Pennsylvania's Children's Health Insurance Program
We Cover All Kids.

wellkids by pa health & wellness

2026 Provider Manual

1-855-445-1920 (TTY: 711) | PAWellKids.com

PROVIDER MANUAL

WELCOME

Welcome to WellKids by PA Health & Wellness! Thank you for being part of our network of healthcare Providers. We look forward to working with you to improve the health of our Pennsylvania communities, one person at a time.

About Us

WellKids by PA Health & Wellness was established to deliver quality healthcare in the state of Pennsylvania through local, regional, and community-based resources. PA Health & Wellness is a Managed Care Organization and subsidiary of Centene Corporation (Centene). PA Health & Wellness exists to improve the health of its Enrollees through focused, compassionate, and coordinated care. Our approach is based on the core belief that quality healthcare is best delivered locally.

WellKids by PA Health & Wellness will serve Enrollees in the Children's Health Insurance Program (CHIP). CHIP is a state and federally funded program providing health coverage to uninsured children and teens, up to age 19, who are not eligible for or enrolled in Medicaid/Medical Assistance.

About this Manual

The Provider Manual contains comprehensive information about WellKids by PA Health & Wellness operations, benefits, policies, and procedures. The most up-to-date version can be viewed from the "For Providers" section of our website PAWellKids.com. You will be notified of updates via notices posted on our website and/or in Provider Newsletters.

KEY CONTACTS

The following chart includes several important telephone and fax numbers available to your office. When calling WellKids by PA Health & Wellness, please have the following information available:

- NPI (National Provider Identifier) number
- Tax ID Number (TIN)
- Enrollee's WellKids by PA Health & Wellness ID number

Department	Telephone Number	Fax Number
Provider Services	1-855-445-1920 TTY 711	1-844-747-0612
Enrollee Services	1-855-445-1920 TTY 711	1-844-747-0612
Prior Authorization Request	1-855-445-1920 TTY 711	Behavioral Health: 844-412-2269
Concurrent Review	1-855-445-1920 TTY 711	-
Self-Referral	1-855-445-1920 TTY 711	-
Care Management	1-855-445-1920 TTY 711	-
24 Hour Nurse Advice Line (24/7 Availability)	1-855-445-1920 TTY 711	-
Teladoc (TeleHealth Vendor)	1-800-835-2362	-
Peer to Peer	1-833-837-0093	-
Centene Vision	1-844-788-4071	-
Centene Dental	1-844-524-8255	-

Apply for Medical Assistance	1-866-550-4355	-
Childline Child Abuse Hotline	1-800-932-0313	-
MA Provider Compliance Hotline	1-866-379-8477	-
Provider Relations	PHWProviderRelations@PAHealthWellness.com	

Paper Claims Submission	**Claim Reconsiderations**	**Pre-Service Medical Necessity Appeal**
WellKids by PA Health & Wellness Attn: Claims P.O. Box 5070 Farmington, MO 63640	WellKids by PA Health & Wellness Attn: Reconsideration P.O. Box 5070 Farmington, MO 63640 Fax: 1-833-641-0902	WellKids by PA Health & Wellness Attn: Medical Necessity Appeals 1700 Bent Creek Blvd Suite 200 Mechanicsburg, PA 17050

Electronic Claims **WellKids by PA Health & Wellness**
c/o Centene EDI payor ID: 68069 Contact by Phone at 1-800-225-2573, ext. 6075525 or by e-mail: EDIBA@centene.com

Centene Dental Claims		
Paper Claims	**Electronic**	**Resources**

Centene Dental PO Box 26631 Tampa, FL 33623-6631	Payer ID Number 46278	Provider Web Portal (PWP) (centenedental.com/logon) Website (centenedental.com) Automated Enrollee Eligibility Verification System and Customer Service Phone Number 1-844-524-8255
Centene Vision Claims		
Paper Claims	Electronic Claims	Resources
Centene Vision PO Box 7548 Rocky Mount, NC 27804	Payer ID# 56190	Member Eligibility and Claims Inquiries: 1-866-921-7965

VERIFYING ELIGIBILITY

Children's Health Insurance Program Providers should verify Enrollee eligibility before every service is rendered, using one of the following methods:

1. **Log on to our Secure Provider Web Portal** at provider.pahealthwellness.com or Availity Essentials at https://www.availity.com/. Using our secure Provider Portal, you can check Enrollee eligibility. You can search by date of service and either of the following: Enrollee name and date of birth, or Enrollee Medicaid ID and date of birth.
2. **Call our automated Enrollee eligibility IVR system.** Call 1-855-445-1920 TTY 711from any touch-tone phone and follow the appropriate menu options to reach our automated Enrollee eligibility-verification system 24 hours a day. The automated system will prompt you to enter the Enrollee ID and the month of service to check eligibility.
3. **Call WellKids by PA Health & Wellness Provider Services.** If you cannot confirm an Enrollee's eligibility using the methods above, call our toll-free number at 1-855-445-1920 TTY 711. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility prior to rendering services. Provider Services will need the Enrollee name, Enrollee ID, and Enrollee date of birth to check eligibility.

Through WellKids by PA Health & Wellness' Secure Provider Portal, PCPs are able to access a list of eligible Enrollees who have selected their services or were assigned to them. The Patient List is reflective of all demographic changes made within the last 24 hours. The list also provides other important information, including indicators for patients whose claims data show a gap in care. To view this list, log on to provider.pahealthwellness.com or Availity Essentials at https://www.availity.com/.

TIP Eligibility changes can occur throughout the month and the Patient List does not prove eligibility for benefits or guarantee coverage. Use one of the above methods to verify Enrollee eligibility on the date of service.

All new WellKids by PA Health & Wellness Enrollees receive a WellKids by PA Health & Wellness Enrollee ID card. A new card is issued only when the information on the card changes, if an Enrollee loses a card, or if an Enrollee requests an additional card.

TIP Possession of an Enrollee ID card is not a guarantee of eligibility. Use one of the above methods to verify Enrollee eligibility on the date of service.

Enrollee Identification Card

Enrollees should present their WellKids by PA Health & Wellness Enrollee ID card each time services are rendered by a Provider.

If you suspect fraud, please contact Provider Services at 1-855-445-1920 TTY 711 immediately.

Sample ID Card (Front & Back):

Online Resources

Our website can significantly reduce the number of telephone calls providers need to make to the health plan. The website allows 24/7 immediate access to current Provider and Enrollee information.

Please contact your Provider Relations Representative or our Provider Services department at 1-855-445-1920 TTY 711with any questions or concerns regarding the website.

WellKids by PA Health & Wellness website is located at PAWellKids.com. Providers can find the following information on the website:

- Prior Authorization List
- Applicable Forms
- WellKids by PA Health & Wellness Plan News
- Clinical Guidelines
- Provider Bulletins
- Contract Request Forms
- Provider Network Specialist Contact Information
- Provider Training Manual
- Provider Education Training Schedule

SECURE PROVIDER PORTAL

The WellKids by PA Health & Wellness Secure Provider Web and Availity Essentials Portals allow Providers to check Enrollee eligibility and benefits, submit and check status of claims, request authorizations and send messages to communicate with WellKids by PA Health & Wellness staff. All Providers and designated office staff have the opportunity to register for the secure portals in just 4 easy steps. Upon registration, tools are available that make obtaining and sharing information easy! It's simple and secure!

Go to provider.pahealthwellness.com to create an account. Please contact a Provider Relations Representative for a tutorial on the Secure Provider Web Portal.

To register for the Availity Essentials portal visit availity.com's Get Started page.

Functionality

Through either Secure Provider Web Portal, you can:

- Check Enrollee eligibility
- View Enrollee health records
- View the PCP panel (patient list)
- View and submit claims and adjustments
- Verify claim status
- Verify proper coding guidelines
- View payment history
- View and submit authorizations
- Check authorization requirements
- Verify authorization status
- View Enrollee gaps in care
- Contact us securely and confidentially
- Add/Remove account users
- Determine payment/check clear dates
- Add/Remove TINs from a user account
- View PCP Quality Incentive Report
- View & print Explanation of Payment (EoP)

Secure Portal Disclaimer

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

GUIDELINES FOR PROVIDERS

Patient Centered Medical Home

WellKids by PA Health & Wellness is committed to supporting its network Providers in achieving recognition as Patient Centered Medical Homes (PCMH) and will promote and facilitate the capacity of primary care practices to function as Medical Homes by using systematic, patient-centered and coordinated Care Management processes.

WellKids by PA Health & Wellness will support Providers in obtaining either NCQA's Physician Practice Connections®-Patient-Centered Medical Home (PPC®-PCMH) recognition or the Joint Commission's Primary Care Medical Home Option for Ambulatory Care accreditation.

The purpose of the Medical Home program is to promote and facilitate a Medical Home model of care that will provide better healthcare quality, improve self-management by Enrollees of their own care and reduce avoidable costs over time. WellKids by PA Health & Wellness will actively partner with Providers, community organizations, and groups representing our Enrollees to increase the numbers of Providers who are recognized as Medical Homes (or committed to becoming recognized).

WellKids by PA Health & Wellness has dedicated resources to ensure its Providers achieve the highest level of Medical Home recognition with a technical support model that will include:

- Readiness survey of contracted Providers
- Education on the process of becoming certified
- Resources, tools, and best practices

The Secure Provider Web Portal offers tools to help support PCMH accreditation elements. These tools include:

- Online care gap notification
- Enrollee panel roster (including Enrollee detail information)

For more information on the Medical Home model or to how to become a Medical Home, contact your Provider Relations Representative.

Bright Futures Overview

Bright Futures is based on the recommendations of the American Academy of Pediatrics (AAP), American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD). All PCPs who provide services to members under age 19 are encouraged to provide comprehensive health care, screening, and preventive services. We require our network PCPs to provide all Bright Futures services in compliance with federal and state regulations and periodicity schedules. You can find the most recent periodicity guidelines at **https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf**.

Current recommended childhood and adolescent immunization schedules can be viewed at **https://www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html.**

PCPs must report Encounter Data associated with Bright Futures screens, using a format approved by the Department, to WellKids by PA Health & Wellness within ninety (90) days from the date of service.

Referrals

Obtaining referrals from the PCP are not required by WellKids by PA Health & Wellness as a condition of payment for services. WellKids by PA Health & Wellness prefers that the PCP coordinates healthcare services. PCPs are encouraged to refer an Enrollee to another Provider when medically necessary care is needed that is beyond the scope of what the PCP can provide.

The PCP must obtain prior authorization from WellKids by PA Health & Wellness for referrals to certain Specialty Providers as noted on the prior authorization list. All out-of-network services require Prior Authorization as further described in this manual, except for family planning, emergency room, and table-top x-ray services. Providers are also required to promptly notify WellKids by PA Health & Wellness when prenatal care is rendered.

WellKids by PA Health & Wellness encourages Specialists to communicate to the PCP the need for a referral to another Specialist. This allows the PCP to better coordinate care and become aware of the additional service request.

Providers are prohibited from making referrals for designated health services to healthcare entities with which the Provider or a member of the Providers' family has a financial relationship.

Enrollees with disabling conditions or chronic illnesses may request that their PCP be a Specialist. The designation of the Specialist as a PCP must be in consultation with the current PCP, Enrollee, and the Specialist. The Specialist serving as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and provide those specialty medical services consistent with the Enrollee's disabling condition, chronic illness, or special healthcare needs in accordance with the PCP responsibilities included in this manual. To initiate a PCP change to a Specialist, Enrollees should contact WellKids by PA Health & Wellness Enrollee Services at our toll-free number. The Health Plan will verify the change with the current PCP and the intended Specialist to be assigned as the PCP and coordinated the PCP change.

An Enrollee may self-refer for vision, dental care, obstetrical and gynecological (OB/GYN) services, provided the Enrollee obtains the specialty care or services within the Wellkids by PA Health & Wellness Provider network. Wellkids by PA Health & Wellness does not use the referral process nor Prior Authorizations to manage the utilization of Family Planning Services. Wellkids by PA Health & Wellness provides access, at a minimum, to Family Planning Services and procedures as outlined in the CHIP Eligibility and Benefits Handbook.

Self-Referral

Enrollees do not need a prior-authorization or referral for the following types of services when they are rendered by a WellKids by PA Health & Wellness participating Provider:

- Prenatal visits
- Routine obstetric (OB) care
- Routine gynecological (GYN) care

- Family planning services (may see out-of-network Provider)
- Routine dental services
- Routine eye exams
- Emergency services
- Specialist services
- Surgical consultation
- Behavioral Health

Appointment Availability and Access Standards

WellKids by PA Health & Wellness follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. WellKids by PA Health & Wellness monitors compliance with these standards on an annual basis and will use the results of appointment standards monitoring to ensure adequate appointment availability and reduce unnecessary emergency room utilization.

TYPE OF APPOINTMENT	SCHEDULING REQUIREMENT
Primary Care Providers, OB-GYN, Certified Nurse Midwifes	Timeframe
Emergency Medical Condition	**Immediately seen or referred to an emergency facility**
Urgent Medical Condition	Within twenty-four **(24) hours** of presentation or request
Routine Appointments	Within ten **(10) business days**.
Health Assessment/General Physical Examinations	Within three **(3) weeks** of enrollment or request
Pregnant Women	**First Trimester**- within ten **(10) business days** of the Enrollee being identified as being pregnant **Second Trimester**- within five **(5) business days** of the Enrollee being identified as being pregnant **Third Trimester**- within four **(4) business days** of the Enrollee being identified as being pregnant **High-Risk pregnancies**- within twenty-four **(24) hours** of identification of being high risk

Bright Futures Screening	Appointments must be scheduled within **45 days** of enrollment unless the child is already under the care of a PCP and current with screens
Initial Appointment for Enrollees with HIV/AIDS	Appointment with PCP or Specialist must occur within seven (7) days of enrollment unless enrollee is already being treated by a PCP or specialist.

Specialists	Timeframe
Emergency Medical Condition	**Immediate** upon referral
Urgent Medical Condition	Within twenty-four **(24) hours** of referral
Routine Care	Within thirty **(30) calendar days** for all specialty Provider types

Primary Care Provider, Maternity, and Specialist	**Office Wait Times**
Walk-in	Within two **(2) hours** or schedule an appointment within the standards of appointment availability
Previously scheduled appointment	Within one **(1) hour** of appointment
Life-threatening emergency	**Immediate**

Covering Providers

PCPs and Specialty Physicians must arrange for coverage with another Provider during scheduled or unscheduled time off, preferably with another WellKids by PA Health & Wellness network Provider. In the event of unscheduled time off, please notify Provider Services department of coverage arrangements as soon as possible. The covering physician is compensated in accordance with the fee schedule in their agreement, and, if not a WellKids by PA Health & Wellness network Provider, he/she will be paid as a non-participating Provider.

Telephone Arrangements

PCPs, Dentists and Specialists must:

- Answer the Enrollee's telephone inquiries on a timely basis
- Prioritize appointments
- Schedule a series of appointments and follow-up appointments as needed by an Enrollee
- Conduct affirmative outreach whenever an Enrollee misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the Enrollee. Such attempts may include but are not limited to written attempts, telephone calls and home visits. At least one (1) such attempt must be a follow-up telephone call.
- Identify special Enrollee needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments)
- Adhere to the following response time for telephone call-back waiting times:
    - After-hours telephone care for non-emergent, symptomatic issues within 30 minutes
    - Same day for non-symptomatic concerns
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a Provider's absence
- After-hour calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the Enrollee's medical record

NOTE: If after-hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department in order to notify the facility. Notification is not required prior to Enrollee receiving urgent or emergent care.

WellKids by PA Health & Wellness will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program (QIP).

24-Hour Coverage

WellKids by PA Health & Wellness PCPs and Specialty Physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services and shall ensure that such services are accessible to Enrollees as needed 24 hours a day, 365 days a year as follows:

- A Provider's office phone must be answered during normal business hours
- During after-hours, a Provider must have arrangements for one of the following:
    - Access to a covering physician
    - An answering service
    - Triage service
    - A voice message that provides a second phone number that is answered
    - Any recorded message must be provided in English and Spanish, if the Provider's practice includes a high population of Spanish speaking Enrollees

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

- The Provider's office telephone number is only answered during office hours
- The Provider's office telephone is answered after hours by a recording that tells patients to leave a message
- The Provider's office telephone is answered after hours by a recording that directs patients to go to an Emergency Room for any services needed
- A Clinician returning after-hours calls outside 30 minutes

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

WellKids by PA Health & Wellness will monitor Providers' offices after-hour coverage through surveys and through mystery shopper calls conducted by WellKids by PA Health & Wellness Provider Network staff.

Confidentiality Requirements

Providers must comply with all federal, state, and local laws and regulations governing the confidentiality of medical information. This includes all laws and regulations pertaining to, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) and applicable contractual requirements. Providers are also contractually required to safeguard and maintain the confidentiality of data that addresses medical records and confidential Provider and Enrollee information, whether oral or written, in any form or medium. The following information is considered confidential:

All "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The privacy rule calls this information protected health information (PHI). "Individually identifiable health information," including demographic data, is information that relates to:

- The individual's past, present or future physical or mental health or condition
- The provision of health care to the individual
- The past, present, or future payment for the provision of healthcare to the individual
- Information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual
- Many common identifiers (e.g., name, address, birth date, social security number)

The privacy rule excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the family educational rights and privacy act, 20 u.s.c. § 1232g.

Provider offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of WellKids by PA Health & Wellness.

Release of data to third parties requires advance written approval from the Department of Human Services, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by Enrollees or releases required by court order, subpoena, or law.

Enrollee Privacy Rights

WellKids by PA Health & Wellness privacy policy assures that all Enrollees are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements. WellKids by PA Health & Wellness' privacy policy conforms with 45 CFR including relevant sections of the HIPAA that provide Enrollee privacy rights and place restrictions on uses and disclosures of protected health information (PHI) (§164.520, 522, 524, 526, and 528).

WellKids by PA Health & Wellness' policy also assists our personnel and Providers in meeting the privacy requirements of HIPAA when Enrollees or authorized representatives exercise privacy rights through privacy request including:

Use and Disclosure Guidelines

WellKids by PA Health & Wellness is required to use and disclose only the minimum amount of information necessary to accommodate the request or carry out the intended purpose.

Limitations

A privacy request may be subject to specific limitations or restrictions as required by law. WellKids by PA Health & Wellness may deny a privacy request under any of the following conditions:

- WellKids by PA Health & Wellness does not maintain the records containing the PHI
- The requester is not the Enrollee and we're unable to verify his/her identity or authority to act as the Enrollee's authorized representative
- The documents requested are not part of the designated record set (e.g., credentialing information)
- Access to the information may endanger the life or physical safety of or otherwise cause harm to the Enrollee or another person
- WellKids by PA Health & Wellness is not required by law to honor the particular request (e.g., accounting for certain disclosures)
- Accommodating the request would place excessive demands on us or our time and resources and is not contrary to HIPAA

Cultural Competency

Cultural Competency within WellKids by PA Health & Wellness is defined as the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. Cultural Competency is developmental, community focused, and family oriented.

In particular, it is the promotion of quality services to understand racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions, and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

WellKids by PA Health & Wellness will ensure that inclusiveness and fairness are a part of all of our activities. We will be proactive in our efforts to extend our services and programs to our Limited English Proficiency (LEP) Enrollees.

WellKids by PA Health & Wellness will ensure compliance with the following statues and regulations to ensure eligible Enrollees have equal access to quality health care regardless of their race, color, creed, national origin, religion, disability, or age: Title VI of the Civil Rights Act of 1964 (which prohibits discrimination on the basis of race, color and national origin); Section 504 of the Rehabilitation Act of 1973 (which prohibits discrimination on the basis of disability); and The Age discrimination of 1975 (which prohibits discrimination on the basis of age).

All subcontracts with providers of health care will include a non-discrimination provision, which incorporates the requirements of the Civil Rights Act of 1964.

Evidence of coverage for all lines of business will include a non-discrimination provision, which incorporates the requirements of the Civil Rights Act of 1964. WellKids by PA Health & Wellness is committed to the development, strengthening, and sustaining of healthy Provider/Enrollee relationships. Enrollees are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, Enrollees are at risk for sub-optimal care. Enrollees may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process. Providers should note that the experience of an Enrollee begins at the front door. Failure to use Culturally Competent and linguistically competent practices could result in the following:

- Feelings of being insulted or treated rudely
- Reluctance and fear of making future contact with the office
- Confusion and misunderstanding
- Treatment non-compliance
- Feelings of being uncared for, looked down on, and devalued
- Parents resisting to seek help for their children
- Unfilled prescriptions
- Missed appointments
- Misdiagnosis due to lack of information sharing
- Wasted time

- Increased grievances or complaints

WellKids by PA Health & Wellness will evaluate the Cultural Competency level of its network Providers and provide access to training to assist providers in developing Culturally Competent and culturally proficient practices. Training resources can be located in the Provider Training section of our website. Network Providers must ensure:

- Enrollees understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them. Enrollees or their representatives may request an interpreter be assigned to accompany them to any covered service. When the Enrollee has identified the need to have an interpreter accompany them to their appointment, the WellKids by PA Health & Wellness Enrollee Services Representative can make the arrangements for the Enrollee with the designee vendor. Recipients or their representatives can contact Enrollee Services for a list of translation vendors in their area. Enrollee Services can access the use of the Language Services, TDD telephone line or the hearing-impaired relay service to assist in this matter.
- Medical care is provided with consideration of the Enrollee's race/ethnicity and language and its impact/influence on the Enrollee's health or illness.
- Office staff that routinely interact with Enrollees have access to and participate in Cultural Competency training and development.
- Office staff responsible for data collection make reasonable attempts to collect race and language information from the Enrollee. Staff will also explain race/ethnicity categories to an Enrollee so that the Enrollee is able to identify the race/ethnicity of themselves and their children.
- Treatment plans are developed with consideration of the Enrollee's race, country of origin, native language, social class, religion, mental and physical abilities, heritage, culture, age, gender, sexual orientation, and other characteristics that may influence the Enrollee's perspective on healthcare.
- Office sites have posted and printed materials in English and Spanish, and other prevalent non-English languages required by the Pennsylvania Department of Health.
- In order to help us deliver more culturally sensitive care by better understanding our provider demographics, providers may contact Provider Services at 1-855-445-1920 TTY 711to let us know the languages in which you are fluent, what language services are available through your practice, or your race and ethnicity.
- To obtain an interpreter for a WellKids by PA Health & Wellness Enrollee, call Enrollee Services at 1-855-445-1920 TTY 711. Enrollees have access to interpreter services 24/7, at no cost to them.

The road to developing a Culturally Competent practice begins with the recognition and acceptance of the value of meeting the needs of the patients. WellKids by PA Health & Wellness is committed to helping each Provider reach this goal. The following questions should be considered as care is provided to WellKids by PA Health & Wellness Enrollees:

- What are your own cultural values and identity?
- How do or can cultural differences impact your relationship with your patients?
- How much do you know about your patient's culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?
- Do you embrace differences as allies in your patients' healing process?

The U.S. Department of Health and Human Services' Office of Minority Health has published a suite of online educational programs to advance health equity at every point of contact through development and promotion of culturally and linguistically appropriate services. Visit Think Cultural Health at www.thinkculturalhealth.hhs.gov to access these free online resources.

Americans with Disabilities Act (ADA)

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

- Exclusion from participation in the benefits of services, programs or activities of a public entity.
- Denial of the benefits of services, programs or activities of a public entity.
- Discrimination by any such entity.

Providers should ensure that their offices are as accessible as possible to persons with disabilities.

Providers are required to comply with ADA accessibility guidelines. WellKids by PA Health & Wellness must inspect the office of any Provider who provides services on-site at the Provider's location and who seeks to participate in the Provider Network to determine whether the office is architecturally accessible to persons with mobility impairments. Architectural accessibility means compliance with ADA accessibility guidelines with reference to parking (if any), path of travel to an entrance, and the entrance to both the building and the office of the Provider, if different from the building entrance.

If the office or facility is not accessible under the terms of this paragraph, the office or facility may participate in the Provider Network provided that the office or facility: 1) Requests and is determined by WellKids by PA Health & Wellness to qualify for an exemption from this paragraph, consistent with the requirements of the ADA, or 2) Agrees, in writing, to remove the barrier to make the office or facility accessible to persons with mobility impairments within one hundred eighty (180) days after WellKids by PA Health & Wellness has identified the barrier.

Providers should also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. WellKids by PA Health & Wellness offers sign language and telephonic interpreter services at no cost to the Provider or Enrollee. Call your Provider Relations Representative at 1-855-445-1920 TTY 711for more information.

Reporting Suspected Abuse and Neglect

All WellKids by PA Health & Wellness Providers and their employees and administrators of a facility are mandatory reporters of suspected abuse and neglect of WellKids by PA Health & Wellness Enrollees. This requirement is further detailed under the Child Protective Services Law, 23 Pa. C.S. §§6301 et seq. and Department regulations. These laws have been established in order to detect, prevent, reduce, and eliminate, abuse, neglect, exploitation and abandonment of adults in need including WellKids by PA Health & Wellness Enrollees. If you suspect child abuse or neglect call ChildLine at 1-800-932-0313, available 24 hours a day, seven days a week. Reports can also be made online using the Child Welfare Portal at https://www.compass.dhs.pa.gov/cwis. Following an examination for suspected abuse or neglect, should a Network PCP determine that a mental health assessment is needed, the PCP must inform the Enrollee or County Children and Youth representative on how to access mental health services and coordinate access to these services when necessary.

Abuse is defined by 6 PA Code § 15.2 as one or more of the following acts: a) the infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish b) the willful deprivation by a caretaker of goods or services necessary to maintain physical or mental health c) sexual harassment, rape, or abuse. Sexual abuse of an Enrollee is defined as intentionally, knowingly, or recklessly causing or attempting to cause the rape of involuntary sexual intercourse with sexual assault of, statutory sexual assault of, aggravated indecent assault of, indecent assault of, or incest with an Enrollee.

Neglect is the failure to provide for oneself or the failure of a caretaker to provide goods or services essential to avoid a clear and serious threat to physical or mental health.

For further information, please refer to the DHS website at http://dhs.pa.gov/.

Mainstreaming

WellKids by PA Health & Wellness shall prohibit network Providers from intentionally segregating Enrollees in any way from other individuals receiving services. WellKids by PA Health & Wellness shall investigate complaints and take affirmative action so that Enrollees are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, language, health status, disease or preexisting condition, anticipated need for health care or physical or mental disability, except where medically indicated. Examples of practices prohibited by a Provider include, but are not limited to, the following:

- Denying or not providing an Enrollee any CHIP covered service.
- Denying or not providing access to a facility within the WellKids by PA Health & Wellness network.

Primary Care Practitioner (PCP)

The Primary Care Practitioner (PCP) a specific physician, physician group or a CRNP operating under the scope of his or her licensure, and who is responsible for supervising, prescribing, and providing Primary Care services, locating, coordinating and monitoring other medical care and rehabilitative services and \maintaining continuity of care on behalf of an Enrollee, including Bright Futures evaluations

and screenings. PCPs are the cornerstone of WellKids by PA Health & Wellness service delivery model. The PCP serves as the “Medical Home” for the Enrollee. The Medical Home concept assists in establishing an Enrollee/Provider relationship, supports continuity of care, and patient safety. This leads to elimination of redundant services, cost effective care, and better health outcomes.

WellKids by PA Health & Wellness offers a robust network of primary care Providers to ensure every Enrollee has access to a Medical Home within the required travel distance standards (urban areas 2 within 30 minutes of each Enrollee’s home and rural 2 within 60 minutes of each Enrollee’s home).

WellKids by PA Health & Wellness requires PCPs, dentists, and Specialists to conduct affirmative outreach whenever an Enrollee misses an appointment and to document this in the medical record. An effort will be considered reasonable if it includes three (3) attempts to contact the Enrollee. Attempts may include but are not limited to written attempts, telephone calls, and home visits. At least one (1) such attempt must be a follow-up telephone call.

Provider Types That May Serve as PCPs

Specialty types who may serve as PCPs include:

- Family Practitioner
- Federally Qualified Health Center (FQHC)
- General Practitioner
- Internist
- Pediatrician
- Physician Assistant
- Obstetrician or Gynecologist (OB/GYN)
- Rural Health Center (RHC)

Specialists as PCPs

Enrollees with disabling conditions or chronic illnesses may request that their PCP be a Specialist. The designation of the Specialist as a PCP must be in consultation with the current PCP, Enrollee, and the Specialist. The Specialist serving as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and provide specialty medical services consistent with the Enrollee's disabling condition, chronic illness or special healthcare needs in accordance with the PCP responsibilities included in this manual.

Enrollee Panel Capacity

All PCPs reserve the right to determine the number of Enrollees they are willing to accept into their panel. WellKids by PA Health & Wellness **does not** guarantee any Provider will receive a certain number of Enrollees. The PCP to Enrollee ratio shall not exceed 1,000 Enrollees to a single PCP. If a Provider offers CRNP and PA services in addition to physician services at the location where the services of a PCP are provided, the Provider will be permitted to add an additional one thousand Enrollees to the panel. The number of Enrollees assigned to a PCP may be decreased by Wellkids by PA Health & Wellness, if necessary, to maintain the appointment availability standards.

PCPs interested in exceeding the Enrollee limit should contact their Provider Relations Representative to discuss providing satisfactory evidence of added capacity by use of physician extenders and/or extended office hours to accommodate additional Enrollees. This ratio applies to all MCOs.

If a PCP declares a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact WellKids by PA Health & Wellness Provider Services at 1-855-445-1920 TTY 711. A PCP shall not refuse to treat Enrollees as long as the physician has not reached their requested panel size.

Providers shall notify WellKids by PA Health & Wellness in writing at least 45 days in advance of his or her inability to accept additional CHIP covered persons under WellKids by PA Health & Wellness agreements. In no event shall any established patient who becomes a WellKids by PA Health & Wellness Enrollee be considered a new patient.

PCP Assignment

WellKids by PA Health & Wellness Enrollees have the freedom to choose a PCP from our comprehensive Provider network. All enrolled children must have a PCP. Enrollees have ten (10) calendar days from the receipt of notice of enrollment letter to select a PCP. If a PCP is not selected by that time, WellKids by PA Health & Wellness will assign the Enrollee to a PCP.

Primary Care Practitioner (PCP) Responsibilities

WellKids by PA Health & Wellness will monitor PCP actions for compliance with the following responsibilities. The PCP must serve as an Enrollee's initial and most important point of contact regarding health care needs. At a minimum, the PCP is responsible for:

- Primary care, including well-child care is provided in accordance with the schedule established by the American Academy of Pediatrics. Services related to those visits,

include, but are not limited to, immunizations, health education, tuberculosis testing, and developmental screening in accordance with routine schedule of well-child visits. Care must also include a comprehensive physical examination, including X-rays if necessary, for any child exhibiting symptoms of possible child neglect or abuse.

- Conducting all Bright Futures screens for CHIP Enrollees. Should the PCP be unable to conduct the necessary Bright Futures screens, the PCP shall arrange to have the necessary screens conducted by another network Provider and ensure that all relevant medical information, including the results of the screens, are incorporated into the Enrollee's medical record.
- Providing primary and preventive care in accordance with the Bright Futures/American Academy of Pediatrics Periodicity Schedule and acting as an Enrollee's advocate, providing, recommending, and arranging for care.
- Reporting Encounter Data associated with Bright Futures screens, using a format approved by the Department, to WellKids by PA Health & Wellness within ninety (90) days from the date of service
- Documenting all care rendered in a complete and accurate encounter record that meets or exceeds the Department's data specifications.
- Maintaining continuity of each Enrollee's health care, participating in or coordinating with an overall chronic care management team, where appropriate.
- Communicating effectively with an Enrollee by using sign language interpreters for an Enrollee who is deaf or hard of hearing and oral interpreters for an Enrollee with LEP when needed by the Enrollee. Services must be free of charge to an Enrollee.
- Making referrals for specialty care and other Medically Necessary services, both in and out-of-network.
- Maintaining a current medical record for an Enrollee, including documentation of all services provided to the Enrollee by the PCP, as well as any specialty or referral services.
- Providing office hours accessible to an Enrollee for a minimum of 20 hours per week and directly or through on-call arrangements with other qualified, network PCPs 24 hours per day, 7 days a week for urgent and emergency care.
- Complying with all conditions and standards applicable to MCOs set forth in 40 P.S. §§ 991.2101 – 991.2194 unless otherwise specified.

Specialist Responsibilities

WellKids by PA Health & Wellness encourages Specialists to communicate to the PCP the need for a referral to another Specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the Enrollees' care and ensure the referred Specialty physician is a participating Provider within the WellKids by PA Health & Wellness network and that the PCP is aware of the additional service request. The Specialty physician may order diagnostic tests without PCP involvement by following WellKids by PA Health & Wellness referral guidelines.

Emergency admissions will require notification to WellKids by PA Health & Wellness' Medical Management department within the standards set forth in the Utilization Management section of this manual. All non-emergency inpatient admissions require Prior Authorization from WellKids by PA Health & Wellness.

The Specialist Provider must:

- Maintain contact with the PCP.
- Obtain authorization from WellKids by PA Health & Wellness Medical Management department if needed before providing services.
- Coordinate the Enrollee's care with the PCP.
- Provide the PCP with consultation reports and other appropriate records within five (5) business days.
- Be available for or provide on-call coverage through another source 24 hours a day for management of Enrollee care.
- Maintain the confidentiality of medical information.
- Allow WellKids by PA Health & Wellness direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs.

WellKids by PA Health & Wellness Providers should refer to their contract for complete information regarding their obligations and mode of reimbursement. Such reimbursement shall be no less than the published Medicaid fee-for-service rate in effect on the date of service or its equivalent (such as a DRG case rate), unless mutually agreed to by both WellKids by PA Health & Wellness and the Provider in the Provider contract.

The WellKids by PA Health & Wellness requires PCPs, Dentists, and Specialists to conduct affirmative outreach whenever an Enrollee misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the Enrollee. Such attempts may include but are not limited to written attempts, telephone calls and home visits. At least one (1) such attempt must be a follow-up telephone call.

Hospital Responsibilities

WellKids by PA Health & Wellness utilizes a network of Hospitals to provide services to WellKids by PA Health & Wellness Enrollees.

Hospitals must:

- Notify the PCP immediately or at most no later than the close of the next business day after the Enrollee's emergency room visit.
- Obtain authorizations for all inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency stabilization services.

- Notify WellKids by PA Health & Wellness Medical Management department by sending an electronic file of the ER admission within 24 hours or the next business day. The electronic file should include the Enrollee's name, Medicaid ID, presenting symptoms/diagnosis, DOS, and Enrollee's phone number.
- Notify WellKids by PA Health & Wellness Medical Management department of all admission within one business day.
- Notify WellKids by PA Health & Wellness Medical Management department of all newborn deliveries within two (2) business days of the delivery.
- Allow WellKids by PA Health & Wellness direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs.

Voluntarily Leaving the Network

Providers must give WellKids by PA Health & Wellness notice of voluntary termination following the terms of their participating agreement with our Health Plan. In order for a termination to be considered valid, Providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, Providers must supply copies of medical records to the Enrollee's new Provider upon request and facilitate the Enrollee's transfer of care at no charge to WellKids by PA Health & Wellness or the Enrollee.

WellKids by PA Health & Wellness will notify affected Enrollees in writing of a Provider's termination, thirty (30) days prior to the effective date of Provider's termination, or fifteen (15) calendar days of the receipt of the termination notice from the Provider, provided that such notice from the Provider was timely.

BENEFIT EXPLANATIONS AND LIMITATIONS

WellKids by PA Health & Wellness network Providers supply a variety of medical benefits and services, some of which are itemized on the following pages. For specific information not covered in this provider manual, please contact Provider Services at 1-855-445-1920 TTY 711. A Provider Service Representative will be happy to assist you.

WellKids by PA Health & Wellness covers, at a minimum, those core benefits and services specified in our Agreement with Pennsylvania State Medicaid and defined in the administrative rules and Department policies and procedure handbook.

In order for a Provider to be eligible for payment for services provided to a WellKids by PA Health & Wellness Enrollee after the Provider is terminated from the Network, the Provider must agree to meet the same terms and conditions as participating Providers.

Covered Services

The below lists the services that are covered by **WellKids by PA Health & Wellness** when the services are medically necessary. Some of the services have limits or require prior authorization by

WellKids by PA Health & Wellness. All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan.

- Doctors Office Visit
  - Well-Child Primary Care Physician (PCP)
  - Other Primary Care Physician (PCP) Visit
  - Specialist Visit
  - Routine Gynecology Visit
  - Other Gynecology Visit
  - Obstetrical (maternity) visit
  - Inpatient/Outpatient behavioral health visit for mental health or substance use care
  - Outpatient occupational, physical, or speech therapy visit
  - Emergency department (waived if admitted)
  - Urgent care visits, including out-of-area urgent care

- Virtual Visits
  - Primary Care Virtual Visit
  - Specialty Virtual Visit
  - Behavioral Health Virtual Visit

- Pharmacy - May Require Prior Authorization
  - Generic drug
  - Brand-Name Drug
  - Preventive Drug

- Dental and Vision
  - Routine Dental Services
  - Routine Eye Exams

*Abortion is only a covered service if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16) Rape or incest must have been reported to law enforcement authorities or child protective services, unless the treating physician certifies that in his or her professional judgment, the member is physically or psychologically unable to comply with the reporting requirement. Includes only abortions that satisfy the requirements of 18 PA C.S.§3204-3206 and 35 P.S. §§ 10101, 10103-10105. Covered abortions include those that meet the following criteria: A physician has certified that the abortion is necessary to save the life of the mother or the abortion is performed to terminate a pregnancy resulting from an act of rape or incest reported within 72 hours from the date when the female first learned she was pregnant. Services rendered to treat illness of injury resulting from an elective abortion are covered. The contractor and its subcontractors will respect the conscience rights of individual providers and provider organizations and comply with Pennsylvania law prohibiting discrimination on the basis of the refusal or willingness to participate in certain abortion and sterilization activities as outlined in 43 P.S. §955.2 and 18 PA C.S.A. §3213(d). Elective abortions are not covered.

Women's Health Care

If the Enrollee's PCP is not a women's health Specialist, WellKids by PA Health & Wellness will provide direct access to a network Specialist for core benefits and services necessary to provide women routine and preventive health care. Enrollees are allowed to utilize their own PCP or any family planning service Provider for family planning services without the need for a referral or a prior authorization.

In addition, Enrollees will have the freedom to receive family planning services and related supplies from an out-of-network provider without any restrictions. Family planning services include examinations, assessments, traditional contraceptive services, preconception and inter-conception care services. In situations where a new Enrollee is pregnant and already receiving care from an out-of-network OB/GYN Specialist at the time of enrollment, the Enrollee may continue to receive services from that Specialist throughout the pregnancy and postpartum care related to the delivery.

WellKids by PA Health & Wellness will make every effort to contract with all local family planning clinic and Providers and will ensure reimbursement whether the Provider is participating or out-of-network.

Gender Transition: These services include coverage related to gender affirming services that otherwise fall within the beneficiary's scope of covered services including physician services, inpatient and outpatient hospital services, surgical services, prescribed drugs, therapies, and behavioral health care. Medical necessity is to be determined utilizing the World Professional Association for Transgender Health (WPATH) guidelines and any successor to WPATH guidelines.

Services provided for a sudden onset of a medical condition that is accompanied by rapidly progressing symptoms such that the member would suffer serious impairment or loss of function of a body part or organ, or whose life or life of an unborn child would be in in danger. No limits apply.

NETWORK DEVELOPMENT AND MAINTENANCE

Wellkids by PA Health & Wellness offers a comprehensive network including but not limited to hospitals, specialty clinics, trauma centers, facilities for high-deliveries and neonates, specialists, dentists, orthodontists, PCPs, pharmacies, emergency transportation services, long-term care facilities, rehab facilities, home health agencies, certified hospice Providers and DME suppliers to ensure every Enrollee has access to covered services in a timely manner. Below are the travel time and access standards that Wellkids by PA Health & Wellness utilizes to monitor network adequacy to meet the medical needs of its Enrollees, both adults and children, in compliance with DHS's access and availability requirements.

PCPs

Enrollees will have a choice of at least two appropriate PCPs with open panels whose offices are located within a travel time no greater than 30 minutes (urban) and 60 minutes (rural). This travel time is measured via public transportation, where available.

An Enrollee may, at the Enrollee's discretion, select a PCP located further from the Enrollee's home.

PEDIATRICIANS AS PCPs

Enrollee's will have access to an adequate number of pediatricians with open panels to permit all Enrollees who want a pediatrician as a PCP to have a choice of two pediatricians within the travel time limits (30 minutes in urban areas, 60 minutes in rural areas).

SPECIALISTS

For the following Provider types, Enrollees will have a choice of two Providers who are accepting new patients within the travel time limits (30 minutes in urban areas, 60 minutes in rural areas):

General Surgery
Obstetrics & Gynecology
Oncology
Physical Therapy
Cardiology
Pharmacy
Orthopedic Surgery
General Dentistry

For the following Provider types, Enrollees will have a choice of one Provider who is accepting new patients within the travel time limits (30 minutes in urban areas, and 60 minutes in rural areas), and a second choice within the CHIP service area:

Oral Surgery
Nursing Facility
Dermatology
Urology
Neurology
Otolaryngology

HOSPITALS

Enrollees will have access to at least one hospital within the travel time limits (30 minutes in urban areas, and 60 minutes in rural areas), and a second choice within the CHIP service area.

ANESTHESIA FOR DENTAL CARE

For Enrollees needing anesthesia for dental care, PHW will ensure a choice of at least two dentists within the Provider network with privileges or certificates to perform specialized dental procedures under general anesthesia or cover these services out of network.

CERTIFIED NURSE MIDWIVES AND CERTIFIED REGISTERED NURSE PRACTITIONERS

Enrollees will have access to a sufficient number of Certified Nurse Midwives (CNMs) and Certified Registered Nurse Practitioners (CRNPs). And will maintain payment policies that reimburse CNMs

and CRNPs for all services provided within the scope of their practice and allow them to practice to the fullest extent of their education, training and licensing.

REHABILITATION FACILITIES

Enrollees will have access to at least two rehabilitation facilities within the Provider network.

BEHAVIORAL HEALTH PROVIDERS

Enrollee's will have a choice of at least two behavioral health Providers within the Provider network accepting new patients within the travel times of 30 minutes in urban areas, and 60 minutes in rural areas.

Enrollees will have access to a sufficient number of psychiatrists, psychologists, licensed clinical social workers, and other behavioral health Providers to serve the needs of Enrollees.

TELEPHONIC PSYCHIATRIC CONSULTATION TEAM SERVICES

The Telephonic Psychiatric Consultation Service Program (TiPS) is a statewide program to increase the availability of peer-to-peer child psychiatry consultation teams to PCPs, medical specialists, and other prescribers of psychotropic medications for children insured by CHIP.

Non-Discrimination

We do not limit the participation of any Provider or facility in the network, and/or otherwise discriminate against any Provider or facility based solely on any characteristic protected under state or federal discriminate laws.

Furthermore, we do not and have never had a policy of terminating any provider who:

- Advocated on behalf of an Enrollee
- Filed a complaint against us
- Appealed a decision of ours

Tertiary Care

WellKids by PA Health & Wellness offers a network of tertiary care inclusive of trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities and medical subspecialists available 24-hours per day in the geographical service area.

Out-of-Network

In the event that the Wellkids by PA Health & Wellness Network is unable to provide necessary medical services to a particular Enrollee, WellKids by PA Health & Wellness shall adequately cover these services out-of-network. Wellkids by PA Health & Wellness shall provide out-of-network coverage for the Enrollee for as long as the Wellkids by PA Health & Wellness Network is unable to provide the service(s). Wellkids by PA Health & Wellness shall coordinate with the out-of-network Provider with respect to authorization and payment.

For assistance in making a referral to a specialist for a WellKids by PA Health & Wellness Enrollee, please contact our Medical Management team at 1-855-445-1920 TTY 711and we will identify a Provider to make the necessary referral.

Network Termination

Refer to your Participating Provider Agreement (PPA) for additional information on termination from the network.

MEDICAL MANAGEMENT

Overview

WellKids by PA Health & Wellness Medical Management department hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m., EST (excluding holidays). After normal business hours, our 24/7 nurse advice hotline staff is available to answer questions about prior authorization.

Medical Management services include the areas of utilization management, care management, population health management, and quality review. The department clinical services are overseen by the WellKids by PA Health & Wellness Chief Medical Officer. To reach the Chief Medical Officer contact Medical Management please contact: 1-855-445-1920 TTY 711

Medically Necessary

Medically Necessary (also referred to as Medical Necessity) — Compensable under CHIP and meeting any one of the following standards:

- Will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist an Enrollee to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Enrollee and those functional capacities that are appropriate for Enrollees of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing. The determination is based on medical information provided by the Enrollee, the Enrollee's family/caretaker and the Primary Care Practitioner, as well as any other Providers, programs, agencies that have evaluated the Enrollee.

All such determinations must be made by qualified and trained health care providers.

Care Management Program

WellKids by PA Health & Wellness care management model is designed to help your WellKids by PA Health & Wellness Enrollees obtain needed services, whether they are covered within the WellKids by PA Health & Wellness array of covered services, from community resources, or from other non-

covered venues. Our model will support our provider network whether you work in an individual practice or large multi-specialty group setting.

The program is based upon a coordinated care model that uses a multi-disciplinary care management team in recognition that a holistic approach yields better outcomes. The goal of our program is to help Enrollees achieve the highest possible levels of wellness, functioning, and quality of life.

The program includes a systematic approach for early identification of eligible Enrollees, needs assessment, and development and implementation person centered care plan that includes Enrollee/family education and actively links the Enrollee to providers and support services as well as outcome monitoring and reporting back to the PCP.

Needs Screening

Upon Enrollment, the WellKids by PA Health & Wellness will conduct a needs screening using a tool approved by the Department to identify any unmet needs, healthcare needs requiring chronic condition or disease management or service gaps. Any Enrollee whose needs screening reflects unmet needs or service gaps will be referred to the care management program.

We will coordinate access to services not included in the core benefit package such as dental, vision and pharmacy services. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs.

A Care Management (CM) team is available to help all providers manage their WellKids by PA Health & Wellness Enrollees. Listed below are programs and components of special services that are available and can be accessed through the care management team. We look forward to hearing from you about any WellKids by PA Health & Wellness Enrollees that you think can benefit from the addition of a WellKids by PA Health & Wellness care management team Enrollee.

- Link the Enrollee to a Medical Home
- Educate Enrollees about Self-Management of their condition
- Ensure Enrollee awareness of and compliance with medications
- Connect the Enrollee to needed supports
- Whole-Person Care Management
- Coordination of Enrollee Services
- Discharge planning/coordination
- Linkage to the MA PH95 program if special needs are identified

To contact a care manager, call 1-855-445-1920 TTY 711.

Pregnancy Program

The Maternity Team will implement our *Start Smart for Your Baby*® Program (Start Smart), which incorporates care management, care coordination, and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. Start Smart is a unique perinatal program that follows women for up to one year after delivery and includes neonates and qualified children up to one year of age.

The program goals are improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant Enrollees and providing care management to high and moderate risk Enrollees through the postpartum period. A nurse care manager with obstetrical experience will serve as lead care manager for Enrollees at high risk of early delivery or who experience complications from pregnancy. A nurse care manager with obstetrical experience will be the lead CM for newborns being discharged from the NICU unit and will follow them through the first year of life as needed based on their specific condition or diagnosis.

The Maternity team has physician oversight advising the team on overcoming obstacles, helping identify high risk Enrollees, and recommending interventions. These physicians will provide input to WellKids by PA Health & Wellness Medical Director on obstetrical care standards and use of newer preventive treatments.

Contact the WellKids by PA Health & Wellness care management department for enrollment in the obstetrical program.

Chronic Care/Disease Management Programs

As a part of WellKids by PA Health & Wellness services, Chronic Care Management Programs (CCMP) is offered to Enrollees. Chronic Care Management/Disease Management is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care.

Chronic care management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

WellKids by PA Health & Wellness programs include but are not limited to asthma, diabetes and congestive heart failure. Our programs promote a coordinated, proactive, disease-specific approach to management that will improve Enrollees' self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical conditions.

Not all Enrollees having the targeted diagnoses will be enrolled in the CCMP. Enrollees with selected disease states will be stratified into risk groups that will determine need and level of intervention. High-risk Enrollees with co-morbid or complex conditions will be referred for care management program evaluation. Chronic care management is considered an opt-out program such that all eligible members have the right to participate or to decline to participate.

To refer an Enrollee for chronic care management:

- Call WellKids by PA Health & Wellness Health Coaches at 1-855-445-1920 TTY 711
- Online: PAWellKids.com

UTILIZATION MANAGEMENT

The WellKids by PA Health & Wellness Utilization Management Program (UMP) is designed to ensure Enrollees of WellKids by PA Health & Wellness Network receive access to the right care at the right

place and right time. Our program is comprehensive and applies to all eligible Enrollees across all eligibility types, age categories, and range of diagnoses. It provides for aggregate and individual analysis and feedback of Provider and plan performance in providing access to care, the quality of care provided to Enrollees, and utilization of services. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, home health, maternity care and ancillary care services.

WellKids by PA Health & Wellness UMP seeks to optimize an Enrollee's health status, sense of well-being, productivity, and access to quality healthcare, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Our program goals include:

- Development of quality standards for the region with the collaboration of the Provider Standards Committee.
- Monitoring utilization patterns to guard against over- or under- utilization
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction
- Identification and provision of care and/or population management for Enrollees at risk for significant health expenses or ongoing care
- Development of an infrastructure to ensure that all WellKids by PA Health & Wellness Enrollees establish relationships with their PCPs to obtain preventive care
- Implementation of programs that encourage preventive services and chronic condition self-management
- Creation of partnerships with Enrollees/Providers to enhance cooperation and support for UMP goals

Prior Authorizations

Failure to obtain the required approval or pre-certification may result in a denied claim(s). All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines. WellKids by PA Health & Wellness providers are contractually prohibited from holding any WellKids by PA Health & Wellness Enrollee financially liable for any service administratively denied by WellKids by PA Health & Wellness for the failure of the Provider to obtain timely authorization. All out-of-network services require Prior Authorization except for family planning, emergency room, post-stabilization services and tabletop x-rays.

This list is not all inclusive. Please visit PAHealthWellness.com and use the "Pre-Auth Check" tool to determine if a service requires Prior Authorization and to easily submit a request for Prior Authorization or referral.

Services That Require Prior Authorization

Ancillary Services

- Air ambulance transport (non-emergent fixed wing airplane)
- Durable Medical Equipment (DME)

- Home Health Care
- Hospice
- Furnished Medical Supplies and DME
- Orthotics/Prosthetics
- Genetic Testing
- Specialty Pharmaceuticals
- All Out-of-Network Providers and services require Prior Authorization (excluding emergency room services)

Procedures/Services

- Potentially cosmetic
- Bariatric surgery
- Transplants
- High tech imaging requests: RadMD.com
- High tech imaging administered by Evolent, i.e., CT, MRI, PET
- Obstetrical ultrasound
  Two (2) allowed in nine months.
  Prior authorization required for additional ultrasound(s), except if rendered by a Perinatologist
- Pain management
- Specific procedures identified in the "Pre-Auth Check" tool on the Provider Portal
- Services that are experimental/investigational

Inpatient Authorization

All elective/scheduled admission notifications requested at least five days prior to the scheduled date of admission including but not limited to:

- Medical admissions
- Surgical admissions
- All services performed in out-of-network facilities
- Rehabilitation facilities
- Observation stays exceeding 23 hours require Inpatient Authorization/Concurrent Review
- Outpatient Programs

Procedures for Requesting Prior-Authorization

The preferred method for submitting authorizations is through the Secure Provider Web Portal at Provider.PAHealthWellness.com or Availity at www.availity.com. The Provider must be a registered user on each Secure Provider Web Portal. If the Provider is not already a registered user on the Secure Provider Web Portal and needs assistance or training on submitting Prior Authorizations, the Provider should contact his or her dedicated Provider Relations Representative. Other methods of submitting the Prior Authorization requests are as follows:

- **Call** the Medical Management Department at 1-855-445-1920 TTY 711. Please note: The Medical Management normal business hours are Monday – Friday 8am to 5pm. Voicemails left after hours will be responded to on the next business day.
- **Fax** prior authorization requests utilizing the Medicaid Prior Authorization fax forms posted on PAHealthWellness.com to 844-307-0997. *Please note faxes will not be*

monitored after hours and will be responded to on the next business day. Behavioral Health Authorizations should be faxed to 844-412-2269.

Timeframes for Prior Authorization Requests and Notifications

Authorization must be obtained prior to the delivery of certain elective and scheduled services. The following timeframes are required for prior authorization and notification.

Any prior authorization request that is faxed or sent via the website after normal business hours (8:00 am – 5:00 pm, Monday – Friday, excluding holidays) will be processed the next business day.

Failure to obtain authorization may result in administrative claim denials.

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five business days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five business days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within 24 hours or by the next business day
Observation – 23 hours or less	Notification within one business day for non-participating providers
Observation – greater than 23 hours	Requires inpatient prior authorization within one business day
Maternity admissions	Notification within one business day, with delivery outcome

Authorization Determination Timelines

WellKids by PA Health & Wellness decisions are made as expeditiously as the Enrollee's health condition requires.

Type	Timeframe
Preservice/Urgent	2 Business Days, not to exceed 3 calendar days
Preservice/Non-Urgent	2 business days of the receipt of all supporting information reasonably necessary to complete

	the review request. An additional 14 calendar days if additional information is needed.
Concurrent review	1 business day from receipt of all supporting information reasonably necessary to complete the review request.

Clinical Information

WellKids by PA Health & Wellness clinical staff request clinical information minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), WellKids by PA Health & Wellness is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations, with the authorization of the Enrollee.

Information necessary for authorization of covered services may include but is not limited to:

- Enrollee's name, Enrollee ID number
- Provider's name and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g., primary and secondary diagnosis, planned surgical procedures, surgery date)
- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date, if the request is for a surgical procedure
- Discharge plans
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate including the date of birth and gender of infant must be provided to WellKids by PA Health & Wellness within 2 business days or before discharge

If additional clinical information is required, a nurse or medical service representative will notify the caller of the specific information needed to complete the authorization process.

Clinical Decisions

WellKids by PA Health & Wellness affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. WellKids by PA Health & Wellness does not reward practitioners or other individuals for issuing denials of service or care. Financial incentives for Utilization Management (UM) decision makers do not encourage decisions that result in underutilization.

Delegated Providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Enrollee.

The treating physician, in conjunction with the Enrollee, is responsible for making all clinical decisions regarding the care and treatment of the Enrollee. The PCP, in consultation with the WellKids by PA Health & Wellness Medical Director, is responsible for making utilization management (UM) decisions in accordance with the Enrollee's plan of covered benefits and established PC criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

Review Criteria

WellKids by PA Health & Wellness has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the Enrollee's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Providers may obtain the criteria used to make a specific adverse determination by contacting Medical Management at 1-855-445-1920 TTY 711. Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted through Provider Services by calling WellKids by PA Health & Wellness main toll-free phone number at 1-855-445-1920 TTY 711and ask for a Peer Review with the Medical Director. A care manager may also coordinate communication between the Medical Director and requesting practitioner.

Providers or Enrollees may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing:

Mail to:

WellKids by PA Health & Wellness
Attn: Complaints and Grievances Unit
1700 Bent Creek Blvd, Suite 200
Mechanicsburg, PA 17050

Email: CHIPComplaintsandGrievances@pahealthwellness.com

Phone: 1-855-445-1920 TTY 711

Fax: 844-747-0599

Behavioral Health Appeals

Mail to:

WellKids by PA Health & Wellness

Attn: Complaints and Grievances Unit
P.O. Box 10378
Van Nuys,CA 91410-0378

Fax: 866-714-7991

NOTE: PHW will not accept data stored on external storage devices such as USB devices, CD-R/W, DVD-R/W, or flash media.

Second Opinion

Enrollees or a healthcare professional, with the Enrollee's consent, may request and receive a second opinion from a qualified professional within the WellKids by PA Health & Wellness network. If there is not an appropriate Provider to render the second opinion within the network, the Enrollee may obtain the second opinion from an out-of-network provider at no cost to the Enrollee. Out-of-network and in-network Providers require prior authorization by WellKids by PA Health & Wellness when performing second opinions.

Assistant Surgeon

Reimbursement for an assistant surgeon's service is based on the procedure itself and the assistant surgeon's presence at the time of the procedure. Hospital medical staff by-laws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

New Technology

WellKids by PA Health & Wellness evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the WellKids by PA Health & Wellness population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management department at 1-855-445-1920 TTY 711.

Notification of Pregnancy

Enrollees that become pregnant while covered by WellKids by PA Health & Wellness may remain a WellKids by PA Health & Wellness Enrollee during their pregnancy. The managing physician should notify the WellKids by PA Health & Wellness prenatal team by completing the Notification of Pregnancy (NOP) form (available at PAHealthWellness.com) within five days of the first prenatal visit. Providers are expected to identify the estimated date of confinement and delivery facility. See the Case

Management section for information related to our Start Smart for Your Baby® program and our 17-P program for women with a history of early delivery.

Concurrent Review and Discharge Planning

Concurrent Review Nurses conduct concurrent review for inpatient admissions through onsite or telephonic methods through contact with the hospital's Utilization and Discharge Planning departments and when necessary, with the Enrollee's attending physician. The Concurrent Review Nurse will review the Enrollee's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within one (1) business day of receipt of clinical information. For a length of stay extension request, clinical information must be submitted by 3:00 p.m. EST on the day review is due. Written or electronic notification includes the number of days of service approved, and the next review date.

Routine, uncomplicated vaginal or C-section delivery, does not require concurrent review, however; the hospital must notify WellKids by PA Health & Wellness within two (2) business days of delivery with complete information regarding the delivery status and condition of the newborn.

Retrospective Review

Retrospective review is an initial review of services provided to an Enrollee, but for which authorization and/or timely notification to WellKids by PA Health & Wellness was not obtained due to extenuating circumstances (i.e. Enrollee was unconscious at presentation, Enrollee did not have their Medicaid ID card, or otherwise indicated Medicaid coverage, services authorized by another payer who subsequently determined Enrollee was not eligible at the time of service). Requests for retrospective review must be submitted promptly. A decision will be made within 30 calendar days following receipt of request, not to exceed 90 calendar days from date of service. Presumptive eligibility rules apply. If the date of your retrospective review exceeds 90 calendar days from the date of service, follow the claims reconsideration process outlined in the Provider Billing Manual: https://www.pahealthwellness.com/providers/resources/forms-resources.html.

Speech Therapy and Rehabilitation Services

WellKids by PA Health & Wellness offers our Enrollees access to all covered, medically necessary outpatient physical, occupational and speech therapy services.

Prior authorization is required for outpatient occupational, physical or speech therapy services and should be submitted to WellKids by PA Health & Wellness as described in Procedures for Requesting a Prior Authorization section of this Manual.

Advanced Diagnostic Imaging

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our Enrollees, WellKids by PA Health & Wellness is using Evolent to provide prior authorization services and utilization. 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
- MRI/MRA
- Key Provisions
- Emergency room, observation and inpatient imaging procedures do not require authorization
- It is the responsibility of the ordering physician to obtain authorization
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment

To reach Evolent and obtain authorization, please call 1-855-445-1920 TTY 711and 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

WellKids by PA Health & Wellness, in collaboration with Evolent, will launch a cardiac imaging program to promote health care quality for patients with possible cardiac disease.

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

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

Program Components

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

How the Program Works

In addition to the other procedures that currently require prior authorization for Enrollees, 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 1-855-445-1920 TTY 711and 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.

CLINICAL PRACTICE GUIDELINES

WellKids by PA Health & Wellness clinical and quality programs are based on evidence based preventive and clinical practice guidelines. Whenever possible, WellKids by PA Health & Wellness adopts guidelines that are published by nationally recognized organizations or government institutions as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field.

WellKids by PA Health & Wellness providers are expected to follow these guidelines and adherence to the guidelines will be evaluated at least annually as part of the Quality Management Program. Following is a sample of the clinical practice guidelines adopted by WellKids by PA Health & Wellness:

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
- American Diabetes Association: Standards of Medical Care in Diabetes
- Center for Disease Control and Prevention (CDC): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations for Adult Preventive Health

For links to the most current version of the guidelines adopted by WellKids by PA Health & Wellness, visit our website at PAWellKids.com. A paper copy of the practice guidelines can be requested by calling the Provider Relations department at 1-855-445-1920 TTY 711.

Tuberculosis Control

For all services provided in a state mental health ("MH") facility or a state intellectual disability ("ID") center, Providers will comply with the Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Settings, 2005, issued by the Centers for Disease Control and Prevention ("CDC"), as these guidelines may be updated. The guidelines are available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s_cid=rr5417a1_e.

PHARMACY

WellKids by PA Health & Wellness is committed to providing appropriate, high quality, and cost-effective outpatient medications as listed on the CMS Quarterly Drug Information File, when determined to be medically necessary to all WellKids by PA Health & Wellness Enrollees. We work with Providers and Pharmacists to ensure medications used to treat a variety of conditions and diseases are covered pharmacy benefits.

WellKids by PA Health & Wellness covers prescription drugs and certain over the counter (OTC) drugs when ordered by a WellKids by PA Health & Wellness prescriber at a $0-$36 copay. The pharmacy program covers medications that are covered under the WellKids by PA Health & Wellness CHIP formulary. Certain medications may require prior authorization (PA) and/or have limitations on age, dosage and/or maximum quantities.

This section provides an overview of WellKids by PA Health & Wellness pharmacy program. For more detailed information, please visit our website at PAHealthWellness.com.

Working with the Pharmacy Benefit Manager (PBM)

WellKids by PA Health & Wellness works with Express Scripts to administer pharmacy benefits and with Pharmacy Services for the Prior Authorization process. Certain drugs require Prior Authorization to be approved for payment by WellKids by PA Health & Wellness.

These include:

- All medications designated as non-preferred on the CHIP formulary
- Some preferred drugs (designated as prior authorization required on the CHIP formulary)

Utilization Management (UM)

Both brand and generic drugs are listed within the CHIP formulary. Next to the medication in question, any associated utilization management abbreviations will be listed. Please reference the table below for additional UM abbreviation explanations.

Abbreviation	Term	Explanation
AL	Age Limit	Drug is only covered for certain ages
NP	Non-preferred	These drugs are non-preferred and may need to meet prior authorization before they will be covered
P	Preferred	Drug is preferred
QL	Quantity Limit	These drugs are only covered for a certain total amount
ST	Step Therapy	In some cases, you must first try certain drugs before WellKids by PA Health & Wellness covers another drug for your medical condition
MP	Maintenance Product	Drug that can be dispensed at a 90-day supply (2x copay)

Pharmacy Prior Authorization

Drug Prior Authorization request for non-specialty drugs can be submitted to Pharmacy Services through phone, fax or online. To ensure timeliness of our Enrollees' pharmacy needs, WellKids by PA Health & Wellness has a strict twenty-four (24) hour turnaround time requirement to process these requests.

Phone

- Prescribers may call Pharmacy Services to initiate a Prior Authorization or request a peer-to-peer by calling 1-877-236-1477.
- During regular business hours, licensed Clinical Pharmacists and Pharmacy Technicians are available to answer questions and assist Providers. NurseWise is available to assist Providers outside regular business hours.
- For claims related issues, the Pharmacy Help Desk can be reached by calling 1-833-750-9898.

FAX

- Prescribers may complete the WellKids by PA Health & Wellness Medication Prior Authorization Request form, found on the WellKids by PA Health & Wellness website at PAHealthWellness.com

- Fax pharmacy requests to 1-844-205-3386 or buy and bill drug requests to 1-833-541-2294. The prescriber will be notified of approval by fax.
- If the clinical information provided does not explain the reason for the requested medication, a response is sent to the prescriber by fax, offering formulary alternatives when available.

Online Prior Authorization - Pharmacy

- CoverMyMeds is an online drug prior authorization (PA) program that allows prescribers to submit the PA process electronically. Prescribers locate the correct form, fill it out online, and then submit it to Pharmacy Services via fax. CoverMyMeds simplifies the prior authorization submission process by automating drug prior authorizations for any medication. Additional chart notes may be required.
- CoverMyMeds can be found at https://www.covermymeds.com/main/prior-authorization-forms/

For urgent or after-hours requests, the Pharmacy Services call center can be reached at 1-877-236-1477. The pharmacy can provide up to a 72-hour supply of medically necessary outpatient medications at point of sale using an override code.

Pharmacy Claim Submission

For Pharmacy Services Pharmacy Paper Claim submissions, send correspondence to:

Centene Pharmacy Services
Attn: Paper Claims
7625 N Palm Ave, Suite 107
Fresno, CA 93711

Pharmacy Claim Appeals

First Level Appeal: The right to appeal by a network pharmacy shall be limited to fourteen (14) calendar days following the initial claim. PBM shall investigate and resolve the appeal through an internal process within fourteen (14) calendar days of receipt of the appeal by the PBM. A Pharmacy may speak with an individual who is involved in the appeal process at (314) 848-5606. If PBM denies an appeal, PBM shall provide the reason for the denial and identify the national drug code of an equivalent drug that is available for purchase by the network pharmacy in this commonwealth from wholesalers at a price that is equal to or less than the NADAC cost for the appealed drug as determined by the PBM. If PBM grants and appeals, PBM shall make the price correction, permit the reporting pharmacy to reverse and rebill the appealed claim and make the price correction effective for all similarly situated pharmacies from the date of the approved appeal. 40 P. S. §4533.

Second Level Appeal: After submitting a first level pricing appeal to PBM, if Provider has received a denial and wants to further dispute the outcome of the appeal, Provider may contact the PHW Clinical Pharmacy Services department by mail or secure email to:

PHW Clinical Pharmacy Services
1700 Bent Creek Blvd.
Suite 200
Mechanicsburg, PA 17050

PharmacyEscalationsPHW@PaHealthWellness.com

The following information must be submitted along with the Second Level Dispute:

- Evidence that the Pharmacy Provider has exhausted all its remedies against the PBM (e.g. first level appeal outcome)
- Claim details, including:
  - Pharmacy National Council for Prescription Drug Programs (NCPDP) number
  - Pharmacy Name
  - Name of PSAO (if applicable)
  - Prescription number
  - National Drug Code (NDC)
  - Drug Name
  - Date of Fill
- Documentation of pricing information, as applicable:
  - From at least two wholesalers, inclusive of any additional rebates or discounts, showing that the wholesaler prices are not equal to or less than the contracted price.
  - Desired pricing/reimbursement rate and reasoning for pricing change.
- Second Level Pricing Dispute can be denied if required information was not submitted by Pharmacy Provider.

Timeframes for submission and resolution of Second Level PBM Provider Pricing Disputes:

1. Second Level Pricing Disputes must be submitted to PHW within 15 business days of receiving a pricing appeal denial from the PBM.
2. PHW will respond to the Pharmacy Provider and the PBM with a final determination within 30 business days of receiving the Second Level Pricing Dispute from the Pharmacy Provider.

WellKids by PA Health & Wellness CHIP Formulary

WellKids by PA Health & Wellness utilizes a combination of a CHIP formulary to determine drugs covered by your prescription benefit. These lists are updated often and may change. To view the latest CHIP formulary, visit our website at WellKids.com or call us at 1-855-445-1920 TTY 711. The CHIP formulary includes all therapies available with and without PA. The CHIP formulary includes those drugs that require Prior Authorization for coverage. The CHIP Formulary applies to all medications an Enrollee may receive at network outpatient pharmacies. The CHIP formulary is continually evaluated by the PA Health & Wellness Pharmacy and Therapeutics (P&T) Committee to promote the appropriate and cost-effective use of medications. The Committee is composed of the PA Health & Wellness Medical Director, Pharmacy Director, and Pennsylvania physicians, pharmacists, and healthcare Providers.

The CHIP formulary does not:

- Require or prohibit the prescribing or dispensing of any medication
- Substitute for the independent professional judgment of the Provider or Pharmacist
- Relieve the Provider or Pharmacist of any obligation to the Enrollee or others

The CHIP formulary includes a broad spectrum of generic and brand name drugs. Some preferred drugs require Prior Authorization (PA). Medications requiring PA are listed with a "PA" notation throughout the CHIP formulary.

A paper copy of the current CHIP formulary can be requested by calling Provider Services at 1-855-445-1920 TTY 711.

Providers are requested to utilize the CHIP formulary when prescribing medication to WellKids by PA Health & Wellness Enrollees. If a pharmacist receives a prescription for a drug that requires a prior authorization request, the pharmacist should attempt to contact the provider to request a change to a product included in the CHIP formulary.

Pharmacy and Therapeutics Committee (P&T)

The WellKids by PA Health & Wellness Pharmacy and Therapeutics (P&T) Committee continually evaluates the therapeutic classes included in the CHIP formulary. The primary purpose of the Committee is to assist in developing and monitoring the CHIP formulary in establishing programs and procedures that promote the appropriate and cost-effective use of medically necessary medications. The P&T Committee schedules meetings 4 times a year, the second Wednesday at the beginning of the quarter. All changes to the CHIP formulary, including revisions that adversely impacts our Enrollees will be communicated at least 30 days in advance of those changes. WellKids by PA Health & Wellness will follow all State policies regarding Enrollee notification when changes are made to prior authorizations.

Unapproved Use of Preferred Medication

Medication coverage under this program is limited to non-experimental indications as approved by the FDA. Other indications may also be covered if they are accepted as safe and effective using current medical and pharmaceutical reference texts and evidence-based medicine. Reimbursement decisions for specific non-approved indications will be made by WellKids by PA Health & Wellness. Experimental drugs and investigational drugs are not eligible for coverage.

Prior Authorization Process

The CHIP Formulary includes a broad range of brand name and generic drugs. Clinicians are encouraged to prescribe from the preferred medications included in the CHIP formulary for their patients who are Enrollees of WellKids by PA Health & Wellness. Some drugs will require PA (Prior Authorization) and are listed on the PA list. In addition, all name brand drugs not listed on either the CHIP formulary or PA list will require prior authorization. If a request for PA is needed the information should be submitted by the physician/clinician to Pharmacy Services on the WellKids by PA Health

& Wellness form: Medication Prior Authorization Request Form. This form should be faxed to Pharmacy Services at 1-844-205-3386. This document is located on the WellKids by PA Health & Wellness website at PAWellKids.com. WellKids by PA Health & Wellness will cover the medication if it is determined that:

- There is a medical reason the Enrollee needs the specific medication.
- Depending on the medication, other medications on the CHIP formulary have not worked.

Prior Authorization requests for specialty medications should be faxed to Pharmacy Services at 1-844-205-3386.

All reviews are performed using the criteria approved by the PA Health & Wellness P&T Committee and Pennsylvania Department of Human Services. If an adverse medical determination is recommended by the clinical pharmacist, a Pennsylvania licensed physician will make the decision to deny this PA request. Only a licensed physician can issue a medical denial determination. Once approved, the prescriber/clinician will be notified by fax. If the clinical information provided does not meet the medical necessity and prior authorization guidelines for the requested medication, WellKids by PA Health & Wellness will notify the Enrollee and the prescriber and provide information for the appeal process.

The PA Health & Wellness P&T Committee has reviewed and approved, with input from its Enrollees and in consideration of medical evidence, the list of drugs requiring PA within the CHIP formulary. This formulary attempts to provide appropriate and cost-effective drug therapy to all Enrollees covered under the WellKids by PA Health & Wellness pharmacy program. If a patient requires a brand name medication that does not appear on the CHIP formulary, the physician/clinician can make a PA request for the brand name medication. It is anticipated that such exceptions will be rare and that CHIP formulary medications will be appropriate to treat the vast majority of medical conditions. A phone or fax-in process is available for PA requests.

Pharmacy Solutions Contact Information:

Prior Authorization FAX for pharmacy requests: 1-844-205-3386

Prior Authorization FAX for provider buy and bill requests: 1-833-541-2294

Prior Authorization Phone: 1-877-236-1477

Mailing Address:
Pharmacy Department
5 River Park Place East, Suite 210
Fresno, CA 93720

72 Hour Emergency Supply of Medications

Commonwealth and federal law require that a pharmacy dispense a minimum 72-hour supply. WellKids by PA Health & Wellness will allow a 72-hour supply of medication to any patient awaiting a prior authorization determination. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are authorized to provide a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72-hour supply of medication, whether or not the PA request is ultimately approved or denied. The pharmacy will submit override codes provided in point of sale (POS) messaging.

Newly Approved Products

We review new drugs for safety and effectiveness before adding them to the CHIP formulary. During this period, access to these medications will be granted to all new drugs approved by the Food and Drug Administration (FDA) and meet the definition of a Covered Outpatient Drug either by addition to the CHIP formulary, or through prior authorization, within 10 days from their availability in the marketplace.

Step Therapy

Some medications listed on the CHIP formulary may require specific medications to be used before you can receive the step therapy medication. If WellKids by PA Health & Wellness does not have a record that the required medication was tried, the Enrollee or physician/clinician may be required to provide additional information. If WellKids by PA Health & Wellness does not grant PA, we will notify the Enrollee and physician/clinician and provide information regarding the appeal process.

Benefit Exclusions

The following drug categories are not part of the WellKids by PA Health & Wellness PDL and are not covered by the 72-hour emergency supply policy:

- Drugs for weight loss or weight management
- Drugs used for fertility
- Drugs used for cosmetic reasons
- Drugs for sexual/erectile dysfunction
- Drugs from manufacturers that have not entered into a rebate agreement with a Federal Drug Rebate Program with the Center for Medicare and Medicaid Services (CMS)
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective
- Over the counter (OTC) drugs in the form of troches, lozenges, throat tablets, cough drops, chewing gum, mouthwashes and similar products (except tobacco cessation products)
- Pharmaceutical services provided during hospital stay
- Products classified as experimental or not approved by the FDA (Food Drug Administration)
- Placebos
- Soaps, cleaning agents, dentifrices, mouthwashes, douche solutions, diluents, ear wax removal agents, deodorants, liniments, antiseptics, irrigants and other personal care and medicine cabinet items

Anything prescribed by a prescriber barred or suspended from the MA (medical assistance) program.

Injectable Drugs

Injections as defined by CMS list of covered outpatient drugs as listed on the CMS Quarterly Drug Information File when determined to be medically necessary are approved pharmacy benefits to our WellKids by PA Health & Wellness Enrollees.

Dispensing Limits, Quantity Limits and Age Limits

Drugs may be dispensed up to a maximum 34-day supply for each new or refill non-controlled substance. A total of 80 percent (80%) of the days supplied for a non-controlled medication must have elapsed before the prescription can be refilled without a PA approval. A prescription can be filled after 28 days. Dispensing outside the quantity limit (QL) or age limits (AL) requires PA. WellKids by PA Health & Wellness may limit how much of a medication an Enrollee can get at one time. If the physician/clinician feels an Enrollee has a medical reason for getting a larger amount, he or she can ask for PA. If WellKids by PA Health & Wellness does not grant a PA, we will notify the Enrollee and physician/clinician and provide information regarding the appeal process. Some medications on the formulary may have age limits. These are set for certain drugs based on Food and Drug Administration (FDA) approved labeling and for safety concerns as well as current medically accepted quality standards of care as supported by clinical literature. The age limits align with current FDA and medical standards of care for the appropriate use of pharmaceuticals in improving outcomes for our Enrollees. There is always consideration of the exception process for medically necessary treatments.

Mandatory Generic Substitution

Generic drugs have the same active ingredient, work the same as brand name drugs, and have lower copayments. If the Enrollee or physician/clinician feels a brand name drug is medically necessary, the physician/clinician can ask for an authorization. We will cover the brand name drug according to our clinical guidelines if there is a medical reason the Enrollee needs the particular brand name drug. If WellKids by PA Health & Wellness does not grant authorization, we will notify the Enrollee and physician/clinician and provide information regarding the appeal process. Medication therapeutic substitutions, or the process of filing of a medication prescription with a different medication in the same pharmacologic class, will not be conducted at a retail setting without consultation with the prescriber.

Over-The-Counter Medications (OTC)

The pharmacy program covers certain OTC medications as included within the formulary. All OTC medications must be written on a valid prescription by a licensed physician to be reimbursed.

Prior Authorization by Phone

When calling, please have Enrollee information, including CHIP ID number, Enrollee date of birth, complete diagnosis, medication history, and current medications readily available. If the request is approved, information in the online pharmacy claims processing system will be changed to allow the specific Enrollees to receive this specific drug.

If the request is denied, information about the denial will be provided to the Provider and the Enrollee.

In the event that a Provider or Enrollee disagrees with the decision regarding coverage of a medication, the Enrollee or the Provider, on the Enrollee's behalf, may submit an appeal, verbally or in writing. For additional information about appeals, please refer to the Appeals section herein.

PROVIDER RELATIONS AND SERVICES

Provider Relations

WellKids by PA Health & Wellness' Provider Relations department is committed to supporting Providers as they care for our Enrollees. Through ongoing training and support of daily business operations, we will strive to be your partners in good care. Upon credentialing approval and contracting, each Provider will be assigned a Provider Representative.

Reasons to Contact a Provider Relations Representative

- Report any changes to your practice (locations, NPI, TIN numbers)
- Initiate credentialing of a new practitioner
- Schedule an in-service training for new staff
- Conduct ongoing education for existing staff
- Obtain clarification of policies and procedures
- Obtain clarification of a provider contract
- Request fee schedule information
- Obtain Enrollee roster
- Obtaining Provider Profiles
- Learn how to use electronic solutions on web authorizations, claims submissions and Enrollee eligibility
- Open/close patient panel

Provider Services

Provider Services is available at 1-855-445-1920 TTY 711, Monday 8:00am – 8:00pm EST, Tuesday through Friday 8:00am to 5:00pm EST and closed on State holidays.

CREDENTIALING AND RE-CREDENTIALING

Overview

The purpose of the credentialing and re-credentialing process is to help make certain that WellKids by PA Health & Wellness maintains a high-quality healthcare delivery system. The credentialing and re-credentialing process helps achieve this aim by validating the professional competency and conduct of our Providers. This includes verifying licensure, board certification, and education, and identification of adverse actions, including malpractice or negligence claims, through the applicable state and federal agencies and the National Practitioner Data Base. Participating providers must meet the criteria established by WellKids by PA Health & Wellness, as well as government regulations and standards of accrediting bodies.

WellKids by PA Health & Wellness requires re-credentialing at a minimum of every 3 years because it is essential that we maintain current Provider professional information. This information is also critical for WellKids by PA Health & Wellness' Enrollees, who depend on the accuracy of the information in its Provider directory.

Note: In order to maintain a current Provider profile, Providers are required to notify WellKids by PA Health & Wellness of any relevant changes to their credentialing information in a timely manner.

Which Providers Must be Credentialed?

The following Providers are required to be credentialed:

Medical practitioners

- Medical doctors
- Oral surgeons
- Chiropractors
- Osteopaths
- Podiatrists
- Nurse practitioners
- Other medical practitioners

Behavioral healthcare practitioners

- Psychiatrists and other physicians
- Addiction medicine specialists
- Doctoral or master's-level psychologists
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- Other behavioral healthcare specialists

Information Provided at Credentialing

All new practitioners and those adding practitioners to their current practice must submit at a **minimum** the following information when applying for participation with WellKids by PA Health & Wellness:

- A Valid Medicaid ID Number
- A completed, signed and dated Credentialing application
- Providers must authorize WellKids by PA Health & Wellness access to their information on file with the CAQH (Council for Affordable Quality Health Care) www.CAQH.org. A CAQH attestation must be dated within 60 days of request of enrollment.
- A signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with Pennsylvania regulations regarding malpractice coverage or alternate coverage
- Copy of current Drug Enforcement Administration (DEA) registration Certificate
- Copy of W-9

- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Curriculum vitae listing, at minimum, a five-year work history (not required if work history is completed on the application)
- Signed and dated release of information forms not older than 90 days
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
- Disclosure of Ownership & Controlling Interest Statement

If applying as an individual practitioner or group practice, please submit the following information along with your signed participation agreement:

- A completed, signed and dated Pennsylvania Standardized Credentialing application

If applying as a Facility (Ancillary, Clinic, FQHC, Hospital, RHC or any Provider billing on an UB form), please submit the following information along with your signed participation agreement:

- Valid Medicaid ID Number
- Hospital/Ancillary Provider Credentialing Application Completed (one per Facility/Ancillary Provider)
- Copy of State Operational License
- Copy of Accreditation/certification (by a nationally recognized accrediting body, e.g., TJC/JCAHO)
    - If not accredited by a nationally recognized body, Site Evaluation Results by a government agency
- Copy of Current General Liability coverage (document showing the amounts and dates of coverage)
- Copy of Medicaid/Medicare Certification (if not certified, provide proof of participation)
- Disclosure of Ownership & Controlling Interest Statement
- Other applicable State/Federal/Licensures (e.g., CLIA, DEA, Pharmacy, or Department of Health)
- Copy of W-9

Once WellKids by PA Health & Wellness has received an application, it verifies the following information, at a minimum, submitted as part of the Credentialing process (please note that this information is also re-verified as part of the re-credentialing process):

- Current participation in the Pennsylvania Medicaid Program
- A current Pennsylvania license through the appropriate licensing agency
- Board certification, or residency training, or medical education
- National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions
- Hospital privileges in good standing or alternate admitting arrangements
- Five-year work history
- Social Security Death Master File

- Federal and state sanctions and exclusions including the following sources:
    a. Office of Inspector General (OIG)
    b. The System for Award Management (SAM)
    c. PA Medicheck
    d. Medicare Opt-Out Listing

Once the application is complete, the WellKids by PA Health & Wellness Credentialing Committee (Credentialing Committee) renders a final decision on acceptance following its next regularly scheduled meeting.

Per Pennsylvania Medical Assistance bulletin 99-11-05 effective 8/15/15, providers who participate in the Medical Assistance Program are required to screen their employees and contractors, both individuals and entities, to determine if they have been excluded from participation in Medicare, Medicaid, and any other federal health care program. These sources include at a minimum OIG, SAM and PA Medichek.

Credentialing Committee

The Credentialing Committee is responsible for establishing and adopting as necessary, criteria for Provider participation. It is also responsible for termination and direction of the credentialing procedures, including Provider participation, denial and termination.

Committee meetings are held at least monthly and more often as deemed necessary.

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

Re-Credentialing

To comply with accreditation standards, WellKids by PA Health & Wellness re-credentials Providers at least every 36 months from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status that may affect the ability to perform services the Provider is under contract to provide. This process includes all Providers, Primary Care Providers, Specialists and ancillary Providers/facilities previously credentialed to practice within the WellKids by PA Health & Wellness network.

In between credentialing cycles, WellKids by PA Health & Wellness conducts ongoing monitoring activities on all network providers. This includes an inquiry to the appropriate state licensing agency to identify newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry helps make certain that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, WellKids by PA Health & Wellness reviews monthly reports including OIG, SAM, Medicare Opt Out and PA Medicheck to identify network Providers who have been newly sanctioned or excluded from participation in federal and state programs.

Loss of Network Participation

A Provider's agreement may be terminated at any time if WellKids by PA Health & Wellness' Credentialing Committee determines that the Provider no longer meets the credentialing requirements.

Upon notification from the Department that a Provider with whom WellKids by PA Health & Wellness has entered into an agreement is suspended or terminated from participation in the Medicaid or Medicare Programs, WellKids by PA Health & Wellness will immediately act to terminate the Provider from participation. Terminations for loss of licensure and criminal convictions will coincide with the effective date of the action.

Right to Review and Correct Information

All Providers participating within the WellKids by PA Health & Wellness network have the right to review information obtained by the Health Plan that is used to evaluate Providers' credentialing and/or re-credentialing applications. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing agencies. This does not allow a Provider to review peer review-protected information such as references, personal recommendations, or other information.

Should a Provider identify any erroneous information used in the credentialing/re-credentialing process, or should any information gathered as part of the primary source verification process differ from that submitted by the Provider, the Provider has the right to correct any erroneous information submitted by another party. To request release of such information, a provider must submit a written request to WellKids by PA Health & Wellness' Credentialing Department. Upon receipt of this information, the provider has 14 days to provide a written explanation detailing the error or the difference in information. The WellKids by PA Health & Wellness Credentialing Committee will then include the information as part of the credentialing/re-credentialing process.

Right to Appeal Adverse Credentialing Determinations

WellKids by PA Health & Wellness may decline an existing Provider applicant's continued participation for reasons such as quality of care or liability claims issues. In such cases, the Provider has the right to request reconsideration in writing within 14 days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in the WellKids by PA Health & Wellness network. The Credentialing Committee will review the reconsideration request at its next regularly scheduled meeting, but in no case later than 60 days from the receipt of the additional documentation. WellKids by PA Health & Wellness will send a written response to the Provider's reconsideration request within two weeks of the final decision.

Disclosure of Ownership and Control Interest Statement

Federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require Providers (other than an individual practitioner or group of practitioners) who are entering into or renewing a Provider agreement to disclose:

- The identity of all owners with a control interest of *5%* or greater

- Certain business transactions as described in 42 CFR 455.105
- The identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity

WellKids by PA Health & Wellness furnishes Providers with the Disclosure of Ownership and Control Interest Statement as part of the initial contracting process. This form should be completed and returned along with the signed Provider agreement. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to WellKids by PA Health & Wellness within 30 days of the change. Please contact WellKids by PA Health & Wellness Provider Relations Department at 1-855-445-1920 TTY 711if you have questions or concerns regarding this form, or if you need to obtain another copy of the form.

PROVIDER EDUCATION

Overview

Provider Education is offered throughout the year. All online education can be found on our website at PAWellKids.com. WellKids by PA Health & Wellness develops and maintains a Provider Network that is knowledgeable and experienced in treating and supporting Enrollees in the Children's Health Insurance Program. WellKids by PA Health & Wellness includes feedback gathered from Providers, Enrollees, advocates, direct care worker representatives, and family members in design and implementation of the annual provider education offered. If you have any feedback on the training or have suggestions on how it can be improved, please email us at ProviderTraining@PAHealthWellness.com or call us at 1-855-445-1920 TTY 711.

Provider Education: Training Offered

WellKids by PA Health & Wellness offers trainings throughout the year that include a wide variety of material. CEU's may be available dependent on topic, information regarding this can be found within the training registration materials. We include training on the following topics, in addition to special topic trainings each month:

- Cultural Awareness & Sensitivity
- Basics of Dementia
- Quality and Administrative Processes
- Suicide Risk and Prevention
- Integration Healthcare for all Providers - The training highlights on defining integrated healthcare, review of the Integrated Practice Assessment (IPAT), discuss the framework to integration approach, and provide best practices for all clinicians.
- Clinical Documentation Improvement

RIGHTS AND RESPONSIBILITIES

WellKids by PA Health & Wellness and its network of providers do not discriminate against Members based on race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, language, CHIP status, income status, program participation, health status, disease or pre-existing condition, anticipated need for healthcare, or physical or mental disability, except where medically indicated.

As a WellKids by PA Health & Wellness enrollees have the following rights and responsibilities.

Enrollee Rights

1. Receive required information.
2. To be treated with consideration and respect, recognizing dignity and need for privacy, by WellKids by PA Health & Wellness staff and network providers.
3. To get information in a way the enrollee can easily understand and receive help when needed.
4. To get information the enrollee can easily understand about WellKids by PA Health & Wellness, its services, and the doctors and other providers.
5. To pick the network health care providers the enrollee wants to treat them.
6. To receive emergency services when needed from any provider without WellKids by PA Health & Wellness's approval.
7. To get information the enrollee can easily understand and talk to their providers about treatment options, risks of treatment, alternative therapies, and consultation or tests that may be self-administered without any interference from WellKids by PA Health & Wellness regardless of cost or benefit coverage.
8. To make all decisions about their health care, including the right to refuse treatment. If the enrollee cannot make treatment decisions by themselves, they have the right to have someone else help make decisions or make decisions for them.
9. To have privacy protected and to talk with providers in confidence and to have health care information and records kept confidential.
10. To see and get a copy of medical records and to ask for changes or corrections to medical records in a timely manner.
11. Be furnished with covered health care services.
12. To ask for a second opinion.
13. To file a grievance if the enrollee disagree with WellKids by PA Health & Wellness's decision that a service is not medically necessary.
14. To file a complaint if the Enrollee is unhappy about the care or treatment they have received.

15. To ask for a DHS External Review.

16. To be free from any form of restraint or seclusion used to force the enrollee to do something, to be disciplined, to make it easier for the provider, or to punish the enrollee.

17. To receive information about services that WellKids by PA Health & Wellness or a provider does not cover because of moral or religious objections and about how to obtain those services.

18. To exercise rights without it negatively affecting the way DHS, WellKids by PA Health & Wellness, and network providers treat the Enrollee.

19. To make recommendations about the rights and responsibilities of WellKids by PA Health & Wellness's Enrollees.

Enrollee Responsibilities

Members are asked to work with their health care service providers. WellKids by PA Health & Wellness are responsible for the following to make sure they get the services and supports needed.

Enrollees have the responsibility to:

1. Provide, to the extent able, information needed by providers.

2. Follow instructions and guidelines given by providers.

3. Be involved in decisions about their health care and treatment.

4. Work with their providers to create and carry out their treatment plans.

5. Tell providers what they want and need.

6. Learn about WellKids by PA Health & Wellness coverage, including all covered and non-covered benefits and limits.

7. Use only network providers unless WellKids by PA Health & Wellness approves an out-of-network provider. Enrollees may have to pay if they do not use in-network providers.

8. Get a referral from their PCP to see a specialist.

9. Respect other patients, provider staff, and provider workers.

10. Make a good-faith effort to pay co-payments.

11. Report fraud and abuse to the DHS Fraud and Abuse Reporting Hotline.

Provider Rights

WellKids by PA Health & Wellness Providers have the **right** to:

- Be treated by their patients and other healthcare workers with dignity and respect
- Receive accurate and complete information and medical histories for Enrollees' care

- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly
- Expect other network providers to act as partners in Enrollees' treatment plans
- Expect Enrollees to follow their directions
- Make a complaint or file an appeal against WellKids by PA Health & Wellness and/or an Enrollee
- File a grievance with WellKids by PA Health & Wellness on behalf of an Enrollee, with the Enrollee's consent
- Have access to information about WellKids by PA Health & Wellness Quality Improvement programs, including program goals, processes, and outcomes that relate to Enrollee care and services
- Contact WellKids by PA Health & Wellness Provider Services with any questions, comments, or problems
- Collaborate with other healthcare professionals who are involved in the care of Enrollees
- Not be prohibited or restricted, if acting within the lawful scope of practice, from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of an Enrollee, including information regarding the nature of treatment options in order to decide among those options; the risks, benefits, and consequences of treatment and non-treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered.
- Not be prohibited or restricted, if a Provider acting within the lawful scope of practice, from discussing needed services and advising or advocating appropriate services with or on behalf of an Enrollee, including information regarding the nature of options; risks; and the availability of alternative services.

Provider Responsibilities

WellKids by PA Health & Wellness providers have the **responsibility** to:

- Be enrolled with the Department and possess an active PROMISe ID for each location in which they provide services for WellKids by PA Health & Wellness. Providers can register on-line at PROMISe Provider Enrollment.
- Observe and protect Enrollee rights. An Enrollee's exercise of rights shall not adversely affect how the Enrollee is treated by Providers.
- Maintain the necessary licensure and certifications required by the Commonwealth to practice in their field. Complete the recommendations outlined in the American Academy of Pediatrics Bright Futures periodicity schedule located at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
- Comply with the FWA requirements listed in this Manual as well as federal regulations

including but not limited to 42 CFR §§ 457.915, 457.925, 457.930, 457.935, and 457.1285 referencing 438.608.

- Have mechanisms that guard against unauthorized or inadvertent disclosure of confidential information to persons outside WellKids by PA Health & Wellness.
- Comply with CHIP regulations and enforcement actions directly initiated by the Department under regulations, including termination and restitution actions.
- Treat Enrollees with fairness, dignity, and respect
- Not discriminate against Enrollees on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency
- Maintain the confidentiality of Enrollees' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
- Provide Enrollees with an accounting of the use and disclosure of their personal health information in accordance with HIPAA, and allow Enrollees to request restrictions on the use and disclosure of their personal health information
- Provide Enrollees, upon request, access to inspect and receive a copy of their personal health information, including medical records
- Provide clear and complete information to Enrollees, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the Enrollee to participate in the decision-making process
- Tell an Enrollee if the proposed medical care or treatment is part of a research experiment and give the Enrollee the right to refuse experimental treatment
- Allow an Enrollee who refuses or requests to stop treatment the right to do so, as long as the Enrollee understands that by refusing or stopping treatment the condition may worsen or be fatal
- Allow Enrollees to appoint a parent, guardian, family member, or other representative if they can't fully participate in their treatment decisions
- Allow Enrollees to obtain a second opinion, and answer Enrollees' questions about how to access healthcare services appropriately
- Follow all state and federal laws and regulations related to patient care and patient rights
- Participate in WellKids by PA Health & Wellness data collection initiatives, such as HEDIS and other contractual or regulatory programs
- Review clinical practice guidelines distributed by WellKids by PA Health & Wellness
- Comply with WellKids by PA Health & Wellness Medical Management program as outlined in this handbook
- Disclose overpayments or improper payments to WellKids by PA Health & Wellness

- Obtain and report to WellKids by PA Health & Wellness information regarding other insurance coverage
- Notify WellKids by PA Health & Wellness in writing if the provider is leaving or closing a practice
- Provide services in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in the Participating Provider Agreement
- Allow WellKids by PA Health & Wellness direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs

ENROLLEE COMPLAINT AND GRIEVANCE PROCESS

An Enrollee, Enrollee's representative or an Enrollee's Provider (with written consent from the Enrollee), may file an Enrollee Complaint or Grievance either verbally or in writing. *These processes exclude Provider claims reconsiderations or claims inquiries.*

WellKids by PA Health & Wellness provides Enrollees assistance in completing all forms and taking other steps of the Complaint and Grievance process, including, but not limited to, providing translation services, communication in alternative languages and toll-free numbers with TTY/TDD.

WellKids by PA Health & Wellness values its Providers and will not take punitive action, including termination of a Provider agreement or other contractual arrangements, for Providers who file a Complaint or Grievance on an Enrollee's behalf. WellKids by PA Health & Wellness aids both Enrollees and Providers with filing a Complaint or Grievance by contacting our Enrollee and Provider Services Department at 1-855-445-1920 TTY 711.

Enrollee Complaints

An Enrollee Complaint is defined as a dispute or objection regarding a Provider or the coverage, operations, or management policies of WellKids by PA Health & Wellness, which has not been resolved by WellKids by PA Health & Wellness and has been filed with WellKids by PA Health & Wellness or with DOH or PID, including but not limited to:

- a denial because the requested service or item is not a Covered Service, which does not include BLE;
- the failure of WellKids by PA Health & Wellness to meet the required time frame for providing a service or item;
- the failure of WellKids by PA Health & Wellness to decide a Complaint or Grievance within the specified time frames;
- a denial of payment by WellKids by PA Health & Wellness after a service or item has been delivered because the service or item was provided without authorization or by a provider not enrolled in the MA Program;
- a denial of payment by WellKids by PA Health & Wellness after a service or item has been delivered because the service or item provided is not a Covered Service for the Enrollee; or

- a denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

The term does not include a Grievance.

The Enrollee must file a Complaint within sixty (60) days from the date of the incident complained of or the date the Enrollee receives written notice of a decision. An Enrollee Complaint is subject to resolution by WellKids by PA Health & Wellness within thirty (30) days of receipt of the Complaint unless the time frame for deciding the Complaint has been extended by up to fourteen (14) days at the request of the Enrollee. WellKids by PA Health & Wellness has a two-level Complaint process.

Acknowledgement

If WellKids by PA Health & Wellness staff receive Complaints through the Plan's Customer Service Call Center, the complaints are documented, and an attempt is made to resolve immediately. Staff document the substance of the Complaint, any actions taken to resolve the issue and any requested actions made by the Enrollee. All Complaints are forwarded to the Complaint and Grievance Unit for final follow-up and resolution. Written complaints are time and date stamped upon receipt and an acknowledgment letter, which includes a description of the complaint, procedures and resolution time frames is sent within one (1) business day of receipt.

First Level Complaint Review

WellKids by PA Health & Wellness permits an Enrollee, the Enrollee's representative or the Enrollee's Provider (with written permission of the Enrollee) to file a written or oral Complaint. The Enrollee, the Enrollee's representative or the Enrollee's Provider may review information related to the Complaint upon request and submit additional material to be considered by WellKids by PA Health & Wellness. The Enrollee and/or the Enrollee's representative may attend the first level Complaint review in person, via telephone or videoconference. The Enrollee may elect not to attend the first level Complaint review meeting, but the meeting will be conducted with the same protocols as if the Enrollee was present.

The first level Complaint review is performed by a first level Complaint review committee, which includes one or more employees of WellKids by PA Health & Wellness. Any individuals who make a decision on Complaints will not be involved in any previous level of review or decision making regarding the subject of the Complaint. In any case, where the reason for the complaint involves clinical issues or relates to denial of expedited resolution of a grievance, WellKids by PA Health & Wellness ensures that the decision makers are health care professionals with the appropriate clinical expertise in treating the Enrollee's condition or disease.

The Enrollee will receive written notice of the first level Complaint committee's decision within thirty (30) days from the date of receipt of the Complaint unless the time frame for deciding the Complaint has been extended by up to fourteen (14) days at the request of the Enrollee. The notification will include the Compliant resolution as well as instructions on how to file a second level Complaint review or external review, whichever is applicable.

If the Complaint disputes one of the following, the Enrollee may file a request for an external review :

- a denial because that the service or item is not a Covered Service;

- the failure of WellKids by PA Health & Wellness to provide a service or item in a timely manner, as defined by the Department;
- the failure of WellKids by PA Health & Wellness to decide the Complaint or Grievance within the specified time frames;
- a denial of payment by WellKids by PA Health & Wellness after the service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA Program;
- a denial of payment by WellKids by PA Health & Wellness after the service or item has been delivered because the service or item provided is not a Covered Service for the Enrollee; or
- a denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

The Enrollee, Enrollee's representative, or the Enrollee's Provider (with written permission of the Enrollee) may file a request for an external review in writing or orally with WellKids by PA Health & Wellness within fifteen (15) days from the date the Enrollee receives written notice of the first level Complaint decision.

For all other Complaints, the Enrollee, Enrollee's representative, or the Enrollee's Provider (with written permission of the Enrollee) may file a second level Complaint either in writing or orally within forty-five (45) days from the date the Enrollee receives written notice of the first level Complaint decision.

Second Level Complaint Review

Upon receipt of the request for a second level Complaint review, WellKids by PA Health & Wellness sends the Enrollee, and when applicable, the Enrollee's representative an acknowledgement letter confirming the second level Complaint within three (3) business days of receipt of the request. The Enrollee and/or Enrollee's representative may attend the second level review in person, via telephone or video conference. WellKids by PA Health & Wellness notifies the Enrollee and/or Enrollee's representative at least fifteen (15) days prior to the date of the second level Complaint review meeting.

The second level Complaint review is performed by a second level review committee made up of three (3) or more individuals who did not participate in the matter under review. At least one third of the second level review committee will be a representative of the community and not an employee of WellKids by PA Health & Wellness or any affiliate.

The second level review committee issues a formal decision within forty-five (45) days of the receipt of the request for a second level Complaint review. WellKids by PA Health & Wellness sends a written notice of the decision to the Enrollee and/or Enrollee's representative.

If the Enrollee is dissatisfied with the second level review committee decision, the Enrollee, Enrollee's representative, or Enrollee's Provider may file in writing or orally with WellKids by PA Health & Wellness for an external review of the second level Complaint decision by PID's BMC within fifteen (15) days from the date the Enrollee receives the written notice of the second level Complaint decision.

Notice of Resolution

The Complaint and Grievance Unit provides written resolution to the Enrollee, the Enrollee's representative or Enrollee's Provider within the timeframes noted above. The Complaint response

includes, but is not limited to, a statement of the issue reviewed by the Committee, the decision reached by WellKids by PA Health & Wellness, the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the Enrollee, if any. Logs and records of disposition or written complaints are retained for ten years.

Complaints may be submitted by written notification to:

WellKids by PA Health & Wellness
Attn: Complaints and Grievances Unit
1700 Bent Creek Blvd
Suite 200
Mechanicsburg, PA 17050

Enrollee Grievances

An Enrollee, Enrollee's representative, or Enrollee's Provider (with written permission from the Enrollee) must file a grievance within sixty (60) days from the date the Enrollee receives written notice of decision. Grievances may be filed either orally or in writing via mail, by fax, via secure web portal, or by email.

An Enrollee Grievance is a request to an MA Managed Care Plan by an Enrollee or a health care provider (with the written consent of the Enrollee), or an Enrollee's authorized representative to have an MA Managed Care Plan reconsider a decision solely concerning the medical necessity, appropriateness, health care setting, level of care or effectiveness of a health care service. If the MA Managed Care Plan is unable to resolve the matter, a grievance may be filed regarding the decision that:

- disapproves full or partial payment for a requested healthcare service;
- approves the provision of a requested health care service for a lesser scope or duration than requested;
- disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service;
- reduces, suspends, or terminates a previously authorized service.

This term does not include a Complaint

An Enrollee who files a Grievance to dispute a decision to discontinue, reduce, or change a service or item that the Enrollee has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance, if the request for review of the Grievance is made orally, hand delivered, faxed, submitted via secure web portal, or post-marked within fifteen (15) days from the mail date on the written notice of decision.

Acknowledgement

Grievances received orally through the Plan's Customer Service Call Center are date and time stamped in the Call Center system. Written Grievances are date and time stamped upon initial receipt.

Upon receipt of a valid grievance, an acknowledgment letter is sent within one (1) business day, which includes a description of the Grievance, procedures, and resolution time frames.

Grievance Review

WellKids by PA Health & Wellness must give the Enrollee at least fifteen (15) days advance written notice of the Grievance review date. The Enrollee, Enrollee's representative, or Enrollee's Provider who filed the grievance may attend the Grievance review in person, via telephone or video conference. The Enrollee may elect not to attend the Grievance review meeting, but the meeting must be conducted with the same protocols as if the Enrollee was present. All Grievance review meetings must be recorded and transcribed verbatim, and the recording and transcription must be maintained as part of the Grievance record.

The Grievance review must be conducted by a Grievance review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance. The Grievance review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. If Grievance is related to dental services, the Grievance review committee must include a dentist. Other appropriate providers may participate in the review, but the licensed physician must decide the Grievance.

Enrollee Grievance Resolution Time Frame

Grievance resolution occurs as expeditiously as the Enrollee's health condition requires, not to exceed thirty (30) calendar days from the date of the initial receipt of the Grievance, unless the time frame for deciding the Grievance has been extended by up to fourteen (14) days at the request of the Enrollee.

Notice of Resolution

A copy of all grievances logs, and records of disposition or written grievances are retained for ten years. WellKids by PA Health & Wellness notifies the Enrollee, the Enrollee's representative, or Enrollee's Provider, if the provider filed a Grievance, with Enrollee consent, of the Grievance review committee decision in writing. The decision letter will include: the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the Enrollee.

The Enrollee or Enrollee's representative, which may include the Enrollee's Provider, with proof of the Enrollee's written authorization for a representative to be involved and/or act on the Enrollee's behalf, may file a request with WellKids by PA Health & Wellness for an external review of a Grievance decision by a certified review entity (CRE) appointed by PID's BMC. The request must be filed in writing or orally within fifteen (15) days from the date the Enrollee receives the written notice of the Grievance decision.

Expedited Enrollee Grievances

An Enrollee has the right to request an Expedited Grievance review at any stage of the Grievance review process. Expedited Grievances may be requested with a certification from the Enrollee's Provider that the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process. The

certification must include the Provider's signature. No punitive action is taken against a Provider that requests an expedited resolution or supports an Enrollee's Grievance. In instances where the Enrollee's request for an Expedited Grievance is denied, the Grievance is transferred to the timeframe for standard resolution of Grievances.

Decisions for Expedited Grievances are issued within either forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Enrollee's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited Grievance has been extended by up to fourteen (14) days at the request of the Enrollee.

A decision letter will be sent to the Enrollee, Enrollee's representative, or Enrollee's Provider that will include: the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the Enrollee.

The Enrollee may file a request for an Expedited External Review within two (2) business days from the date the Enrollee receives WellKids by PA Health & Wellness' expedited Grievance decision. .

External Enrollee Grievance Review Process

WellKids by PA Health & Wellness establishes and maintains an external Grievance review process by which an Enrollee, their representative or a Provider, with the written consent of the Enrollee, may request an external review of a Grievance decision.

Any Grievance review that is not resolved wholly in favor of the Enrollee by WellKids by PA Health & Wellness may be grieved by the Enrollee or the Enrollee's representative in an external review. An Enrollee, the Enrollee's representative, or Enrollee's Provider who filed the grievance has fifteen (15) days from receipt of the Grievance review decision to file a request for an external review with WellKids by PA Health & Wellness. Within five (5) business days of receipt of the request for an external Grievance review, WellKids by PA Health & Wellness must notify the Enrollee, Enrollee's representative, if applicable, or the Provider, and the PID's BMC that the request for external Grievance review has been filed. Within two (2) business days of receipt of the request for an external Grievance review PID's BMC will randomly assign a CRE to conduct the review and notify WellKids by PA Health & Wellness and assigned CRE of the assignment.

The assigned external review entity reviews and issues a written decision within sixty (60) days of the filing of the request for an external Grievance review. The decision is sent to the Enrollee, the Enrollee's representative, or Provider, if the provider filed the grievance with Enrollee's written consent, WellKids by PA Health & Wellness, and PID's BMC. The decision includes the credentials of the individual reviewer, a list of the information considered in reaching the decision, the basis and clinical rationale for the decision and a brief statement of the decision.

The Enrollee, the Enrollee's representative, or Enrollee's Provider have sixty (60) days from receipt of the decision to appeal to a court of competent jurisdiction.

WellKids by PA Health & Wellness complies with the external review entity's decision.

Reversed Enrollee Grievance Resolution

In accordance with 42 CFR §438.424, if WellKids by PA Health & Wellness or the External Review Entity decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, WellKids by PA Health & Wellness authorizes the disputed services promptly and as expeditiously as the Enrollee's health condition requires. Additionally, in the event that services were continued while the appeal was pending, WellKids by PA Health & Wellness provides reimbursement for those services in accordance with the terms of the final decision rendered by the External Review Entity and applicable regulations.

To file a request for an external Grievance review:

WellKids by PA Health & Wellness
Attn: Complaints and Grievances Unit
1700 Bent Creek Blvd
Suite 200
Mechanicsburg, PA 17050

PROVIDER DISPUTES

WellKids by PA Health & Wellness maintains a Provider Dispute Resolution Process, which provides for informal resolution of Provider Disputes at the lowest level and a formal process for Provider Appeals. The Provider dispute process excludes claims. The resolution of all issues regarding the interpretation of Department of Health approved Provider Agreements must be handled between the Provider and WellKids by PA Health & Wellness and does not involve the Department of Health; therefore, these are not within the scope of the Department's Bureau of Hearings and Appeals (BHA). Additionally, the Department's BHA or its designee is not an appropriate forum for Provider Disputes/Appeals with WellKids by PA Health & Wellness.

A Provider Dispute is a written communication to WellKids by PA Health & Wellness, made by a Provider, expressing dissatisfaction with a WellKids by PA Health & Wellness decision that directly impacts the Provider, excluding decisions concerning Medical Necessity and/or claims. Providers are allowed Thirty (30) days to file a dispute. If the issue being disputed is associated with dissatisfaction with PHW Policies or Procedures, the Provider should file a dispute within Thirty (30) Days of becoming aware of the issue.

A Provider Appeal is a written request from a Provider for reversal of a determination by Wellkids by PA Health & Wellness. Network Providers have Sixty (60) days to file a Provider Appeal from the date of determination by WellKids by PA Health & Wellness. Provider Appeals include but are not limited to:

- a Provider credentialing denial;
- a claim denial for participating providers
- a Provider agreement termination.

It is important to note that inquiries or appeals related to claims are handled separately from provider appeals or disputes through the Claims Reconsideration process. Please see the Claims Reconsideration Section of the Provider Billing Manual.

WellKids by PA Health & Wellness' Informal and formal processes for settlement of Provider Disputes and Provider Appeals includes the following:

- Acceptance and usage of the Department's definition of Provider Appeals and Provider Disputes
- Time frames for submission and resolution of Provider Disputes and Provider Appeals
- Processes to ensure equitabilities for all Providers
- Mechanisms and time frames for reporting Provider Appeal decisions to WellKids by PA Health & Wellness' administration, QM, Provider Relations and the Department
- Establishment of a WellKids by PA Health & Wellness Committee to process formal Provider Appeals which provides:
    - At least one-fourth (1/4th) of the members of the Committee must be composed of Providers/peers
    - Committee Enrollees have the authority, training, and expertise to address and resolve Provider Dispute/Provider Appeal issues
    - Access to data necessary to assist committee Enrollees in making decisions
    - Documentation of meetings and decisions of the Committee

FRAUD, WASTE AND ABUSE

WellKids by PA Health & Wellness takes the detection, investigation, and prosecution of fraud, waste, and abuse very seriously, and has a Fraud, Waste, and Abuse (FWA) program that complies with Pennsylvania and federal laws. WellKids by PA Health & Wellness successfully operates a Special Investigations Unit (SIU). WellKids by PA Health & Wellness performs front and back-end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system; please review the Billing and Claims Manual located on our website. WellKids by PA Health & Wellness performs retrospective audits which in some cases may result in taking actions against those providers who, individually or as a practice, commit fraud, waste, and/or abuse. These actions include but are not limited to:

- Remedial education and/or training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement

- Civil and/or criminal prosecution
- Onsite Investigations
- Corrective Action Plan
- Any other remedies available to rectify

WellKids by PA Health & Wellness instructs and expects all its contractors and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provisions (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- HIPAA
- Social Security Act
- US Criminal Codes
- Audit inspection authority of the Pennsylvania Office of Attorney General Medicaid Fraud Control pursuant to 42 CFR §438.230(3).

Types of Fraud:

Recipient Fraud: Someone who receives cash assistance, Supplemental Nutritional Assistance Program (SNAP) benefits, Heating/Energy Assistance (LIHEAP), child care, medical assistance, or other public benefits AND that person is not reporting income, not reporting ownership of resources or property, not reporting who lives in the household, allowing another person to use his or her ACCESS/MCO card, forging or altering prescriptions, selling prescriptions/medications, trafficking SNAP benefits or taking advantage of the system in any way.

Provider Fraud: Billing for services not rendered, billing separately for services in lieu of an available combination code; misrepresentation of the service/supplies rendered (billing brand named for generic drugs; upcoding to more expensive service than was rendered; billing for more time or units of service than provided, billing incorrect provider or service location); altering claims, submission of any false data on claims, such as date of service, provider or prescriber of service, duplicate billing for the same service; billing for services provided by unlicensed or unqualified persons; billing for used items as new.

WellKids by PA Health & Wellness requires all its contractors and subcontractors to report violations and suspected violations on the part of its employees, associates, persons or entities providing care or services to all WellKids by PA Health & Wellness Enrollees. Examples of such violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, health care fraud, obstruction of a state and/or federal health care fraud investigation, money laundering, failure to provide medically necessary services, marketing schemes, prescription forging or altering, physician illegal remuneration schemes, compensation for prescription drug switching, prescribing drugs that are not medically necessary, theft of the prescriber's DEA number or prescription pad, identity theft or Enrollees' medication fraud.

FWA information is available via our company website, Provider Newsletter and included in multiple trainings throughout the year. Please visit PAWellKids.com.

To report any Fraud, Waste and Abuse concerns please call the Fraud and Abuse Line at 1-866-685-8664.

Medical Assistance Provider Compliance Hotline

The Medical Assistance (MA) Provider Compliance Hotline, established by and located in the DHS Bureau of Program Integrity, is designed to provide easy access for reporting suspected fraudulent and abusive practices by providers in managed care within the Pennsylvania MA Program. The Hotline is staffed with medical professionals who are available from 8:30 a.m. to 3:30 p.m. (Eastern Time), Monday through Friday. Voice messaging is available outside these hours. Non-English speaking interpreter services are available to provide assistance to callers and TTY services for persons with hearing impairment are also available.

Contact Information for Fraud and Abuse Reporting by telephone (including TTY service): 1-866-379-847

Self-Audit Protocol

WellKids by PA Health & Wellness encourages providers to voluntarily come forward and disclose overpayments or improper payments of Medicaid (or Medical Assistance (MA)) funds within 60 calendar days of the date the overpayment was identified. While providers have a legal duty to promptly return inappropriate payments that they have received from the MA Program, the use of the protocol is voluntary. The protocol simply provides guidance to providers on the preferred methodology to return inappropriate payments. Details on the DHS Self-Audit Protocol may be found on the DHS Website: https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Provider-Self-Audit-Protocol.aspx. Providers should return any payments identified through this protocol directly to PA Health & Wellness if applicable but must also make the self-disclosure directly to DHS.

At any time a provider believes that they have been inappropriately paid by WellKids by PA Health & Wellness, they should promptly contact WellKids by PA Health & Wellness to disclose and return the inappropriate payment(s):

1. Provider Self-Audit findings should be disclosed to PA Health & Wellness using the Provider Self-Audit Disclosure Form located at https://www.pahealthwellness.com/providers/resources/forms-resources.html via email to PHWFWA@PaHealthWellness.com or by mail to:

WellKids by PA Health & Wellness
Attn: Compliance
1700 Bent Creek Blvd., Suite 200
Mechanicsburg, PA 17050

2. Provider Self-Audit findings may also be disclosed to PA Health & Wellness using the online web-form, located here: https://www.pahealthwellness.com/providers/resources/provider-self-audit.html

3. To the extent that payments can be returned through the claim adjustment process, the provider should follow the claim adjustment instructions in the located in the Provider Billing Manual. Otherwise, Providers should send refund checks made payable to the "WellKids by PA Health & Wellness" to the following address:

PA Health & Wellness
P.O. Box 3765
Carol Stream, IL 60132-3765

*Refund checks should be accompanied by the list of the impacted claim(s).

QUALITY MANAGEMENT

WellKids by PA Health & Wellness culture, systems and processes are structured around its mission to improve the health of all enrolled Enrollees. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of healthcare provided to all Enrollees, including those with special needs.

This system provides a continuous cycle for assessing and analyzing the quality of care and service among plan initiatives including primary, secondary, and tertiary care, preventive health, acute and/or chronic care, dental healthcare, over and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions. The system allows for systemic analysis and re-measurement of barriers to care, the quality of care, and utilization of services over time.

WellKids by PA Health & Wellness recognizes its legal and ethical obligation to provide Enrollees with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, we will provide for the delivery of quality care with the primary goal of improving the health status of Enrollees.

Where the Enrollee's condition is not amenable to improvement, WellKids by PA Health & Wellness will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the Enrollee. This will include the identification of Enrollees at-risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions.

Whenever possible, the WellKids by PA Health & Wellness QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of Enrollees.

Program Structure

The WellKids by PA Health & Wellness Board of Directors has the ultimate authority and accountability for the oversight of the quality of care and service provided to Enrollees. The Board of Directors oversees the QAPI Program and has established various committees and ad-hoc committees to monitor and support the QAPI Program.

The Quality Management Committee (QMC) is a senior management committee with WellKids by PA Health & Wellness network physician representation that is directly accountable to the Board of Directors. The purpose of this committee is to provide oversight and direction in assessing the appropriateness and to continuously enhance and improve the quality of care and services provided to Enrollees. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems, the identification of opportunities to improve Enrollee outcomes, and the education of Enrollees, providers and staff regarding the Quality and Medical Management programs.

The following committees report directly to the Quality Management Committee (QMC):

- Utilization Management Committee (UMC)
- Pharmacy & Therapeutics Committee (P&T)
- Credentialing Committee (CC)
- Complaints and Grievance Committee
- Provider Advocacy Committee (PRAC)
- Enrollee Advisory Committee (PAC)

In addition to the committees reporting to the QMC, WellKids by PA Health & Wellness has sub-committees and workgroups that report to the above committees including, but not limited to:

- Peer Review Committee
- Dental Advisory Committee
- Health Education Advisory Committee

Provider Involvement

WellKids by PA Health & Wellness recognizes the integral role practitioner involvement plays in the success of its QAPI Program. As part of this program, providers and practitioners are required to cooperate with Quality Improvement (QI) activities and allow the WellKids by PA Health & Wellness to

use their performance data. Practitioner involvement in various levels of the process is highly encouraged through Provider representation and participation on the Quality Committees. WellKids by PA Health & Wellness encourages PCP, specialty, OB/GYN, Pharmacy, Dental, and Behavioral Health representation on key quality committees including, but not limited to, the QMC, UMC, P&T, Credentialing, Provider and Enrollee Advisory, as well as select ad-hoc committees.

Quality Assessment and Performance Improvement Program

Scope

The scope of the QAPI Program is comprehensive and addresses both the quality of clinical care and the quality of service provided to WellKids by PA Health & Wellness Enrollees. WellKids by PA Health & Wellness's QAPI Program incorporates all demographic groups, care settings, and services in quality improvement activities, including preventive care, primary care, specialty care, acute care, short-term care, ancillary services, and operations.

Goals

WellKids by PA Health & Wellness's primary QAPI Program goal is to improve Enrollees' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

The WellKids by PA Health & Wellness QAPI Program monitors the following:

- Acute and chronic care management
- Compliance with confidentiality laws and regulations
- Compliance with preventive health guidelines and clinical practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency
- Marketing practices
- Enrollee enrollment and disenrollment
- Enrollee Complaint and Grievance System
- Enrollee experience
- Patient safety
- Primary Care Provider changes
- Pharmacy
- Provider and Plan after-hours telephone accessibility
- Provider appointment availability
- Provider Complaint System
- Provider network adequacy and capacity
- Provider experience
- Selection and retention of providers (credentialing and re-credentialing)
- Utilization Management, including over, under and mis-utilization
- Service Coordination authorization and communication to providers

Patient Safety and Quality of Care

Patient Safety is a key focus of WellKids by PA Health & Wellness QAPI Program. Monitoring and promoting patient safety is integrated throughout many activities across the plan, but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of an Enrollee.

WellKids by PA Health & Wellness employees (including Medical Management staff, Enrollee Services staff, Provider Services, Complaint Coordinators, etc.), panel practitioners, facilities or ancillary Providers, Enrollees or Enrollee representatives, Medical Directors or the Board of Directors may advise the Quality Management (QM) Department of potential quality of care issues. Adverse events may also be identified through claims-based reporting. Potential quality of care issues requires investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated.

Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

WellKids by PA Health & Wellness QMC reviews and adopts an annual QAPI Program and Work Plan aligned with WellKids by PA Health & Wellness vision and goal and appropriate industry standards. The QM Department implements quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving Enrollee health outcomes, quality of access to care and services.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each performance improvement initiative is also designed to allow WellKids by PA Health & Wellness to monitor improvement over time. Quality Performance Measures have been identified based on the potential to improve health care for WellKids by PA Health & Wellness Enrollees. The measures are physical health focused HEDIS measures, integrated behavioral health care, HEDIS measures, along with Commonwealth identified metrics. Performance is measured against established benchmarks and progress to performance goals.

Annually, WellKids by PA Health & Wellness develops a QAPI Work Plan for the upcoming year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates QMC activities, reporting, and studies from all areas of the organization (clinical and service). It also includes timelines for completion and reporting to the QMC

and requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

WellKids by PA Health & Wellness communicates activities and outcomes of its QAPI Program to both Enrollees and Providers through avenues such as the Enrollee newsletter, Provider newsletter, and the WellKids by PA Health & Wellness web portal at provider.pahealthwellness.com.

At any time, WellKids by PA Health & Wellness Providers may request additional information on the Health Plan programs, including a description of the QAPI Program and a report on WellKids by PA Health & Wellness progress in meeting the QAPI Program goals, by contacting the Quality Improvement department.

Feedback on Provider Specific Performance

As part of the quality improvement process, performance data at an individual Provider, practice or site level is reviewed and evaluated. This performance data may be used for quality improvement activities, including use by WellKids by PA Health & Wellness quality committees (Quality Management and Utilization Management Committee, Credentialing Committee, Performance Improvement Committee and/or other committees involved in the quality program). This review of provider specific performance data may include, but is not limited to:

- Site evaluation results including medical record audit, appointment availability, after-hours access, cultural proficiency, and in-office waiting time.
- Preventive care, including wellness exams, immunizations, prenatal care, lead screening, cervical cancer screening, breast cancer screening, and other age-appropriate screenings for detection of chronic diseases or conditions.
- Enrollee complaint and grievance data.
- Utilization management data including emergency room visits/1000 and bed days/1000 reports.
- Service coordination data.
- Critical Incident reporting, sentinel events and adverse outcomes.
- Compliance with clinical practice guidelines.
- Pharmacy data including use of generics or specific drugs.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows comparison across Health Plans. HEDIS gives purchasers and consumers the ability to distinguish between Health Plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the Pennsylvania Department of Health contract.

As both the Pennsylvania and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the Health Plan, but to the individual provider. Pennsylvania purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a Health Insurance Company's ability to demonstrate an improvement in

preventive health outreach to its Enrollees. Physician specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs, such as “Pay for Performance.” These programs pay providers an increased premium based on scoring of such quality indicators used in HEDIS.

How are HEDIS rates calculated?

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

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of Enrollee medical records to abstract data for services rendered that were not reported to the Health Plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate procedure and diagnosis codes can reduce the necessity of medical record reviews (see WellKids by PA Health & Wellness website and HEDIS brochure for more information on reducing HEDIS medical record reviews and improving your HEDIS scores).

Measures typically requiring medical record review include diabetic HbA1c results, controlling high blood pressure, annual well visits, transition of care, care for older adults, and prenatal and postpartum care.

When Will the Medical Record Reviews (MRR) Occur for HEDIS?

Medical record review audits for HEDIS are usually conducted March through May each year. WellKids by PA Health & Wellness QM representatives, or a national MRR vendor contracted to conduct the HEDIS MRR on WellKids by PA Health & Wellness’ behalf may contact you if any of your patients are selected in the HEDIS samples. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the Enrollee/patient. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with WellKids by PA Health & Wellness which allows them to collect PHI on our behalf.

What can be done to improve my HEDIS scores?

- Understand the specifications established for each HEDIS measure.
- Submit claim/encounter data for each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the clean and efficient way to report HEDIS. If services are not billed or not billed accurately, they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.

- Ensure chart documentation reflects all services provided.
- Bill CPT II codes for HEDIS measures related to blood pressure, hemoglobin A1C, cholesterol, diabetic retinal eye exam, advance care planning, medication list and reviews, care for older adults' functional status and pain assessment, medication list and review, and lastly medication reconciliation post hospital discharge.
- CPT II coding helps track quality performance outcomes in a timelier manner, allowing for identification of care opportunities accurately and quickly deploying member interventions to improve member outcomes. It reduces administrative burden for providers by reducing chart collection/medical record submissions as well as facilitates timely and accurate Pay for Quality (P4Q) reporting.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Management Department at 1-855-445-1920 TTY 711.

MEDICAL RECORDS REVIEW

WellKids by PA Health & Wellness Providers must keep accurate and complete medical records. Such records will enable Providers to render the highest quality healthcare service to Enrollees. They will also enable WellKids by PA Health & Wellness to review the quality and appropriateness of the services rendered. To ensure the Enrollee's privacy, medical records should be kept in a secure location.

WellKids by PA Health & Wellness requires Providers to maintain all records for Enrollees for at least ten (10) years. See the Enrollee Rights section of this handbook for policies on Enrollee access to medical records. WellKids by PA Health & Wellness may conduct medical record reviews for the purposes including, but not limited to, utilization review, quality management, medical claim review, and Enrollee complaint/appeal investigation. Providers must meet 80% of the requirements for medical record keeping; elements scoring below 80% are considered deficient and in need of improvement. WellKids by PA Health & Wellness will work with any physician or Provider who scores less than 80% to develop an action plan for improvement. Medical record review results are filed in the QI Department and shared with the Credentialing Department to be considered at the time of re-credentialing.

Required Information

Medical records mean the complete, comprehensive Enrollee records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the Enrollee's participating primary care physician or Provider, that document all medical services received by the Enrollee, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for Enrollees in accordance with the following standards:

- Enrollee's name, and/or medical record number on all chart pages

- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.)
- Prominent notation of any spoken language translation or communication assistance
- All entries must be legible and maintained in detail
- All entries must be dated and signed, or dictated by the provider rendering the care
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented
- An appropriate history of immunizations is made in chart for adults
- Evidence that preventive screening and services are offered in accordance with WellKids by PA Health & Wellness' practice guidelines
- Appropriate subjective and objective information pertinent to the Enrollee's presenting complaints is documented in the history and physical
- Disposition and follow-up
- Reports of operative procedures and excised tissues
- Past medical history (for Enrollees seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters
- Working diagnosis is consistent with findings
- Treatment plan is appropriate for diagnosis
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed including instructions to the Enrollee
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns
- Signed and dated required consent forms
- Unresolved problems from previous visits are addressed in subsequent visits
- Laboratory and other studies ordered as appropriate
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases
- Health teaching and/or counseling is documented
- Appropriate notations concerning use of tobacco, alcohol and substance use (for Enrollees seen three or more times substance abuse history should be queried)
- Documentation of failure to keep an appointment
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed
- Evidence that the Enrollee is not placed at inappropriate risk by a diagnostic or therapeutic problem
- Confidentiality of Enrollee information and records protected
- Evidence that an Advance Directive has been offered to adults 18 years of age and older

Additionally, the Comprehensive Medical and Service Record should contain:

- Medication Record and Person-Centered Service Plan (PCSP), where applicable
- Services provided as per the PCSP
- Service Coordination contact notes
- Documentation of all aspects of patient care or Enrollee service delivery

Nursing Facility records will also include:

- Substantiation of Preadmission Screening and Resident Review (PASRR)
- Documentation of specialized services delivery
- Evidence of education regarding Patient Rights and Responsibilities
- Acknowledgement that the Enrollee was informed of any patient pay liability
- Documentation of financial eligibility including audit of personal assets and authentication of known personal care accounts
- Other processes identified by either WellKids by PA Health & Wellness or the Department.

Medical Records Release

All Enrollee medical records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person's legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the Enrollee/patient. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with WellKids by PA Health & Wellness which allows them to collect PHI on our behalf. PHW requires its Network Providers to have mechanisms that guard against unauthorized or inadvertent disclosure of confidential information.

Medical Records Transfer for New Enrollees

All PCPs are required to document in the Enrollee's medical record attempts to obtain historical medical records for all newly assigned WellKids by PA Health & Wellness Enrollees. If the Enrollee or Enrollee's guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers then this should also be noted in the medical record. PHW will facilitate the transfer of Enrollee medical records among Providers, as necessary.

Access to Records and Audits by WellKids by PA Health & Wellness

Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit WellKids by PA Health & Wellness or its designated representative access to Provider's Records, at Provider's place of business in this State during normal business hours, or remote access of such Records, in order to audit, inspect, review, perform chart reviews, and duplicate such Records. If performed on site, access to Records for the purpose of an audit shall be scheduled at mutually agreed upon times, upon at least thirty (30) business days prior written notice by WellKids by PA Health &

Wellness or its designated representative, but not more than sixty (60) days following such written notice.

Electronic Medical Record (EMR) Access

Provider will grant WellKids by PA Health & Wellness access to Provider's Electronic Medical Record (EMR) system in order to effectively case manage Members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to WellKids by PA Health & Wellness for this access.

REGULATORY MATTERS

Section 1557 of the Patient Protection and Affordable Care Act

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, creed, religion, national origin, age, disability ,ancestry, marital status, sex (including pregnancy, sexual orientation, and gender identity), MA status, income status, program participation, health status, disease or pre-existing condition, anticipated need for healthcare or physical or mental disability, except where medically indicated. Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in:

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

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

Chapter 1101. General Provisions

All WellKids by PA Health & Wellness Providers must abide by the rules and regulations set forth under the General Provision of 55 PA Code, Chapter 1101. A complete outline of the General Provision is provided below with hyperlinks to the most recent version available from pacode.com.

Preliminary Provisions

1101.11. General provisions.

Definitions

1101.21. Definitions.
1101.21a. Clarification regarding the definition of "medically necessary"—statement of policy.

Benefits

Participation

Responsibilities

Fees and Payments

Administrative Procedures

Violations

PROVIDER BILLING MANUAL

INTRODUCTORY BILLING INFORMATION

Billing Instructions

Wellkids by PA Health & Wellness follows CMS rules and regulations for billing and reimbursement.

General Billing Guidelines

Physicians, other licensed health professionals, facilities, Long Term Support Service Providers, and ancillary providers contract directly with Wellkids by PA Health & Wellness for payment of covered services.

It is important that providers ensure that Wellkids by PA Health & Wellness has accurate billing information onfile. Please confirm with our Provider Relations department that the following information is current in our files:

- Provider name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Taxonomy code
- Physical location address (as noted on current W-9 form)
- Billing name and address
- 13-Digit PROMISe™ ID for each service location**

In order to avoid possible delays in processing, providers must bill claims with all appropriate identifiers validating that both the billing and rendering providers and their service locations are registered in the state of Pennsylvania's PROMISe™ system.

ALL Billing and Rendering provider information will be subject to up front editing against the PROMISe™ system, and claims containing any non-registered or inactive provider records will be rejected. Claims missing the required data will be returned, and a notice sent to the provider, creating payment delays. Such claims are not considered "clean" and therefore cannot be accepted into our system.

**All Providers and Servicing locations must be actively registered with PA-DHS in order for Wellkids by PA Health & Wellness to generate claims payment. Please validate program eligibility prior to claim submission.

We recommend that providers notify Wellkids by PA Health & Wellness 30 days in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider's TIN and/or address are NOT acceptable when conveyed via claim form.

Claims eligible for payment must meet the following requirements:

- The Enrollee must be effective on the date of service (see information below on

identifying the Enrollee),

- The service provided must be a covered benefit under the Enrollee's contract on the date of service, and
- Referral and prior authorization processes must be followed, if applicable.

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual.

When submitting your claim, you need to identify the Enrollee. There are two ways to identify the Enrollee:

- The Wellkids by PA Health & Wellness Enrollee number found on the Enrollee ID card or the provider portal.
- The Medicaid Number ~~provided by the~~ found on the Enrollee ID card or the provider portal.

Paper Claim Submissions

Wellkids by PA Health & Wellness only accepts the CMS 1500 (2/12) and CMS 1450 (UB-04) paper claimforms. Other claim form types will be rejected and returned to the provider.

Professional providers and medical suppliers complete the CMS 1500 (2/12) form and institutional providers complete the CMS 1450 (UB-04) claim form. Wellkids by PA Health & Wellness does not supply claim forms to providers. Providers should purchase these from a supplier oftheir choice. All paper claim forms are required to be typed or printed and in the original red and white version to ensure clean acceptance and processing. **All claims with handwritteninformation or black and white forms will be rejected.** If you have questions regarding what type of form to complete, contact Wellkids by PA Health & Wellness at 1-844-626-6813.

Billing Codes

Wellkids by PA Health & Wellness requires claims to be submitted using codes from the current version of ICD-10, ASA, DRG, CPT4, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations, as necessary.

Below are some code-related reasons a claim may reject or deny:

- The billed code is missing, invalid, or deleted at the time of service
- Code is inappropriate for the age or sex of the Enrollee
- Diagnosis code is missing the 4th or 5th digit as appropriate
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary
- Code billed is inappropriate for the location or specialty billed
- Code billed is a part of a more comprehensive code billed on same date of service

Written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Wellkids by PA Health & Wellness.

CPT® Category II Codes

CPT Category II Codes are supplemental tracking codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of CPT Category II Codes allows data to be captured at the time of service and may reduce the need for retrospective medical record review.

Uses of these codes are optional and are not required for correct coding. They may not be used as a substitute for Category I codes. However, as noted above, submission of these codes can minimize the administrative burden on providers and health plans by greatly decreasing the need for medical record review.

Encounters vs Claim

An encounter is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services, he/she provided our Enrollees. For example, if you are the PCP for a Wellkids by PA Health & Wellness Enrollee and receive a monthly capitation amount for services, you must file an encounter (also referred to as a “proxy claim”) on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or “proxy claim” is paid at zero-dollar amounts. It is mandatory that your office submits encounter data. Wellkids by PA Health & Wellness utilizes the encounter reporting to evaluate allaspects of quality and utilization management, and it is required by HFS and by the Centers for Medicare and Medicaid Services (CMS). Encounters do not generate an Explanation of Payment (EOP).

A claim is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim. Claims will generate an EOP.

You are required to submit either an encounter or a claim for each service that you render to a Wellkids by PA Health & Wellness Enrollee.

Non-Clean Claim Definition

Non-clean claims are submitted claims that require further documentation or development beyond the information contained therein. The errors or omissions in claims result in the request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

Rejection versus Denial

All claims must first pass specific minimum edits prior to acceptance. Claim records that do not pass these minimum edits are invalid and will be rejected or denied.

REJECTION: A list of common upfront rejections can be found listed below. Rejections will not enter our claims adjudication system, so there will be no Explanation. A REJECTION is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. The provider will receive a letter or a rejection report if the claim was submitted electronically.

DENIAL: If all minimum edits pass and the claim is accepted, it will then be entered into the system for processing. A DENIAL is defined as a claim that has passed minimum edits and is entered into the system, however, has been billed with invalid or inappropriate information causing the claim to deny. An EOP will be sent that includes the denial reason. A comprehensive list of common delays and denials can be found below.

Claim Payment

Clean claims will be adjudicated (finalized as paid or denied) at the following levels:

- 90% of clean claims adjudicated within 30 calendar days of receipt
- 100% of clean claims adjudicated within 45 calendar days of receipt
- 100% of All claims adjudicated within 90 calendar days of receipt

Contact Information

Health Plan Address:

Wellkids by PA Health & Wellness
1700 Bent Creek Blvd
Suite 200
Mechanicsburg, PA 17050
Provider Services: 1-855-445-1920 or TT 711

Paper Claims:

Wellkids by PA Health & Wellness
Attn: Claims
P. O. Box 5070
Farmington, MO 63640

Enrollee Services:

1-855-445-1920 or TTY 711

Open Tuesday through Friday from 8:00 AM to 5:00 PM

Open Monday from 8:00 AM to 8:00 PM

CLAIMS PAYMENT INFORMATION

Systems Used to Pay Claims

Wellkids by PA Health & Wellness uses four main systems to process reimbursement on a claim. Thosesystems are:

- Amisys
- DST Pricer
- Rate Manager
- Optum

AMISYS

Our core system: All claims are processed from this system, and structures are maintained to meet the needs of our Provider contracts. However, we are not limited within the bounds of this one system. We utilize multiple systems to expand our universe of possibilities and better meet the needs of our business partners.

DST Pricer

The DST Pricer is a system outside our core system where we have some flexibility in addressing your contractual needs. It allows us to be more responsive to the market demands. It houses both Fee Schedules and procedure codes.

Rate Manager

Rate Manager's primary function is to price Facility claims. It can price inpatient DRG or Outpatient APC. Inpatient claims are based on the type of DRG and the version. Each Hospital in the country is assigned a base rate and add-ons by Medicaid and Medicare based on state or federal guidelines. The add-ons include Education, Burn per diem, and Capital etc. The basic DRG calculation is:

Hospital Base Rate x DRG Relative weight + Add-ons

The payment can be affected by discharge status, length of stay and other charges allowed.

Optum

Optum is the vendor used for pricing inpatient claims by DRG. When inpatient claims require DRG pricing, these are put through the through the Optum pricing tool and priced accordingly.

Claims for Long Term Care Facilities

Long Term Care facilities are required to bill on a UB-04 claim form. Short term acute stays are a covered benefit. When submitting claims for short term sub-acute stays, facilities must ensure they are utilizing the appropriate revenue codes reflecting the short-term stay.

Electronic Claims Submission

Network providers are encouraged to participate in Wellkids by PA Health & Wellness's electronic claims/encounter filing program. Wellkids by PA Health & Wellness can receive ANSI X12N 837 professional, institution or encounter transactions. In addition, it can generate an ANSI X12N835 electronic remittance advice known as an Explanation of Payment (EOP). Providers thatbill electronically have the same timely filing requirements as providers filing paper claims.

In addition, providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Wellkids by PA Health & Wellness's Payor ID is 68069. Our Clearinghouse vendors include Emdeon, Envoy, WebMD, and Gateway EDI. Please visit our website for our electronic Companion Guide which offers more instructions. For questions or more information on electronic filingplease contact:

Wellkids by PA Health & Wellness

c/o Centene EDI Department

1-800-225-2573, extension 25525
Or by e-mail at EDIBA@centene.com

Paper Claim Submission

For Wellkids by PA Health & Wellness Enrollees, all claims and encounters should be submitted to:

Wellkids by PA Health & Wellness

Attn: Claims Department

P. O. Box 5070 Farmington, MO 63640

Requirements

Wellkids by PA Health & Wellness uses an imaging process for paper claims retrieval. To ensure accurateand timely claims capture, please observe the following claims submission rules:

Do's

- Do use the correct P.O. Box number
- Do submit all claims in a 9" x 12" or larger envelope
- Do type all fields completely and correctly

- Do use typed black or blue ink only at 9-point font or larger
- Do include all other insurance information (policy holder, carrier name, ID number and address) when applicable
- Do include the EOP from the primary insurance carrier when applicable. Note: Wellkids by PA Health & Wellness is able to receive primary insurance carrier EOP [electronically]
- Do submit on a proper original form - CMS 1500 or UB 04

Don'ts

- Don't submit handwritten claim forms
- Don't use red ink on claim forms
- Don't circle any data on claim forms
- Don't add extraneous information to any claim form field
- Don't use highlighter on any claim form field
- Don't submit photocopied claim forms (no black and white claim forms)
- Don't submit carbon copied claim forms
- Don't submit claim forms via fax
- Don't utilize staples for attachments or multi page documents

Basic Guidelines for Completing the CMS-1500 Claim Form (detailed instructions in appendix):

- Use one claim form for each recipient.
- Enter one procedure code and date of service per claim line.
- Enter information with a typewriter or a computer using black type.
- Enter information within the allotted spaces.
- Make sure whiteout is not used on the claim form.
- Complete the form using the specific procedure or billing code for the service.
- Use the same claim form for all services provided for the same recipient, same provider, and same date of service.
- If dates of service encompass more than one month, a separate billing form must be used for each month.

Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

Wellkids by PA Health & Wellness provides Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) to its participating providers to help them reduce costs, speed secondary billings, and improve cash flow by enabling online access of remittance

information, and straightforward reconciliation of payments. As a Provider, you can gain the following benefitsfrom using EFT and ERA:

1. Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or Enrollee accounting systems, eliminating the need for manual re-keying

2. Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow

3. Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported

4. Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily

For more information on our EFT and ERA services, please visit our website at PAWellKids.com or contact our Provider Services Department at

Wellkids by PA Health & Wellness

1-855-445-1920 TTY 711

Common Causes of Claims Processing Delays and Denials

- Incorrect Form Type
- Diagnosis Code Missing Digits
- Missing or Invalid Procedure or Modifier Codes
- Missing or Invalid DRG Code
- Explanation of Benefits from the Primary Carrier is Missing or Incomplete
- Invalid Enrollee ID
- Invalid Place of Service Code
- Provider TIN and NPI Do Not Match
- Invalid Revenue Code
- Dates of Service Span Do Not Match Listed Days/Units
- Missing Physician Signature
- Invalid TIN
- Missing or Incomplete Third-Party Liability Information

Wellkids by PA Health & Wellness will send providers written notification via the EOP for each claim that isdenied, which will include the reason(s) for the denial.

Common Causes of Up-Front Rejections

- Unreadable Information
- Missing Enrollee Date of Birth
- Missing Enrollee Name or Identification Number
- Missing Provider Name, Tax ID, or NPI Number
- The Date of Service on the Claim is Not Prior to Receipt Date of the Claim
- Dates Are Missing from Required Fields
- Invalid or Missing Type of Bill
- Missing, Invalid or Incomplete Diagnosis Code
- Missing Service Line Detail
- Enrollee Not Effective on The Date of Service
- Admission Type is Missing
- Missing Enrollee Status
- Missing or Invalid Occurrence Code or Date
- Missing or Invalid Revenue Code
- Missing or Invalid CPT/Procedure Code
- Incorrect Form Type
- Claims submitted with handwritten data or black and white forms

Wellkids by PA Health & Wellness will send providers a detailed letter for each claim that is rejectedexplaining the reason for the rejection.

CLIA Accreditation

Labs who participate in the Medicare or Medicaid sector Wellkids by PA Health & Wellness must be CLIAaccredited. Requirements for laboratory accreditation are contained in the Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing (CAMLAB) located at the following link: http://www.jcrinc.com/store/publications/manuals/

How to Submit a CLIA Claim

Via Paper

Complete Box 23 of a CMS-1500 form with CLIA certification or waiver number as the prior authorization number for those laboratory services for which CLIA certification or waiver is required.

**Note* - An independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line-item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred

services on the same CMS-1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the reference laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

Via EDI

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

-Or-

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

**Note* - The billing laboratory submits, on the same claim, tests referred to another (referral/rendered) laboratory, with modifier 90 reported on the line item and reports the referral laboratory's CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = F4. When the referring laboratory is the billing laboratory, the reference laboratory's name, NPI, address, and Zip Code shall be reported in loop 2310C. The 2420C loop is required if different than information provided in loop 2310C. The 2420C would contain Laboratory name and NPI.

Via Web

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

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

where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

Claim Requests for Reconsideration and Corrected Claims

All claim requests for reconsideration and corrected claims must be received within 365 calendar days from the date of service.

If a provider has a question or is not satisfied with the information they have received related to a claim, there are four (4) effective ways in which the provider can contact Wellkids by PA Health & Wellness.

1. Contact a Wellkids by PA Health & Wellness Provider Service Representative 1-844-626-6813.Providers may discuss questions with Wellkids by PA Health & Wellness Provider Services Representatives regarding amount reimbursed or denial of a particular service.

2. Submit an Adjusted or Corrected Claim:

Corrected claims can be filed electronically or via paper to

Wellkids by PA Health & Wellness

Attn: Corrected Claim

PO Box 5070

Farmington, MO 63640

To submit a Corrected or Voided Claim electronically:

- For Institutional claims, provider must include the original Wellkids by PA Health & Wellnessclaim number for the claim adjusting or voiding in the REF*F8 (loop and segment) for any 7 (Replacement for prior claim) or 8 (Void/cancel of prior claim) in the standard 837 layout.
- For Professional claims, provider must have the Frequency Code marked appropriately as 7 (Replacement for prior claim) or 8 (Void/cancel of prior claim) in the standard 837 layout.

To submit a Corrected or Voided Claim via paper:

All corrected claims should be free of handwritten or stamped verbiage and submitted on a standard red and white UB-04 or HCFA 1500 claim form.

- For Institutional claims, provider must include the original Wellkids by PA Health & Wellnessclaim number and bill frequency code per industry standards.
- Box 4 – Type of Bill: the third character represents the “Frequency Code”
- Box 64 – Place the Claim number of the Prior Claim in Box 64
- For Professional claims, provider must include the original Wellkids by PA

Health & Wellness claim number and bill frequency code per industry standards. When submitting a Corrected or Voided claim, enter the appropriate bill frequencycode left justified in the left-hand side of Box 22.

Any missing, incomplete, or invalid information in any field may result in a delay in processing, the claim being denied as a duplicate, or a reject or denial for exceeding the timely filing limits.

3. Submit a Request for Reconsideration to:

Wellkids by PA Health & Wellness

Attn: Reconsideration

PO Box 5070

Farmington MO 63640

A request for reconsideration is a written communication from the provider about a disagreement in the way a claim was processed but does not require a claim to be corrected and does not require medical review. Requests for reconsideration should be sent along with the Wellkids by PA Health & Wellness Claim Reconsideration form found in the provider section of our website at: https://www.PAWellKids.com

The documentation must also include a detailed description of the reason for the request and any additional supporting documentation.

If the claim dispute results in an adjusted claim, the provider will receive a revised EOP. If the original decision is upheld, the provider will receive a revised EOP or a letter detailing the decision and steps for escalated reconsideration.

Wellkids by PA Health & Wellness shall process, and finalize all adjusted claims, requests for reconsideration and disputed claims to a paid or denied status 30 business days ofreceipt of the corrected claim, request for reconsideration.

Provider Refunds

When a provider sends a refund for claims processed, the refund must be sent to the following address:

Wellkids by PA Health & Wellness
P.O. Box 3765
Carol Stream, IL 60132-3765

Third Party Liability / Coordination of Benefits

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

Wellkids by PA Health & Wellness, like all Medicaid programs, is always the payer of last resort. Wellkids by PA Health & Wellness providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Pennsylvania Health and Wellness Enrollees. If aEnrollee has other insurance that is primary, you must submit your claim to the primary insurance for consideration, and submit a copy of the Explanation of Benefits (EOB) or Explanation of Payment (EOP), or rejection letter from the other insurance when the claim is filed. If this information is not sent with an initial claim filed for an Enrollee with insurance primary to Medicaid, the claim will pend and/or deny until this information is received. If an Enrollee has more than one primary insurance (Medicaid would be the third payer), the claim cannot be submitted through EDI or the secure web portal and must be submitted on a paper claim.

If the provider is unsuccessful in obtaining necessary cooperation from an Enrollee to identifypotential third-party resources, the provider shall inform Wellkids by PA Health & Wellness that efforts have been unsuccessful. Wellkids by PA Health & Wellness will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, Wellkids by PA Health & Wellness will coordinate with the provider to pay any claims that may have been denied forpayment due to third party liability.

Billing the Enrollee / Enrollee Acknowledgement Statement

Wellkids by PA Health & Wellness reimburses only services that are medically necessary and covered through the Wellkids by PA Health & Wellness program. Providers are not allowed to "balance bill" for covered services if the provider's usual~~ly~~ and customary charge for covered services is greaterthan our fee schedule.

Providers may bill Enrollees for services NOT covered by either Medicaid or Wellkids by PA Health & Wellness or for applicable copayments, deductibles or coinsurance as defined by the State ofPennsylvania.

In order for a provider to bill an Enrollee for services not covered under the Wellkids by PA Health & Wellness program, or if the service limitations have been exceeded, the provider must obtain awritten acknowledgment following this language (the Enrollee Acknowledgement Statement):

I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Integrated Care Program as being reasonable and medically necessary for my care. I understand that Wellkids by PA Health & Wellness through its contract with the Pennsylvania Department of Human Services, determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

WELLKIDS BY PA HEALTH & WELLNESS CODE AUDITING AND EDITING

Wellkids by PA Health & Wellness uses HIPAA compliant clinical claims auditing software for physician and outpatient facility coding verification. The software will detect, correct, and document coding errors on provider claim submissions prior to payment. The software contains clinical logic which evaluates medical claims against principles of correct coding utilizing industry standards and government sources. These principles are aligned with a correct coding "rule."When the software audits a claim that does not adhere to a coding rule, a recommendation known as an "edit" is applied to the claim. When an edit is applied to the claim, a claim adjustment should be made.

While code auditing software is a useful tool to ensure provider compliance with correct coding, a fully automated code auditing software application will not wholly evaluate all clinical Enrollee scenarios. Consequently, Wellkids by PA Health & Wellness uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors.

Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. For example, clinicians review all claims billed with modifiers -25 and -59 for clinical scenarios which justify payment beyond

the basic service performed.

Moreover, Wellkids by PA Health & Wellness may have policies that differ from correct coding principles.Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

CPT and HCPCS Coding Structure

CPT codes are a component of the HealthCare Common Procedure Coding System (HCPCS). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding. Current Procedural Terminology (CPT) codes belong to the Level I subset and consist of the terminology used to describe medical terms and procedures performed by health care professionals. CPT codes are published by the American Medical Association (AMA). CPT codes are updated (added, revised, and deleted) on an annual basis.

1. **Level I HCPCS Codes (CPT):** This code set is comprised of CPT codes that are maintained by the AMA. CPT codes are a 5- digit, uniform coding system used by providers to describe medical procedures and services rendered to an Enrollee. Thesecodes are then used to bill health insurance companies.
2. **Level II HCPCS:** The Level II subset of HCPCS codes is used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment, orthotics, prosthetics etc.). Level II codes are an alphabetical coding system and are maintained by CMS. Level II HCPCS codes areupdated on an annual basis.
3. **Miscellaneous/Unlisted Codes:** The codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with miscellaneous codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claims submission. If the records are not received, the provider will receive a denial indicating that medical records are required. Providers billing miscellaneous codes must submit medical documentation that clearly defines the procedure performed including, but not limited to, office notes, operative report, and pathology report and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) that should have been billed for the service or procedure rendered. Clinical validation also includes identifying other procedures and services billed on the claim for correct coding that may be related to the miscellaneous code. For example, if the miscellaneous code is determined to be the primary procedure, then other procedures and services that are integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.
4. **Temporary National Codes:** These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are considered temporary and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H and T code ranges.

5. **HCPCS Code Modifiers:** Modifiers are used by providers to include additional information about the HCPCS code billed. On occasion, certain procedures require more explanation because of special circumstances. For example, modifier -24 is appended to evaluation and management services to indicate that an Enrollee was seenfor a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

International Classification of Diseases (ICD 10)

These codes represent classifications of diseases. They are used by healthcare providers to classify diseases and other health problems.

Revenue Codes

These codes represent where an Enrollee had services performed in a hospital or the type of services received. These codes are billed by institutional providers. HCPCS codes may be required on the claim in addition to the revenue code.

Edit Sources

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

The software applies edits that are based on the following sources

- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) for professional and facility claims. The NCCI edits includes column 1/column 2, medically unlikely edits (MUE), exclusive and outpatient code editor (OCE) edits. These edits were developed by CMS to control incorrect code combination billing contributing to incorrect payments. Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- CMS Claims Processing Manual
- CMS Medicaid NCCI Policy Manual
- State Provider Manuals, Fee Schedules, Periodic Provider Updates (bulletins/transmittals)
- CMS coding resources such as, HCPCS Coding Manual, National Physician Fee Schedule, Provider Benefit Manual, Claims Processing Manual, MLN Matters and Provider Transmittals
- AMA resources
    - CPT Manual
    - AMA Website
    - Principles of CPT Coding

    - Coding with Modifiers
    - CPT Assistant
    - CPT Insider's View
    - CPT Assistant Archives
    - CPT Procedural Code Definitions
    - HCPCS Procedural Code Definitions
- Billing Guidelines Published by Specialty Provider Associations
    - Global Maternity Package data published by the American Congress of Obstetricians and Gynecologists (ACOG)
    - Global Service Guidelines published by the American Academy of Orthopedic Surgeons (AAOS)
- State-specific policies and procedures for billing professional and facility claims
- Health Plan policies and provider contract considerations

Code Auditing and the Claims Adjudication Cycle

Code auditing is the final stage in the claims adjudication process. Once a claim has completed all previous adjudication phases (such as benefits and Enrollee/provider eligibility review), the claim is ready for analysis.

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

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

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

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

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

Code Auditing Principles

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

Unbundling:

CMS National Correct Coding Initiative- https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

CMS developed the correct coding initiative to control erroneous coding and help prevent inaccurate claims payment. CMS has designated certain combinations of codes that should never be billed together. These are also known as Column 1/Column II edits. The column I procedure code is the most comprehensive code and reimbursement for the column II code is subsumed into the payment for the comprehensive code. The column I code is considered an integral component of the column II code.

The CMS NCCI edits consist of Procedure to Procedure (PTP) edits for physicians and hospitals and the Medically Unlikely Edits for professionals and facilities. While these codes should not be billed together, there are circumstances when an NCCI modifier may be appended to the column 2 code to identify a significant and separately identifiable or distinct service. When these modifiers are billed, clinical validation will be performed.

PTP Practitioner and Hospital Edits

Some procedures should not be reimbursed when billed together. CMS developed the Procedure to Procedure (PTP) Edits for practitioners and hospitals to detect incorrect claims submitted by medical providers. PTP for practitioner edits are applied to claims submitted by physicians, non-physician practitioners and ambulatory surgical centers (ASC). The PTP-hospital edits apply to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy and speech-language pathology providers and comprehensive outpatient rehabilitation facilities.

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

MUE's reflect the maximum number of units that a provider would bill for a single Enrollee, on a single date of service. These edits are based on CPT/HCPCs code descriptions, anatomic specifications, the nature of the service/procedure, the nature of the analyst, equipment prescribing information and clinical judgment.

Code Bundling Rules not sourced to CMS NCCI Edit Tables

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

Procedure Code Unbundling

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

Mutually Exclusive Editing

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

Incidental Procedures

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

Global Surgical Period Editing/Medical Visit Editing

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

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

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

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

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

Global Maternity Editing

Procedures with “MMM”

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

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

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

Multiple Code Rebundling

This rule analyzes whether a provider billed two or more procedure codes when a single more comprehensive code should have been billed to represent all of the services performed.

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the number of times a single code can be reported. There are also codes that are allowed a limited number of times on a single date of service, over a given period of time or during an Enrollee's lifetime. State fee schedules also delineate the number of times a procedure can be billed over a given period of time or during an Enrollee's lifetime. Code editing will fire a frequency edit when the procedure code is billed in excess of these guidelines.

Duplicate Edits

Code auditing will evaluate prospective claims to determine if there is a previously paid claim for the same Enrollee and provider in history that is a duplicate to the prospective claim. The software will also look across different providers to determine if another provider was paid for the same procedure, for the same Enrollee on the same date of service. Finally, the software will analyze multiple services within the same range of services performed on the same day. For example, a nurse practitioner and physician bill for office visits for the same Enrollee on thesame day.

National Coverage Determination Edits

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

Anesthesia Edits

This rule identifies anesthesia services that have been billed with a surgical procedure code instead of an anesthesia procedure code.

Invalid revenue to procedure code editing:

Identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

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

Co-Surgeon/Team Surgeon Edits:

CMS guidelines define whether or not an assistant, co-surgeon or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co or team surgeon.

Add-on and Base Code Edits

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

Bilateral Edits

This rule looks for claims where the modifier -50 has already been billed, but the same procedure code is submitted on a different service line on the same date of service without the modifier -50.

Replacement Edits

These rules recommend that single service lines or multiple service lines are denied and replaced with a more appropriate code. For example, the same provider bills more than one outpatient consultation code for the same Enrollee in the Enrollee's history. This rule will deny the office consultation code and replace it with a more appropriate evaluation and management service, established Enrollee or subsequent hospital care code. Another example: the rule will evaluate if a provider has billed a new Enrollee evaluation and management code within three years of a previous new Enrollee visit. This rule will replace the second submission with the appropriate established Enrollee visit. This rule uses a crosswalk to determine the appropriate code to add.

Missing Modifier Edits

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

Administrative and Consistency Rules

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

Procedure code invalid rules: Evaluates claims for invalid procedure and revenue or diagnosis codes

Deleted Codes: Evaluates claims for procedure codes which have been deleted

Modifier to procedure code validation: Identifies invalid modifier to procedure code combinations. This rule analyzes modifiers affecting payment. As an example, modifiers -24, -25, -26, -57, -58 and -59.

Age Rules: Identifies procedures inconsistent with Enrollee's age

Gender Procedure: Identifies procedures inconsistent with Enrollee's gender

Gender Diagnosis: Identifies diagnosis codes inconsistent with Enrollee's gender

Incomplete/invalid diagnosis codes: Identifies diagnosis codes incomplete or invalid

Prepayment Clinical Validation

Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. An example of Wellkids by PA Health & Wellness's clinical validation services is modifier -25 and -59 review. Some code pairs within the CMS NCCI edit tables are allowed for modifier override when they have a correct coding modifier indicator of "1," Furthermore, public-domain specialty organization edits may also be considered for override when they are billed with these modifiers. When these modifiers are billed, the provider's billing should support a separately identifiable service (from the primary service billed, modifier -25) or a different session, site or organ system, surgery, incision/excision, lesion, or separateinjury (modifier -59). Wellkids by PA Health & Wellness's clinical validation team uses the information onthe prospective claim and claims history to determine whether or not it is likely that a modifierwas used correctly based on the unique clinical scenario for an Enrollee on a given date of service.

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

MODIFIER -59

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

Some providers are routinely assigning modifier 59 when billing a combination of codes that will result in a denial due to unbundling. We commonly find misuse of modifier 59 related to the portion of the definition that allows its use to describe "different procedure or surgery". NCCI

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

Wellkids by PA Health & Wellness uses the following guidelines to determine if modifier -59 wasused correctly:

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

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

MODIFIER -25

Both CPT and CMS in the NCCI policy manual specify that by using a modifier 25 the provider is indicating that a “significant, separately identifiable evaluation and management service was provided by the same physician on the same day of the procedure or other service”.

Additional CPT guidelines state that the evaluation and management service must be significant and separate from other services provided or beyond the usual pre-,intra-, and postoperative care associated with the procedure that was performed.

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

Wellkids by PA Health & Wellness uses the following guidelines to determine whether or notmodifier 25 was used appropriately.

If any one of the following conditions is met then, the clinical nurse reviewer will recommend reimbursement for the E/M service.

- If the E/M service is the first time the provider has seen the Enrollee or evaluated amajor condition
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed
- The Enrollee's condition is worsening as evidenced by diagnostic procedures beingperformed on or around the date of services
- Other procedures or services performed for an Enrollee on or around the same dateof the procedure support that an E/M service would have been required to determine the Enrollee's need for additional services.

To avoid incorrect denials, providers should assign all applicable diagnosis codesthat support additional E/M services.

Inpatient Facility Claim Editing

Potentially Preventable Readmissions Edit. This edit identifies readmissions within a specified time interval that may be clinically related to previous admission. For example, a subsequent admission may be plausibly related to the care rendered during or immediately following a prior hospital admission in the case of readmission for a surgical wound infection orlack of post-admission follow up. Admissions to non-acute care facilities (such as skilled nursing facilities) are not considered readmissions and not considered for reimbursement.

CMS determines the readmission time interval as 30 days; however, this rule is highly customizable by state rules and provider contracts.

Payment and Coverage Policy Edits

Payment and Coverage policy edits are developed to increase claims processing effectiveness, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers regarding these policies. It encompasses the development ofpayment policies based on coding and reimbursement rules and clinical policies based on medical necessity criteria, both to be implemented through claims edits or retrospective audits.These policies are posted on each health plan's provider portal when appropriate. These policies are highly customizable and may not be applicable to all health plans.

Claim Reconsiderations related to Code Auditing and Editing

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

If you disagree with a code audit or edit and request claim reconsideration, you must submit

medical documentation (medical record) related to the reconsideration. If medical documentation is not received, the original code audit or edit will be upheld.

VIEWING CLAIM CODING EDITS

Code Editing Assistant

A web-based code auditing reference tool designed to “mirror” how the code auditing product(s) evaluate code and code combinations during the auditing of claims. The tool is available for providers who are registered on our secure provider portal. You can access the tool in the Claims Module by clicking “Claim Auditing Tool” in our secure provider portal.

This tool offers many benefits:

- PROSPECTIVELY access the appropriate coding and supporting clinical edit clarifications for services BEFORE claims are submitted.
- PROACTIVELY determine the appropriate code/code combination representing the service for accurate billing purposes

The tool will review what was entered, and will determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered.

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

The code editing assistant can be accessed from the provider web portal.

Disclaimer

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

OTHER IMPORTANT INFORMATION

Health Care Acquired Conditions (HCAC) – Inpatient Hospital

Wellkids by PA Health & Wellness follows Medicare’s policy on reporting Present on Admission (POA) indicators on inpatient hospital claims and non-payment for HCACs. Acute care hospitals and Critical Access Hospitals (CAHs) are required to report whether a diagnosis on a Medicaid claim is present on admission. Claims submitted without the required POA indicators are denied. For claims containing secondary diagnoses that are included on Medicare’s most recent list of HCACs and for which the condition was not present on admission, the HCAC secondary diagnosis is not used for DRG grouping. That is, the claim is paid as though any secondary diagnoses (HCAC) were not present on the claim. POA is defined as "present" at the time the order for inpatient admission occurs. Conditions that develop during an outpatientencounter, including emergency department, observation, or

outpatient surgery, are considered Present on Admission. A POA indicator must be assigned to principal and secondary diagnoses. Providers should refer to the CMS Medicare website for the most up to date POA reporting instructions and list of HCACs ineligible for payment.

Reporting and Non-Payment for Provider Preventable Conditions (PPCS)

Provider Preventable Conditions (PPCs) addresses both hospital and non-hospital conditions identified by Pennsylvania Health and Wellness for non-payment. PPCs are defined as Health Care Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs).

Medicaid providers are required to report the occurrence of a PPC and are prohibited from payment.

Non-Payment and Reporting Requirements Provider Preventable Conditions(PPCS) - Inpatient

Wellkids by PA Health & Wellness follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NCDs service/procedure (as a PPC) is reported. If covered services/procedures are also provided during the same stay, Wellkids by PA Health & Wellness follows Medicare's billing guidelines requiring hospitals submit two claims: one claim with covered services, and the other claim with the non-covered services/procedures as a non-pay claim. Inpatient hospitals must appropriately report one of the designated ICD diagnosis codes for the PPC on the no-pay TOB claim. Wellkids by PA Health & Wellness follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NDC service/procedure (as a PPC) is reported.

Other Provider Preventable Conditions (OPPCS) – Outpatient

Medicaid follows the Medicare guidelines and national coverage determinations (NCDs), including the list of HAC conditions, diagnosis codes and OPPCs. Conditions currently identified by CMS include:

- Wrong surgical or other invasive procedure performed on an Enrollee;
- Surgical or other invasive surgery performed on the wrong body part; and
- Surgical or other invasive procedure performed on the wrong Enrollee.

Non-Payment and Reporting Requirements Other Provider Preventable Conditions (OPPCS) – Outpatient

Medicaid follows the Medicare guidelines and NCDs, including the list of HAC conditions, diagnosis codes and OPPCs. Outpatient providers must use the appropriate claim format, TOB and follow the applicable NCD/modifier(s) to all lines related to the surgery(s).

Lesser of Language

Unless specifically contracted otherwise, Wellkids by PA Health & Wellness's policy is to pay the lesser ofbilled charges and negotiated rate.

- Example 1 – Code 12345 – Billed $600. Negotiated Rate is $500. We pay $500 negotiated rate.

- Example 2 – Code 12345 – Billed $500. Negotiated Rate is $600. We pay $500 billed rate.

Timely Filing

Providers must submit all claims and encounters within 180 calendar days of the date of service. When Wellkids by PA Health & Wellness is the secondary payer, claims must be received within90 calendar days of the final determination of the primary payer Explanation of Payment (EOP) or up the original timely filing period, whichever is greater.

All claim requests for reconsideration and corrected claims must be receivedwithin 365 calendar days from the date of service.

Use of Assistant Surgeons

An Assistant Surgeon is defined as a physician who utilizes professional skills to assist the Primary Surgeon on a specific procedure. All Assistant Surgeon's procedures are subject to retrospective review for Medical Necessity by Medical Management. All Assistant Surgeon's procedures are subject to Wellkids by PA Health & Wellness policies and are not subject to policies established by contracted hospitals.

Hospital medical staff bylaws that require an Assistant Surgeon be present for a designated procedure are not grounds for reimbursement. Medical staff bylaws alone do not constitute medical necessity. Nor is reimbursement guaranteed when the Enrollee or family requests anAssistant Surgeon be present for the surgery. Coverage and subsequent reimbursement for an Assistant Surgeon's service is based on the medical necessity of the procedure itself and the Assistant Surgeon's presence at the procedure.

FQHCs and RHCs

General Billing Guidelines for Federally Qualified Health Clinics (FQHCs) and Rural Health Clinics (RHCs). In addition to the information in the remainder of our Billing Manual, we require that our Federally Qualified Health Clinics (FQHCs) and Rural Health Clinics (RHCs) – [PROMISe ™ Provider Type 08] – adhere to the following billing requirements:

- Providers must provide Wellkids by PA Health & Wellness with their most up to date PPS/State Rate Letter. You can send these to your Provider Network Specialist – or to our email inbox PHWProviderRelations@PAhealthwellness.com .

- **Block 24b** – “Place of Service”
    - Acceptable Place of Service Location Codes for **RHCs**:
        - 72 – Rural Health Clinic
        - 12 – Home
        - 21 – Inpatient Hospital
        - 02 – Telehealth provided other than in Enrollee’s home
        - 10 – Telehealth provided in Enrollee’s home
        - 27 – Outreach Site or Street
        - 31 – Skilled Nursing Facility
        - 99 – Other (Community)
    - Acceptable Place of Service Location Codes for **FQHCs**:
        - 50 – Federally Qualified Health Center
        - 12 – Home
        - 21 – Inpatient Hospital
        - 02 – Telehealth provided other than in Enrollee’s home
        - 10 – Telehealth provided in Enrollee’s home
        - 27 – Outreach Site or Street
        - 31 – Skilled Nursing Facility
        - 99 – Other (Community)
- **Block 24d** (Procedures, Services, or Supplies [CPT/HCPCS & Modifier])
    - Enter Procedure Code T1015 in the first section of this block.
    - Failure to use the appropriate modifier(s) will result in inappropriate claims payment or denial.
- **Block 24j** (a) “Rendering Provider ID #” - Do not complete this block.
- **Block 24j** (b) “NPI” - Do not complete this block.
- If an Enrollee has other insurance that is primary, you must submit your claim to the primary insurance for consideration and submit a copy of the Explanation of Benefits (EOB) or Explanation of Payment (EOP).
    - The Primary EOB or EOP must match what is being billed on the secondary claims (i.e., any encounter or procedure codes billed to the primary carrier mustbe included on the secondary claim).
    - If this information is not sent with an initial claim filed for an Enrollee withinsurance primary to Medicaid, the claim will deny.

Interim Billing

For Inpatient Prospective Payment System (IPPS) claims, an initial interim bill can be submitted as TOB 112. The discharge status code should be 30, "Still an Enrollee."

Further DOS can be added by adjusting the original claim using TOB 117. This will result in replacement of the original claim and recalculation of potential payment using the updated LOS and charge information.

Post-Processing Claims Audit

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. To start the audit, Wellkids by PA Health & Wellness Auditors request medical records for a defined review period. Providers have30 calendar days to respond to the request; if no response is received, a second and final request for medical records is forwarded to the Provider. If the Provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, Wellkids by PA Health & Wellness will recover all amounts paid for the services in question.

Wellkids by PA Health & Wellness Auditors review cases for common FWA practices including:

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

Wellkids by PA Health & Wellness Auditors consider State and Federal laws and regulations, Provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician of like specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report which identifies all records reviewed during the audit. If the Auditor determines that clinical documentation does not support the claims payment in some or all circumstances, Wellkids by PA Health & Wellness will seek recovery of all overpayments. Depending on the number of services provided during the review period, Wellkids by PA Health & Wellness may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998). To ensure accurate application of the extrapolated methodology, Wellkids by PA Health & Wellness uses RAT-STATS 2007 Version 2, the OIG's statistical software tool, to select random samples, assist in evaluating audit results, and calculate projected overpayments. Providers who contest the overpayment methodology or wish to calculate an exact overpayment figure may do so by downloading RAT STATS and completing the extrapolation overpayment. Audit findings are reported to the Bureau of Program Integrity and the Office of the Attorney General Medicaid Fraud Control Section.

Appendix I: Common HIPAA Compliant EDI Rejection Codes

These codes are the standard national rejection codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted.

Code	Description
1	Invalid Mbr DOB
2	Invalid Mbr
6	Invalid Prv
7	Invalid Mbr DOB & Prv
8	Invalid Mbr & Prv
9	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
17	Invalid Diag
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
23	Invalid Prv; Invalid Diag
34	Invalid Proc
35	Invalid Mbr DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
38	Mbr not valid at DOS; Prov not valid at DOS; Invalid Diag
39	Invalid Mbr DOB;Mbr not valid at DOS; Prov not valid at DOS; Invalid Diag
40	Invalid Prov; Invalid proc
41	Invalid Mbr DOB; Invalid Prov; Invalid Proc
42	Invalid Mbr; Invalid Prov; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prov not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS; Invalid Proc
49	Mbr not valid at DOS; Invalid Prov; Invalid Proc
51	Invalid Diag; Invalid Proc
74	Services Performed prior to Contract Effective Date
75	Invalid units of service

Appendix II: Instructions For Supplemental Information

CMS-1500 (2/12) Form, Shaded Field 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (2/12) form field 24A-G:

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

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

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

The following qualifiers are to be used when reporting NDC units:\

F2	International Unit
GR	Gram
ML	Milliliter
UN	Unit

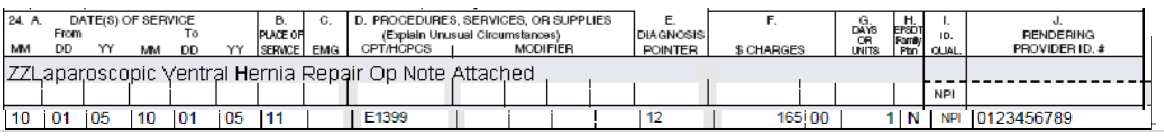
To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

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

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

Unspecified/Miscellaneous/Unlisted Codes



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

NDC Codes

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

Appendix III: Instructions For Submitting NDC Information

Instructions for Entering the NDC:

(Use the guidelines noted below for all claim types including WebPortal submission)

CMS requires the 11-digit National Drug Code (NDC); therefore, providers are required to submit claims with the exact NDC that appears on the actual product administered, which canbe found on the vial of medication. The NDC must include the NDC Unit of Measure and NDCquantity/unit. When reporting a drug, enter identifier N4, the eleven-digit NDC code, Unit Qualifier, andnumber of units from the package of the dispensed drug.

837I/837P		
Data Element	**Loop**	**Segment/Element**
NDC	2410	LIN03
Unit of Measure	2410	CTP05-01
Unit Price	2410	CTP03
Quantity	2410	CTP04

For Electronic submissions, this is highly recommended and will enhance claim reporting/adjudication processes, report in the LIN segment of Loop ID-2410.

Paper Claim Type	**Field**
CMS 1500 (02/12)	24 A (shaded claim line)
UB04	43

Facility

Paper, use Form Locator 43 of the CMS1450 and UB04 (with the corresponding HCPCS code in Locator 44) for Outpatient and Facility Dialysis Revenue Codes 250 – 259 and 634 -636.

Physician

Paper, use the red shaded detail of 24A on the CMS1500 line detail.

Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units.

The NDC must be entered with 11 digits in a 5-4-2-digit format. The first five digits of the NDC are the manufacturer’s labeler code, the middle four digits are the product code, and the last two digits are the package size.

If you are given an NDC that is less than 11 digits, add the missing digits as follows:

For a 4-4-2-digit number, add a 0 to the beginning.

For a 5-3-2-digit number, add a 0 as the sixth digit.

For a 5-4-1-digit number, add a 0 as the tenth digit.

Enter the Unit Qualifier and the actual metric decimal quantity (units) administered to the Enrollee. If reporting a fraction of a unit, use the decimal point. The Unit Qualifiers are:

F2 - International Unit

GR -Gram

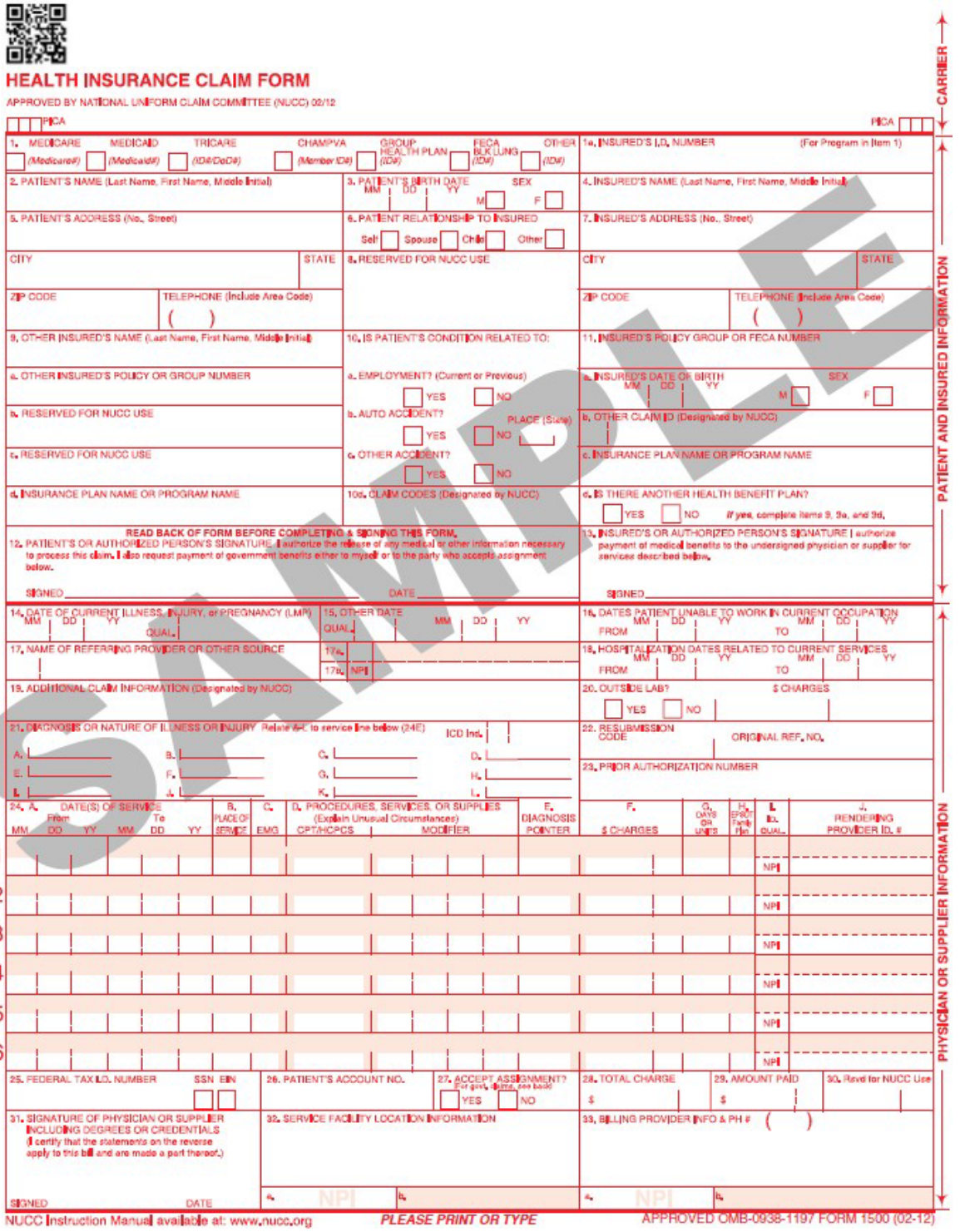
ML - Milliliter

ME – Milligram

UN – Unit

Appendix IV: Claims Form Instructions CMS 1500

CMS 1500 (2/12) Claim Form Instructions



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

NOTE: Claims with missing or invalid Required (R) field information will be rejected or denied.

1	INSURANCE PROGRAM IDENTIFICATION	Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being field. Enter “X” in the box noted “Other.” Select "OTHER" if submitting the Medicaid ID from the Wellkids by PA Health & Wellness ID card -or- Select “MEDICAID” if submitting the Enrollee’s 10-digit (numeric) Medicaid ID found on Pennsylvania’s Eligibility Verification System (EVS)	R
1a	INSURED’S I.D. NUMBER	The 10-digit Medicaid identification number on the Enrollees WELLKIDS BY PA HEALTH & WELLNESS I.D. card. -or- If the Enrollee’s number is not available, access Pennsylvania’s Eligibility Verification System (EVS) by using the beneficiary’s Social Security Number (SSN) and date of birth (DOB). The EVS response will then provide the 10-digit Enrollee number to use for this block.	R
2	ENROLLEES NAME (Last Name, First Name, Middle Initial)	Enter the Enrollee's name as it appears on the Enrollee’s WELLKIDS BY PA HEALTH & WELLNESS I.D. card.Do not use nicknames. ***This field is required when billing for newborns using the mother’s beneficiary number**. Enter the newborn’s name. If the first name is not available, you are permitted to use Baby Boy or Baby Girl	R
3	ENROLLEE’S BIRTH DATE/SEX	Enter the Enrollee’s 8-digit date of birth (MM/DD/YYYY) and mark the appropriate box to indicate the Enrollee’s sex/gender. M= Male F= Female ***Same as the special instruction for Block 2**. Enter the newborn’s date of birth in an 8-digit format. (MM|DD|YYYY)	R
4	INSURED’S NAME	Enter the Enrollee’s name as it appears on the Enrollee’s WELLKIDS BY PA HEALTH & WELLNESS I.D. card.	C

5	ENROLLEE'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the Enrollee's complete address and telephone number, including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, 101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Does not exist in the electronic 837P.	C
6	ENROLLEE'S RELATION TO INSURED	Always mark to indicate self.	C
7	INSURED'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the Enrollee's complete address and telephone number, including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, 101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Does not exist in the electronic 837P.	C
8	RESERVED FOR NUCC USE		Not Required
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the Enrollee. REQUIRED if Enrollee is covered by another insurance plan. Enter the complete name of the insured.	C
9a	*OTHER INSURED'S	REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan.	C

	POLICY OR GROUP NUMBER		
9b	RESERVED FOR NUCC USE		Not Required
9c	RESERVED FOR NUCC USE		Not Required
9d	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.	C
10a,b,c	IS ENROLLEE'S CONDITION RELATED TO	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.	R
10d	CLAIM CODES (Designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code.	C
11	INSURED POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If Item Number 10abc is marked Y, this field should be populated.	C
11a	INSURED'S DATE OF BIRTH / SEX	Enter the 8-digit date of birth (MM|DD|YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.	C
11b	OTHER CLAIM ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number **FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY:** Required if known. Enter the claim number assigned by the payer.	C
11c	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance health plan or program.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete field's 9a-d and 11c.	R
12	ENROLLEE'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the Enrollee's or legal guardian's signature on file or obtain his/her legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	C

13	INSURED'S OR AUTHORIZED PERSONS SIGNATURE	Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File."	Not Required
14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)	Enter the 6-digit (MM_DD_YY) or 8-digit (MM_DD_YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	C
15	IF ENROLLEE HASSAME OR SIMILAR ILLNESS. GIVE FIRST DATE	Enter another date related to the Enrollee's conditionor treatment. Enter the date in the 6-digit (MM_DD_YY) or 8-digit (MM_DD_YYYY) format. Enter the applicable qualifier between the left-hand set of vertical, dotted lines to identify which date is being reported. **454** Initial Treatment **304** Latest Visit or Consultation **453** Acute Manifestation of a Chronic Condition **439** Accident **455** Last X-ray **471** Prescription **090** Report Start (Assumed Care Date) **091** Report End (Relinquished Care Date) **444** First Visit or Consultation	C
16	DATES ENROLLEE UNABLE TO WORK IN CURRENT OCCUPATION	If the Enrollee is employed and is unable to work in current occupation, an 8-digit (MM_DD_YYYY) datemust be shown for the "from–to" dates that the Enrollee is unable to work.	C
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials). If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the applicable qualifier to the left of the vertical, dotted line to identify which provider is being reported. **DN** Referring Provider **DK** Ordering Provider	C

		DQ Supervising Provider	
17a	ID NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. Use G2 qualifier for 13-Digit PROMISe™ ID.	C
17b	NPI NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Enter the Inpatient 8-digit (MM_DD_YYYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization.	C
19	RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL CLAIM INFORMATION	If identifiers are reported in this field, enter the appropriate qualifiers describing the identifier. Do not enter a space, hyphen, or other separator between the qualifier code and the number. Codes reported in this field must not be reportable in other fields, i.e., Item Numbers 17, 24J, 32, or 33.	C
20	OUTSIDE LAB / CHARGES	Complete this field *when billing for purchased services* by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "NO" mark or blank indicates that no purchased services are included on the claim. If "YES" is marked, enter the purchase price under "$Charges" and complete Item Number 32. Each purchased service must be reported on a separate claim form as only one charge can be entered. When entering the charge amount, enter the amount in the field to the left of the vertical line. Enter number right justified to the left of the vertical line. Enter 00 for cents if the amount is a whole number. Do not use dollar signs, commas, or a decimal point when reporting amounts. Negative dollar amounts are not allowed. Leave the right-hand field blank.	C
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS A-L to ITEM 24E BY LINE). NEW FORM ALLOWS UP TO 12 DIAGNOSES,	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM Enter the indicator between the vertical, dotted lines in the upper right-hand area of the field.	R

	AND ICD INDICATOR	Enter the codes left justified on each line to identify the Enrollee's diagnosis or condition. Do not include the decimal point in the diagnosis code, because it is implied. Enter the codes to identify the Enrollee's diagnosis and/or condition. List no more than 12 ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative descriptions in this field. **Note:** Claims missing or with invalid diagnosis codes will be rejected or denied for payment. **Claims with dates of service after 10/1/2017 will	
22	RESUBMISSION CODE / ORIGINAL REF.NO.	For re-submissions or adjustments, and corrected claims, enter the original claim number of the ***original claim***. When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field. 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim	C
23	PRIOR AUTHORIZATION NUMBER or CLIA NUMBER	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services. **NOTE:** Claims for CLIA required laboratory services will be denied for payment if valid CLIA number is not reported on the claim	If auth = C If CLIA = R (If both, always submit the CLIA number)
24a-j General Information	Box 24 contains six claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line, there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are four individual fields labeled 24A-24G, 24H, 24J, and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields. The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Number. Shaded boxes 24 a-g are for line-item supplemental information and provide a continuous line that accepts up to 61 characters. Refer to the instructions listed below for information on how to complete. The un-shaded area of a claim line is for the entry of claim line-item detail.		

24 A-H Shaded	SUPPLEMENTAL INFORMATION	The shaded top portion of each service claim line is used to report supplemental information for: • NDC (*Required for all J & Q HCPCS codes) • Anesthesia Start/Stop time & duration. • Unspecified, miscellaneous, or unlisted • CPT and HCPC code descriptions. • Contract Rate • HIBCC or GTIN number/code. • EPSDT qualifier For detailed instructions and qualifiers refer to Appendix 4 of this manual	C
24 A Unshaded	DATE(S) OF SERVICE	Enter the date the service listed in 24D was performed (MM|DD|YY). If there is only one date enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. ***If identical services (identical CPT/HCPC code(s) & Modifiers) were performed within a date span, enter the date span in the "From" and "To" fields. The count listed in field 24G for the service must correspond with the date span entered. Failure to report services in this manner will cause claims to deny as duplicate services.***	R
24 B Unshaded	PLACE OF SERVICE	Enter the appropriate 2-digit CMS standard place of service (POS) code.	R
24 C Unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	Not Required
24D Unshaded	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Enter the 5-digit CPT or HCPC code and 2-character modifier- if applicable. Only one CPT or HCPC and up to 4 modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim. The following national and Pennsylvania Medicaid/LTSS specific modifiers are recognized as modifiers that will impact the pricing of your claim. *26, 32, 51, 52, 53, 54, 55, 62, 66, 76, 78, 79, 80, 81, 82, 90, 99, AA, AD, AE, AH, AS, AT, FP, GN, GO, GP, GT, HD, HG, HP, NU, QB, QU, RR, SE, SG, SU, TC, TF, TG, TH, TN, TT, TU, U1, U2, U3, U4, U4, U5, U6, U7, U8, U9, UB, UE, ZX* ***Ambulance Providers: For Ambulance providers,***	R

		there must be at least one modifier entered for the service. Ambulance HCPCS codes A0425 (Ground Mileage, per statute mile), and A0430 (Ambulance service, conventional air services, transport, fixed wing) must have Modifier U8 appended to the service in order to avoid denial. ***See Appendix for list of Applicable Ambulance Modifiers***	
24 E **Unshaded**	DIAGNOSIS CODE	Enter the numeric single digit diagnosis pointer (1,2,3,4) from field 21. List the primary diagnosis for the service provided or performed first followed by any additional or related diagnosis listed in field 21 (using the single digit diagnosis pointer, not the diagnosis code.) Do not use commas between the diagnosis pointer numbers. Diagnosis codes must be valid ICD codes for the date of service or the claimwill be rejected/denied	R
24 F **Unshaded**	CHARGES	Enter the charge amount for the claim line-item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	R
24 G **Unshaded**	DAYS OR UNITS	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of 1. Enter numbers left justified in the field. No leading zeroes are required. If reporting a fraction of a unit, use the decimal point. Anesthesia services ***must*** be reported as minutes. Units may only be reported for anesthesia services when the code description includes a time period (such as “daily management”) *****If identical services (identical CPT/HCPC code(s) & Modifiers) were performed within a date span, services should be combined and billed on one line. The count listed in field 24G for the service must correspond with the date span entered***. ***Failure to report services in this manner will cause claims to deny as duplicate services.***	R
24 H **Shaded**	EPSDT (Family Planning)	Leave blank or enter “Y” if the services were performed as a result of an EPSDT referral.	C
24 H **Unshaded**	EPSDT (Family Planning)	When EPSDT services are reported on this claim, identify the status of the referral by entering one of the following reason codes right justified in the shaded area of the field. The following codes for EPSDT are used in 5010A1: **AV** Available – Not Used (Enrollee refused referral.) **S2** Under Treatment (Enrollee is currently under treatment for referred diagnostic or corrective health problem.)	C

		ST New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.) **NU** Not Used (Used when no EPSDT Enrollee referral was given.).	
24 I Shaded	ID QUALIFIER	Use G2 qualifier for 13-Digit PROMISe ID	R
24 J Shaded	NON-NPI PROVIDER ID#	**Enter as designated below the PROMISe ID number for the Rendering Service Provider.** Enter the 13-digit PROMISe ID registered for the Rendering Service Provider and location.	R
24 J Unshaded	NPI PROVIDER ID	**Healthcare Providers ONLY:** Enter the 10- character NPI ID of the provider who rendered services. If the provider is billing as an Enrollee of a group, the rendering individual provider's 10-character NPI ID may be entered. **FQHCs and RHCs**: Leave blank. **Non-Healthcare providers*** (as defined in 45 CFR 160.103): Leave blank. *(Examples of Non-Healthcare Providers include Home Modification, Vehicle Modification, Nonemergency Transportation Services, and others)	C
25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number, and mark the box labeled EIN	R
26	ENROLLEE'S ACCOUNT NO.	Enter the provider's billing account number.	C
27	ACCEPT ASSIGNMENT?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a Medicaid Enrollee using Medicaid funds indicates the provider accepts Medicaid assignment. Refer to the back of the CMS 1500 (12-90) form for the section pertaining to Medicaid Payments.	C

28	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in thearea to the right of the vertical line.	R
29	AMOUNT PAID	**REQUIRED** when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing WELLKIDS BY PA HEALTH & WELLNESS Medicaid programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00in the area to the right of the vertical line	C
30	BALANCE DUE	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid, the claim will be returned unprocessed. **Note:** Does not exist in the electronic 837P.	R
32	SERVICE FACILITY	**REQUIRED if the location where services were rendered is different from the billing address listed in field 33.** Enter the name and physical location. (P.O. Box #'s are **not** acceptable here**.)** • First line – Enter the business/facility/practice name. • Second line– Enter the street address. Do not use commas, periods, or other punctuation in	C

	LOCATION INFORMATION	the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, 101). • Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen.	
32a	NPI – SERVICES RENDERED	**Health care providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33.** Enter the 10-character NPI ID of the facility where services were rendered. **Non-Healthcare providers*** (as defined in 45 CFR 160.103): Leave blank. *(Examples of Non-Healthcare Providers include Home Modification, Vehicle Modification, Nonemergency Transportation Services, and others	c
32b	OTHER PROVIDER ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical Providers: Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces). Atypical Providers: Enter the 2-character qualifier 1D (no spaces).	C
33	BILLING PROVIDER INFO & PH#	Enter the billing provider's complete name, address (include the zip + 4 code), and phone number. • First line – Enter the business/facility/practice name. • Second line– Enter the street address. Do not use commas, periods, or other punctuation at the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, 101). • Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)551414).	R

33a	GROUP BILLING NPI	**Healthcare Providers ONLY:** Enter the 10- character NPI ID of the billing provider group. **Non-Healthcare providers*** (as defined in 45 CFR 160.103): Leave blank. *(Examples of Non-Healthcare Providers include Home Modification, Vehicle Modification, Nonemergency Transportation Services, and others)	R
33b	GROUP BILLING OTHERS ID	Enter as designated below the Billing Group 13-Digit PROMISe™ ID: Enter the Provider PROMISe™ ID Use G2 qualifier. Enter the 13-Digit PROMISe™ ID for Billing Provider registered location	R

Appendix V – Claims Form Instructions – UB

UB-04/CMS 1450 (2/12) Claim Form Instructions

Completing a UB-04 Claim Form

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient. Hospital claim charges for reimbursement by Pennsylvania. In addition, a UB-04 is required for nursing home admissions, and dialysis services. Incomplete or inaccurate information will result in the claim/encounter being rejected for correction.

UB-04 Hospital Outpatient Claims/Ambulatory Surgery

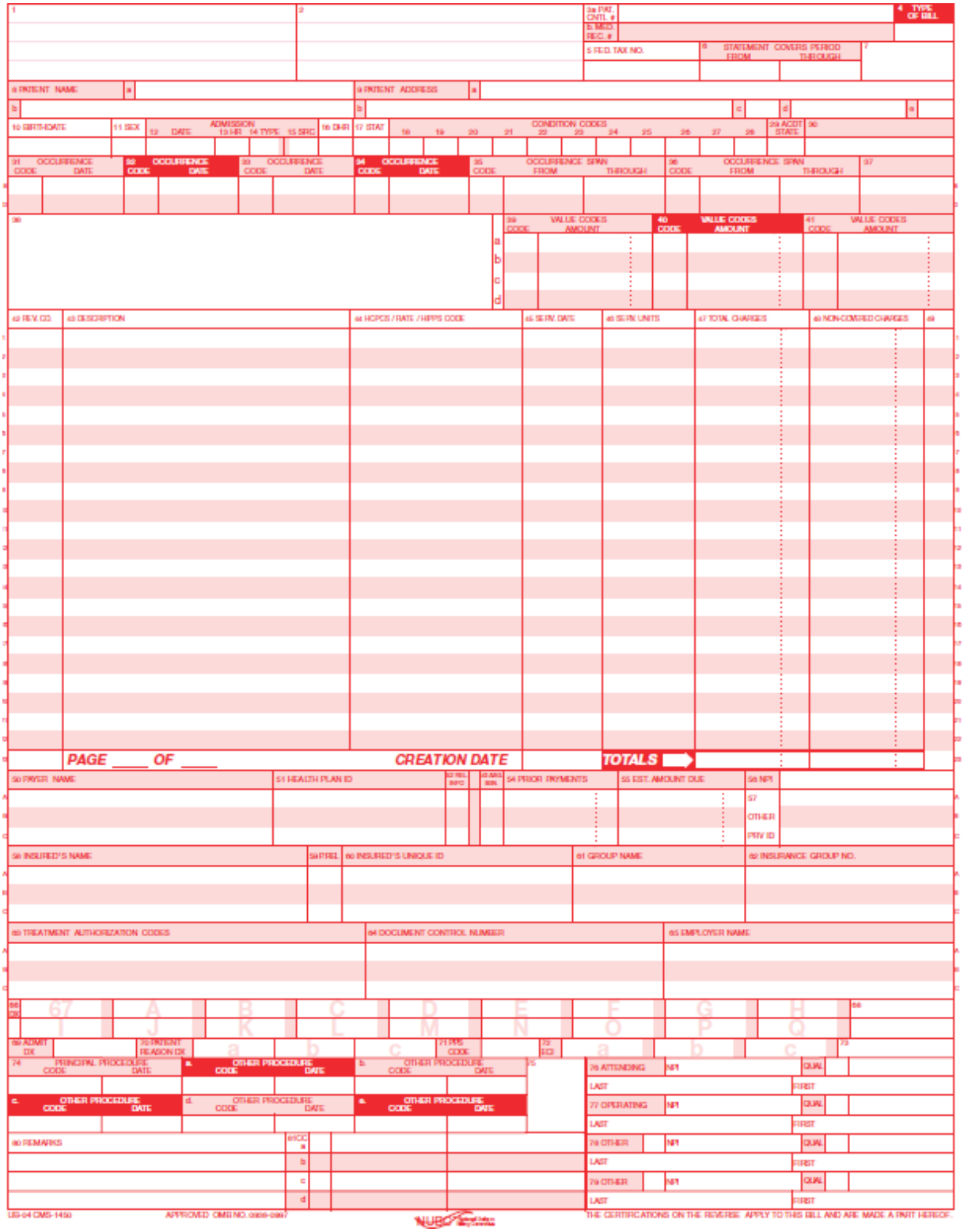
The following information applies to outpatient and ambulatory surgery claims:

Professional fees must be billed on a CMS 1500 claim form.

Include the appropriate CPT code next to each revenue code.

Please refer to your provider contract with Pennsylvania or research the Uniform Billing Editor for Revenue Codes that do not require a CPT Code.

UB-04 Claim Form Example



Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

NOTE: Claims with missing or invalid Required (R) field information will be rejected or denied.

1	UNLABELED FIELD	LINE 1: Enter the complete Provider name. LINE 2: Enter the complete mailing address. LINE 3: Enter the City, State, and Zip +4 codes (include hyphen). NOTE: The 9-digit zip (zip +4 codes) is a requirement for paper and EDI claims. LINE 4: Enter the area code and phone number.	R
2	UNLABELED FIELD	Enter the Pay- to Name and Address.	Not Required
3a	ENROLLEE CONTROL NO.	Enter the facility Enrollee account/control number.	Not Required
3b	MEDICAL RECORD NUMBER	Enter the facility Enrollee medical or health record number.	R
4	TYPE OF BILL	Enter the appropriate Type of Bill (TOB) Code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits shouldbe reflected as follows: 1st Digit – Indicating the type of facility. 2nd Digit – Indicating the type of care. 3rd Digit- Indicating the bill sequence (Frequency code).	R
5	FED. TAX NO	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	STATEMENT COVERS PERIOD FROM/THROUGH	Enter begin and end, or admission and discharge dates, for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and dischargedate. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a datespan. All other outpatient services must be billed using the actual date of service (MMDDYY).	R
7	UNLABELED FIELD	Not used.	Not Required
8a-8b	ENROLLEE NAME	8a – The 10-digit Medicaid identification number on the Enrollee's WELLKIDS BY PA HEALTH & WELLNESS I.D. card. -or- If the Enrollee's number is not available, access Pennsylvania's Eligibility Verification System (EVS) by using the beneficiary's Social Security Number (SSN) and date of birth (DOB). The EVS response will then provide the 10- digit Enrollee number to use for this block	Not Required
		8b – Enter the Enrollee's last name, first name, and middle initial as it appears on the Pennsylvania ID card. Use a comma or space to separate the last and first names.	R

		Titles: (Mr., Mrs., etc.) should not be reported in this field. Prefix: No space should be left after the prefix of a name(e.g., McKendrick. H). Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: a space should separate a last name and suffix. Enter the Enrollee's complete mailing address of the Enrollee. ***This field is required when billing for newborns using the mother's beneficiary number**. Enter the newborn's name. If the first name is not available, you are permitted to use Baby Boy or Baby Girl.	
9	ENROLLEE ADDRESS	Enter the Enrollee's complete mailing address. Line a: Street address Line b: City Line c: State Line d: Zip code Line e: Country Code (NOT REQUIRED)	R (except line 9e)
10	BIRTHDATE	Enter the Enrollee's date of birth (MMDDYYYY). ***Same as the special instruction for Block 8b**. Enter the newborn's date of birth in an 8-digit format. (MM|DD|YYYY)	R
11	SEX	Enter the Enrollee's sex. Only M or F is accepted. Newborn: If submitting a claim for a newborn under the mother's beneficiary number, you must complete this Form Locator with the gender of the newborn.	R
12	ADMISSION DATE	Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services	R

13	ADMISSION HOUR	0012:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02-02:00 to 02:59 14-02:00 to 02:59 03-03:00 to 03:39 15-03:00 to 03:59 04-04:00 to 04:59 16-04:00 to 04:59 05-05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	R
14	ADMISSION TYPE	Required for inpatient and outpatient admissions. Enter the 1-digit code indicating the type of the admission using the appropriate following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	R
Field #	Field Description	Instruction or Comments	Required or Conditional
15	ADMISSION SOURCE	Required for inpatient and outpatient admissions. Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes. For Type of admission 1,2,3, or 5: 1 Physician Referral 2 Clinic Referral 3 Health Maintenance Referral (HMO) 4 Transfer from a hospital 5 Transfer from Skilled Nursing Facility 6 Transfer from another health care facility 7 Emergency Room 8 Court/Law Enforcement 9 Information not available For Type of admission 4 (newborn): 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth 5 Information not available	R

16	DISCHARGE HOUR	Enter the time using 2-digit military times (00-23) for the time of the inpatient or outpatient discharge. **00**- 12:00 midnight to 12:59 **12**-12:00 noon to 12:59 **01**- 01:00 to 01:59 **13**- 01:00 to 01:59 **02**- 02:00 to 02:59 **14**- 02:00 to 02:59 **03**- 03:00 to 03:39 **15**- 03:00 to 03:59 **04**- 04:00 to 04:59 **16**- 04:00 to 04:59 **05**- 05:00 to 05:59 **17**- 05:00 to 05:59 **06**- 06:00 to 06:59 **18**- 06:00 to 06:59 **07**- 07:00 to 07:59 **19**- 07:00 to 07:59 **08**- 08:00 to 08:59 **20**- 08:00 to 08:59 **09**- 09:00 to 09:59 **21**- 09:00 to 09:59 **10**- 10:00 to 10:59 **22**- 10:00 to 10:59 **11**- 11:00 to 11:59 **23**- 11:00 to 11:59	C
17	ENROLLE ESTATUS	REQUIRED for inpatient and outpatient claims. Enter the 2-digit disposition of the Enrollee as of the "through"date for the billing period listed in field 6 using one of the following codes: 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service Organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV Provider 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still Enrollee (To be used only when the client hasbeen in the facility for 30 consecutive days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired—place unknown (hospice use only) 43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) 50 Hospice—Home 51 Hospice—Medical Facility 61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed 62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH) 64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare	R

		65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH)	
18-28	CONDITION CODES	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	C
29	ACCIDENT STATE		Not Required
30	UNLABELED FIELD	NOT USED	Not required
31-34 a-b	OCCURRENCE CODE and OCCURENCE DATE	Occurrence Code: **REQUIRED** when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Date: **REQUIRED** when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	C
35-36 a-b	OCCURRENCE SPAN CODE and OCCURRENCE DATE	Occurrence Span Code: **REQUIRED** when applicable. Occurrence Codes are used to identify events relatingto the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Span Date: **REQUIRED** when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	C
37	(UNLABELED FIELD)	**REQUIRED** for re-submissions or adjustments. Enter the DCN (Document Control Number) of the original claim.	C
38	RESPONSIBLE PARTY NAME AND ADDRESS		Not Required

39-41 a-d	VALUE CODES CODES and AMOUNTS	Code: **REQUIRED** when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All “a” fields must be completed before using “b” fields, all “b” fields before using “c” fields, and all “c” fields before using “d” fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: REQUIRED when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e., 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line. Form Locators 39a through 41a must be completed before Form Locators 39b through 41b. Value code 66 is used for Enrollee Pay only. Value Code 73 is used for Sequestration adjustment amount. Note: As of 1/1/2012, report Medicare Co-Pay with a value code of A7. Note: When submitting a paper crossover claim ona UB04 claim form, use Value Code 73 (Sequestration adjustment amount). For a complete listing and description of Value Codes, please refer to the UB-04 Desk Reference, located in Appendix A of the handbook.	C
General Information Fields 42-47	SERVICE LINE DETAIL	The following UB-04 fields – 42-47: Have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.	
42 Line 1-22	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the Enrollee. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R

42 Line 23	Rev CD	Enter 0001 for total charges.	R
43 Line 1-22	DESCRIPTION	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R
43 Line 23	PAGE___ OF	Enter the number of pages. Indicate the page sequence in the “PAGE” field and the total number of pages in the “OF” field. If only one claim form is submitted, enter a “1” in both fields (i.e., PAGE “1” OF “1”). **(Limited to 4 pages per claim)** ***NOTE: Claims with more than 99 service lines cannot be accepted for processing.**	C
44	HCPCS/RATES	REQUIRED for outpatient claims when an appropriate CPT/HCPCS Code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s), do not use spaces, commas, dashes, or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract.	C
45 Line 1-22	SERVICE DATE	REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims	C
45 Line 23	CREATION DATE	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	R
46	SERVICE UNITS	Enter the number of units, days, or visits for the service. A value of at least “1” must be entered. For inpatient room charges, enter the number of days for each accommodation listed.	R
47 Line 1-22	TOTAL CHARGES	Enter the total charge for each service line.	R
47 Line 23	TOTALS	Enter the total charges for all service lines.	R
48 Line 1-22	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the Revenue Code listed in field 42 of the service line.Do not list negative amounts.	C
48 Line 23	TOTALS	Enter the total non-covered charges for all service lines.	C
49	(UNLABELED FIELD)	Not Used	Not Required

50 A-C	PAYER	Enter the name of each Payer from which reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary	R
51 A-C	HEALTH PLAN IDENTIFCATION NUMBER		Not Required
52 A-C	REL INFO	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter 'Y' (yes) or 'N' (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y.'	R
53	ASG. BEN.	Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R
54 (A,B,C)	PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when Pennsylvania is listed as secondary or tertiary. A – Primary Payer B – Secondary Payer C – Tertiary Payer	C
	A	Due from Primary Payer – Enter the amount of liability toward this hospitalization by any other insurance resource (other than Medicare).	
		Medicare – To ensure the proper use of the Enrollee'sMedicare resources, bill Medicare first for services provided to beneficiaries who may be eligible for Medicare. **i. Deductible Only** – If Medicare applied the entire payment to the Medicare Part B beneficiary's calendar year deductible, report the Medicare Approved Amount here. **ii. Deductible and Coinsurance OR Deductible and Copayment OR Coinsurance OR Copayment Only** – If Medicare applied part of the payment toward the Medicare Part B beneficiary's calendar year deductible and assessed coinsurance or copayment toward the same service or Medicare assessed coinsurance or copayment only, report the Medicare Paid Amount here. PA PROMISe™ Provider Handbook 837 Institutional/UB-04 Claim Form UB-04 Billing Guide for PROMISe™ Outpatient Hospitals Provider Handbook UB-04 January 30, 2017, 14 Form Locator Number Form Locator Name Form Locator Code Notes LB MAPA – Leave Blank – there is no information to place in this Form Locator. See Form Locator 50, Note # 1, for the	

		A, B, C format rules. Only positive dollar amounts are to be entered for any payer and Enrollee when billing MA.	
55	EST. AMOUNT DUE		Not Required
56	NATIONAL PROVIDER IDENTIFIER OR PROVIDER ID	Required: Enter providers 10- character NPI ID.	R
57	OTHER PROVIDER ID	A – Primary Payer B – Secondary Payer C – Tertiary Payer **Medicare** – Enter the Medicare provider number. (Optional) **Commercial Insurance** – Enter the provider number. (Optional) **MAPA** – Enter the 9-digit provider number and 4-digit service location for example, 0342212210001). (Must) Do not use slashes, hyphens, or spaces. See Form Locator 50, Note # 1, for the A, B, C format rules	R
58	INSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the Enrollee. In most cases this will be the Enrollee's name. Enter the name as last name, first name, middle initial.	R
59	ENROLLEE RELATIONSHIP		Not Required
60	INSURED'S UNIQUE ID	REQUIRED: Enter the Enrollee's Insurance ID exactlyas it appears on the Enrollee's ID card. Enter the Insurance ID in the order of liability listed in field 50.	R
61	GROUP NAME	A – Primary Payer B – Secondary Payer C – Tertiary Payer **Medicare**– Leave Blank. **Commercial Insurance** – Enter the name of the group or plan through which insurance has been obtained. **MAPA** – Leave Blank. See Form Locator 50, Note # 1, for the A, B, C format rules.	Not Required
62	INSURANCE GROUP NO.	A – Primary Payer B – Secondary Payer C – Tertiary Payer **Medicare** – Leave Blank. **Commercial Insurance** – Enter the insurance group number which identifies the group listed in Form Locator 61. **MAPA** – Leave Blank. See Form Locator 50, Note # 1, for the A, B, C format rules	Not Required

63	TREATMENT AUTHORIZATIO N CODES	A – Primary Payer B – Secondary Payer C – Tertiary Payer **Medicare**– Leave Blank.	C
		Commercial Insurance– Leave Blank. **MAPA** – Enter the 10-digit prior authorization number. For additional information regarding authorization and your specific provider type, refer to the PA PROMISe™ Provider Handbook for 837 Institutional/UB-04 Claim Form, Section 7, or to the PSR, DRG, or CHR Manuals. Do not enter a treatment authorization number for the following types of treatment: 1. Medicare deductible or coinsurance for treatment with Medicare Part A. 2. Non-Pennsylvania facilities. See Form Locator 50, Note # 1, for the A, B, C format rules. Note: When completing this Form Locator, use the Medical Assistance authorization number only, when applicable. Do not use Medicare or other insurance prior authorization number.	
64	DOCUMENT CONTROL NUMBER	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting Pennsylvania Health Plan from field 50. Applies to claim submitted with a Type of Bill (field 4). Frequency of “7” (Replacement of Prior Claim) or Type of Bill. Frequency of “8” (Void/Cancel of Prior Claim). * Please refer to reconsider/corrected claims section.	C
65	EMPLOYER NAME	A – Primary Payer B – Secondary Payer C – Tertiary Payer **Medicare** – Leave Blank. **Commercial Insurance** – Enter the name of the employer of the insured or possibly insured Enrollee, spouse, parent, or guardian identified in Form Locator 58. **MAPA** – Leave Blank. See Form Locator 50, Note # 1, for the A, B, C format rules. 66 DX Version LB Do not complete this	Not Required
66	DX VERSION QUALIFIER		Not Required
67	PRINCIPAL DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD10-CM Volume 1& 3 for the date of service.	R

67 A-Q	OTHER DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD10-CM Volume 1& 3 for the date of service. Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or	C
		care received using the appropriate release/update of ICD-10-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be valid ICD-10 Codes for the date of service and carried out to its highest level of specificity – 4th or 5 th digit. "E" and most“V” codes are **NOT** acceptable as a primary diagnosis. **Note:** Claims with incomplete or invalid diagnosis codes will be denied.	
68	PRESENT ON ADMISSION INDICATOR		R
69	ADMITTING DIAGNOSIS CODE	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD10-CM Volume 1& 3 for the date of service. Diagnosis Codes submitted must be valid ICD10 Codes for the date of service and carried out to its highest level of specificity – 4th or 5th digits. "E" codesand most “V” are **NOT** acceptable as a primary diagnosis. **Note:** Claims with missing or invalid diagnosis codes will be denied.	R
70	ENROLLEE REASON CODE	Enter the ICD10-CM Code that reflects the Enrollee’s reason for visit at the time of outpatient registration. Field 70a requires entry; fields 70b-70c are conditional. Diagnosis Codes submitted must be valid ICD10 Codes for the date of service and carried out to its highest digit – 4th or 5th. “E” codes and most “V” codes are NOT acceptable as a primary diagnosis. NOTE: Claims with missing or invalid diagnosis codeswill be denied.	R
71	PPS/DRG CODE		Not Required
72 a, b, c	EXTERNAL CAUSE CODE		Not Required
73	UNLABLED		Not Required

74	PRINCIPAL PROCEDURE CODE/DATE	CODE: Enter the ICD-10 Procedure Code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C

74 a-e	OTHER PROCEDURE CODE DATE	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-10 procedure code(s) that identify significant procedure(s) performed other than the principal/primary procedure. Up to five ICD-10 Procedure Codes may be entered. Do not enter the decimal; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
75	UNLABLED		Not Required
76	ATTENDING PHYSICIAN	Enter the NPI and name of the physician in charge of Enrollee care. NPI: Enter the attending physician 10-character NPI ID. G2 – Provider 13-Digit PROMISe™ ID LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	R
77	OPERATING PHYSICIAN	REQUIRED when a surgical procedure is performed. Enter the NPI and name of the physician in charge of Enrollee care. NPI: Enter the attending physician 10-character NPI ID. NPI: Enter the attending physician 10-character NPI ID. G2 – Provider 13-Digit PROMISe™ ID LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name. LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	C
78 & 79	OTHER PHYSICIAN	Enter the Provider Type qualifier, NPI, and name of the physician in charge of the Enrollee care. (Blank Field): Enter one of the following Provider Type Qualifiers: NPI: Enter the attending physician 10-character NPI ID. G2 – Provider 13-Digit PROMISe™ ID	C

		LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	
80	REMARKS	Newborn: When billing for a newborn under the mother's beneficiary number, enter the mother's name, date of birth, and social security number in this Form Locator. Qualified Small Businesses Qualified small businesses must always enter the following message in Form Locator 80 (Remarks a, b, c, d) of the UB-04: "(Name of Vendor) is a qualified small business concern as defined in 4 Pa Code §2.32." Reason For Adjustment Codes Enter one or more of the following reason codes to explain your request for an adjustment: 8001 Change the Enrollee Control Number 8002 Change the Covered Dates 8003 Change the Covered/Non covered Days 8004 Change the Admission Dates/Time 8005 Change the Discharge Times 8006 Change the Status 8007 Change the Medical Record Number 8008 Change the Condition Codes (sometimes to make claim an "outlier" claim) 8009 Change the Occurrence Codes 8010 Change the Value Codes 8011 Change the Revenue Codes 8012 Change the Units Billed 8013 Change the Amount Billed 8014 Change the Payer Codes 8015 Change the Prior Payments 8016 Change the Prior Authorization Number 8017 Change the Diagnosis Codes 8018 Change the ICDN Codes and Dates 8019Change the Phys. ID Numbers 8020 Change the Billed Date	Not Required
81	CC	A: 13-Digit PROMISe™ ID of billing provider. Use G2 qualifier.	R