Home Health Care request:
 - a. Medical reason for the skilled home health service
 - b. MD / DO or Provider prescription with the type of skilled service, frequency and duration
 - c. Homebound status documentation
 - d. Name of participating/in-network Home Health provider

2. Continuation of Home Health Care request:
 - a. Complete Home health evaluation note and most recent home health progress note
 - b. Homebound status documentation

3. Home Infusion Therapy and Intravenous Medication request:
 - a. Medication name
 - b. Dosage
 - c. Frequency and duration
 - d. Type of access IV line
 - e. Mode of delivery (Gravity or Pump)
 - f. If member received this IV drug before
 - g. Available caregiver to teach and train

4. Home Wound Care and Wound Care Supplies request must include:
 - a. Wound location
 - b. Dimensions
 - c. Necrotic tissue

- d. Viable tissue
- e. Drainage
- f. Odor
- g. Surrounding tissue
- h. Skin condition

Durable Medical Equipment (DME)

All DME service requests require a completed Authorization Request Form and medical information necessary to make the final determination. The additional information needed specific to each service is noted as follows:

1. Home oxygen therapy
 - a. Most recent ABG PO₂ rate at or below 55%, or Pulse Oximetry saturation at or below 89%, taken at rest, breathing room air.
 - b. Flow rate, frequency and duration
 - c. Delivery device and type of system
2. Continuous Positive Air Way Device (CPAP, Bi-PAP)
 - a. Most recent Polysomnogram narrative results with and without titration.
3. Manual Wheelchairs and Accessories
 - a. Most recent functional mobility status report (non-ambulatory)
 - b. Height and weight
 - c. Any specific body characteristic or limitations that need to be accommodated in the wheelchair by an extra optional device
4. Electric Wheelchairs, Electric Scooters and Accessories
 - a. Same information as manual wheelchair and
 - b. Upper body limitations that prevents the effective use of a manual wheelchair
5. Hospital Bed and Accessories
 - a. Medically necessary bed positioning not feasible on a regular bed
 - b. Height and weight
 - c. Special needs that need to be accommodated by an optional device
6. Orthotic and Prosthetic Devices

All Outpatient Therapy

- a. Covered HCPCS code for the orthotic or prosthetic item.
1. Initial Outpatient Therapy requests should include the following:
 - a. Medical reason for the skilled therapy service
 - b. Specific type of skilled therapy service
 - c. MD / DO or Provider prescription with frequency and duration
 - d. Name of participating/in-network free-standing center
 2. Continuation of outpatient therapy requests:
 - a. Complete initial therapy evaluation and progress summary notes with objective, measurable, clinical findings and updated goals.
 - b. MD, DO, or a Provider prescription with frequency and duration

Medicare QIO Review Process of SNF/HHA/CORF Terminations

Providers should ensure delivery of written notification two days in advance of services ending for Skilled Nursing Facilities, Home Health Agencies, or Outpatient Rehabilitation Facilities. In the event a member appeals the termination of services, the Plan will work collaboratively with the provider to obtain medical information necessary to review these cases within the allotted timeframe.

Delegated Entities

All participating providers or entities delegated for Utilization Management are to use the same standards as defined in this section. Compliance is monitored on a monthly basis and formal audits are conducted annually.