CALIFORNIA MEDICARE QUICK REFERENCE GUIDE
July 2021
www.wellcare.com/California/Providers/Medicare

Important Note

Please refer to the member ID card to determine appropriate authorization and claims submission process.
Please see below for additional information.

Important Phone Numbers

Nurse Advice Line 1-800-581-9952
Members may call this number to speak to a nurse 24 hours a day, 7 days a week.

Convenient Self-Service

WellCare offers robust technology options to save you time. Below represents the fastest, most effective ways to get what you need.
WellCare Secure Provider Portal

	Portal	Chat	(IVR) Interactive Voice Response
Benefit Information	Fastest Result ✔	Available	Available
Eligibility Verification	Fastest Result ✔	Available	Available

WellCare understands that having access to the right tools can help you and your staff streamline day-to-day administrative tasks.
The Provider Portal will help with those routine tasks.

Provider Portal Registration - click here Provider Portal Training - click here

Provider Services
Interactive Voice Response System Phone: 1-866-999-3945
TTY: 711

WellCare Phone Numbers

Risk Management
Phone: 1-866-685-8664
Fraud, Waste & Abuse Hotline

Community Connections Help Line
Phone: 1-866-775-2192

Utilization Management

Provider Services
Phone: 1-866-999-3945
Fax: 1-855-547-9764
Email: ECFaxMedicalManagement@wellcare.com

Case Management

Provider Services
Phone: 1-866-999-3945 TTY: 711
Fax: 1-855-538-0455 Hours: M-F 8 a.m.-4 p.m. Pacific
Email: ECCaseManagement@wellcare.com

Quality Improvement

Quality of Care
Phone: 1-866-999-3945 Fax: 1-855-671-0254
Email: ECQualityImprovement@wellcare.com
Mail to:
WellCare Health Plans
Quality Improvement Department
10803 Hope St., Suite B
Cypress, CA 90630

HEDIS®
Phone: 1-866-999-3945
Fax: 1-855-696-7549
Mail to:
WellCare Health Plans
Quality Improvement Department
10803 Hope St., Suite B
Cypress, CA 90630

For your convenience, items on this QRG in bold, underlined fonts are hyperlinks to supporting WellCare Health Plan's Provider Job Aids, Resource Guide and forms when the Quick Reference Guide is viewed in an electronic format. NOTE: This guide is not intended to be an all-inclusive list of covered services under WellCare Health Plan but it substantially provides current referral and prior authorization instructions. Authorization does not guarantee claims payment. All services/procedures are subject to benefit coverage, limitations and exclusions as described in the applicable plan coverage guidelines.

Claim Submission Information

Submission Inquiries:

Support from Provider Services 1-866-999-3945
For inquiries related to your electronic or paper submissions to WellCare, please contact our EDI Team at EDI-Master@wellcare.com.

Electronic Funds Transfer and Electronic Remittance Advice:

Register online using the simplified, enhanced provider registration process:
PaySpan.com or call 1-877-331-7154. For more details on PaySpan®, please refer to your Provider Manual.

Clearinghouse Connectivity:

WellCare encourages EDI submissions as they are free to the Provider Community, providing improved accuracy and the fastest turnaround time and enhanced claim status information.

If your clearinghouse or billing system is not connected to Change Healthcare and requires a 5-digit Payer ID, please use the following according to the file type (Fee-For-Service or Encounters).

14163-Fee-For-Service Professional or Institutional	59354 Encounters-Professional or Institutional

Submissions via Change Healthcare, use these CPIDs:

1844 Fee-For-Service Professional	3211 Encounter Professional
8551 Fee-For-Service Institutional	4949 Encounter Institutional

Paper Submission Guidelines:

WellCare follows the Centers for Medicare & Medicaid Services (CMS) guidelines for paper claim submissions. Since Oct. 28, 2010, WellCare accepts only the original "red claim" form for claim and encounter submissions. WellCare does not accept handwritten, faxed or replicated claim forms.

Claim forms and guidelines may be found at www.wellcare.com/California/Providers/Medicare/Claims

Mail paper claim submissions to:

WellCare Health Plans
Claims Department
P.O. Box 260519
Plano, TX 75026-0519

Claim Payment Disputes

The claim payment dispute process is designed to address claim denials for issues related to untimely filing, incidental procedures, unlisted procedure codes, non-covered codes, etc. Claim payment disputes must be submitted in writing to WellCare within 90 days of the date on the EOP for contracted providers. Non-participating provider must submit payment disputes in writing within 120 days of the date on the EOP.

Submit all claims payment disputes with supporting documentation at https://provider.wellcare.com/California

Mail claim payment disputes with supporting documentation to:

WellCare Health Plans
Claim Payment Disputes
P.O. Box 31370
Tampa, FL 33631-3370

Note: Any appeals related to a claim denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification must be sent to the Appeals (Medical) address in the section below. Examples include Explanation of Payment Codes DN001, DN004, DN0038, DN039, VSTEX, DMNNE, HRM16, and KYREC. However, this is not an all-encompassing list of Appeals codes. Anything else related to authorization, or medical necessity that is in question should be sent to the Appeals post office box. Include all substantiating information (please do not include image of Claim) like a summary of the appeal, relevant medical records and member-specific information.

Claim Payment Policy Disputes

The Claims Payment Policy Disputes Department has created a new mailbox for provider issues related strictly to payment policy. Disputes for payment policy-related issues must be submitted to WellCare in writing within 90 calendar days of the date of denial on the EOP for contracted providers. Non-participating provider must submit payment policy-related issues in writing within 120 days of the date on the EOP. Please provide all relevant documentation (please do not include image of Claim), which may include medical records, in order to facilitate the review. Submit all Claims Payment Policy Disputes related to Explanation of Payment Codes beginning with IH###, CE###, CV### (Medical records required) or PD### at: https://provider.wellcare.com/California

Mail all disputes related to Explanation of Payment Codes beginning with IH###, CE###, CV### (Medical records required) or PD### to:	WellCare Health Plans Attn: Claim Payment Policy Disputes P.O. Box 31426 Tampa, FL 33631-3426
Mail all medical records and initial reviews and Appeals related to Explanation of Payment Codes beginning with CPI##:	By Mail (U.S. Postal Service) Phone: 1-844-458-6739 Fax: 1-267-687-0994 OPTUM P.O. Box 52846 Philadelphia, PA 19115 By Delivery Services (FedEx, UPS) OPTUM 458 Pike Road Huntingdon Valley, PA 19006 By Secure Internet Upload Refer to Optum's Medical Record Request letter for further instructions.
Mail all disputes related to Explanation of Payment Codes LT###, RVLT#:	WellCare Health Plans CCR P.O. Box 31394 Tampa, FL 33631-3394
Mail all disputes related to Explanation of Payment Codes RVPI#.	PICRA P.O. Box 31416 Tampa, FL 33631-3416

Recovery/Cost Containment Unit (CCU)

Refund(s) in response to a WellCare overpayment notification should include a copy of the overpayment notification, any applicable attachment(s) and be sent to:	WellCare Health Plans Attn: CCU Recovery P.O. Box 31584 Tampa, FL 33631-3584

If you do not agree with the proposed WellCare overpayment notification related to adjustments RVXX (Except RV059, which should refer to the Claim Payment Disputes section above), you may request an Administrative Review by submitting a dispute in writing within 45 days of the recovery letter date. Your request should detail why you disagree with these findings and must include any supporting evidence/documentation you believe in pertinent to your position.

Mail or fax your Administrative Review request to:	WellCare Health Plans Fax: 1-813-283-3284 Attn: CCU Recovery P.O. Box 31658 Tampa, FL 33631-3658

Additional documentation received after your initial Administrative Review request will not be considered. A Final Determination will be rendered within 30 days of WellCare's receipt of your request. If you do not submit a dispute or render payment within the time period referenced above, we will take action to recover the amount owed as allowed by law, or as outlined within the contract between you and WellCare.

Administrative Reviews related to Explanation of Payment Codes and Comments beginning with DN227, DN228 or RV213 must be submitted in writing and include at a minimum: a summary of the review request, the member's name, member's identification number, date(s) of service, reason(s) why the denial should be reversed, copies of related documentation and all applicable medical records related to both stays to support appropriateness of the services rendered.

Mail or fax your dispute to:	COTIVITI HEALTHCARE Fax: 1-203-202-6607 Attn: WellCare Clinical Chart Validation Hillcrest III Building 731 Arbor Way, Suite 150 Blue Bell, PA 19422

Provider Identified Refund(s) without receiving overpayment notification should include the reason for the overpayment as well as any details that assist in identifying the member and WellCare Claim ID.

Please submit to:	WellCare Health Plans Attn: CCU Recovery P.O. Box 31584 Tampa, FL 33631-3584

Note: For single-claim checks, please use the Refund Check Informational Sheet to help Recovery post accurately and timely. For checks in excess of 25 claims, please complete the Refund Referral Grid and email all supporting documentation, including the grid, to OverpaymentRefunds@wellcare.com to assist with expedited posting. Please note that only check referrals will be accepted by this email box; anything other than check referrals will not be responded to and will be closed.

Appeals (Medical)

All non-par Medicare provider appeals must be submitted within 60 **calendar days** and they must also submit a signed waiver of liability (WOL) with their request for processing. Participating Providers also can seek an appeal through the Appeals Department within 90 **calendar days** of a claim denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification. Examples include Explanation of Payment Codes DN001, DN004, DN0038, DN039, VSTEX, DMNNE, HRM16 and KYREC. However, this is not an all-encompassing list of Appeals codes. Anything else related to authorization, or medical necessity that is in question should be sent to the Appeals PO Box. Include all substantiating information (please do not include image of claim) like a summary of the appeal, relevant medical records and member-specific information.

Mail or fax all medical benefit appeals with supporting documentation to:

WellCare Health Plans
Attn: Appeals Department
P.O. Box 31368
Tampa, FL 33631-3368

Fax: 1-866-201-0657

Medicare Appointment of Representative Form

Grievances

Member grievances may be filed verbally by contacting Customer Service or submitted in writing via mail or fax. Providers may also file a grievance on behalf of the member with the member's written consent. Provider complaints related to any administrative issue, such as WellCare's policies and procedures or authorization/referral process, must be submitted within 60 **calendar days** of the event that gave rise to the complaint.

Mail or fax member grievances to:

WellCare Health Plans
Grievance Department
P.O. Box 31384
Tampa, FL 33631-3384
Email: Operationalgrievance@wellcare.com or pdpgrievance@wellcare.com

Phone: 1-877-902-6784 Fax: 1-866-388-1769

Medicare Appointment of Representative Form

Behavioral Health

Please refer to your Primary Care Provider for a list of options.

Contracted Networks

Dental Delta Dental Phone: 1-855-643-8515	Vision Premier Eye Care Phone: 1-855-818-4778
Hearing Hear USA Phone: 1-877-664-9353	OTC United Medco Phone: 1-888-979-4319

Transportation
Access2Care
Phone: 1-844-809-9034
Members must call 48 **business hours** in advance for routine trips and may call same day for urgent care.
Benefit limitations may apply. Please contact Provider Services for additional information.

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Pharmacy Services

Pharmacy Services: 1-866-999-3945
Including after-hours and weekends (CVS Caremark®)

Rx BIN	Rx PCN	Rx GRP
004336	MEDDADV	788257

AcariaHealth™
AcariaHealth is a national comprehensive specialty pharmacy focused on improving care and outcomes for patients living with complex and chronic conditions. AcariaHealth is comprised of dedicated healthcare professionals who work closely with physician offices, including support with referral and prior authorization processes. This collaboration allows our patients to receive the medicine they need as fast as possible.
Representatives are available from Monday–Thursday, 8 a.m. to 7 p.m., and Friday, 8 a.m. to 6 p.m. ET.

*AcariaHealth™ Pharmacy #26, Inc.
8715 Henderson Rd., Tampa, FL 33634
Phone: 1-866-458-9246 (TTY 1-855-516-5636)
Fax: 1-866-458-9245
Website: www.acariahealth.com

*Effective on or about July 2021

Fax: 1-866-458-9245

CVS Caremark® Mail Service 1-844-635-3406
www.caremark.com TTY: 1-866-507-6135
Fax: 1-866-892-8194

Medication Appeals: 1-866-999-3945
TTY: 711
Fax: 1-866-388-1766

Online:
Request for Redetermination of Medicare Prescription Drug Denial (Appeal)

Mail medication appeal forms with supporting documentation to:

WellCare Health Plans
Attn: Pharmacy Appeals Department
P.O. Box 31383
Tampa, FL 33631

Medication appeals may also be initiated verbally by contacting Provider Services. Please note that all appeals filed verbally also require a signed, written appeal.

Formulary Inclusions:

To request consideration for inclusion of a drug to WellCare's Formulary, providers may submit a medical justification to WellCare in writing.

WellCare Health Plans, Clinical Pharmacy Department
Director of Formulary Services
Pharmacy & Therapeutics Committee
P.O. Box 31577
Tampa, FL 33631-3577

Coverage Determination Requests: 1-866-999-3945
TTY: 711

Mail or fax a Coverage Determination Request Form with supporting documentation to:
Fax: 1-866-388-1767
Online:
Request for Medicare Prescription Drug Coverage Determination form
Mail:

WellCare Health Plans
Attn: Pharmacy — Coverage Determination
P.O. Box 31397
Tampa, FL 33631

Submit a Coverage Determination Request Form for:

- Drugs not listed on the Formulary
- Drugs listed on the Formulary with a prior authorization (PA)
- Duplication of therapy
- Prescriptions that exceed the FDA daily or monthly quantity limits
- Most self-injectable and infusion drugs (including chemotherapy) administered in a physician's office
- Drugs listed on the Formulary with a quantity limit (QL)
- Drugs that have a step edit (ST) and the first line therapy is inappropriate

On the web: www.wellcare.com/California/Providers/Medicare/Pharmacy

- WellCare Formulary
- Participating Pharmacies
- Pharmacy Services Forms
- Exactus Pharmacy Solutions
- CVS Caremark Mail Service Pharmacy

For Home Infusion/Enteral services:

Once Authorization Approval is obtained through WellCare, if required, please contact one of our providers below to initiate services:

Coram®:
Phone: 1-800-423-1411 or Fax: 1-866-462-6726

Option Care Health™ aka Option Care and BioScrip Infusion Services® and Crescent Healthcare:
Phone: 1-833-466-0358

KabaFusion
Phone: 1-562-863-0555 or Fax: 1-877-445-8821

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Prior Authorization (PA) Requirements

WellCare Health Plan delegates Prior Authorization to the contracted MSO, IPA or Medical Groups who then determine prior authorization requirements for their assigned members.

IPAs must make every attempt to authorize services that are the financial responsibility of WellCare Health Plan to a provider within WellCare Health Plan's contracted network. If a member requires out-of-network services because WellCare Health Plan is not contracted with a provider of like specialty, the IPA is required to notify WellCare Health Plan's Utilization Management Department prior to issuing an authorization.

The Utilization Management Department will discuss the case with the WellCare Health Plan Contracting Department and notify the IPA accordingly such that an authorization may be issued. For services that are the financial responsibility of the IPA, the IPA is required to follow its organization's policy in reference to authorization of out-of-network providers.

Emergency admissions that are outside the IPA/Group's service area are monitored by the WellCare Health Plan Utilization Management Department. WellCare Health Plan's Medical Management Department will be responsible for issuing an authorization, performing concurrent review, and working with the IPA to coordinate transfer of the member to an in-network facility once the member has been stabilized.

For specific authorization requirements, please follow your group's direction.