

Medicare Advantage Provider Resource Guide

Thank you for being a star member of our provider team. Wellcare understands that having access to the right tools can help you and your staff streamline day-to-day administrative tasks. This guide will explain the quality services that Wellcare offers to assist with those routine tasks. In this guide you will find information related to:

- Secure Provider Portal
- *Quick Reference Guide*
- Verifying Member Eligibility
- Prior Authorizations
- Claims
- Appeals

Provider Web Portal

The Provider Web Portal offers providers the convenience of exchanging healthcare service information directly with Wellcare. The Provider Web Portal, which is offered at no cost, features many useful tools:

- ✓ View member eligibility status, co-payments and benefit information
- ✓ Request authorizations and check status
- ✓ Submit claims, look up status, submit appeals, disputes and corrected claims
- ✓ The ability to use PaySpan Health's Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA)
- ✓ View member care gaps, care plans, visit history, appointment agenda, and more
- ✓ Take training and complete attestations online
- ✓ Your own inbox for receiving messages from Wellcare
- ✓ Provider Web Portal news and alerts

Quick Reference Guide (QRG)



The **Quick Reference Guide** is a document that lists important mailing addresses, phone and fax numbers, and authorization requirements. You can access the QRG on our website at www.wellcare.com. Select your state from the drop down menu and click on "Overview" under "Medicare" in the "Providers" drop-down menu.

Create a New Account

Users can create an account by visiting our provider website:

<https://provider.wellcare.com/Provider/Accounts/Registration>.

- ✓ You will create a brief profile, and select your username and security questions.
- ✓ You will need to accept the Terms and Conditions.
- ✓ After completing these steps, you will receive an email asking you to confirm your registration.
- ✓ After clicking the confirmation link, you will go to a secure password screen, where you will set your password. Please be sure to keep your username and password for future reference.
- ✓ You will then need one of the following to request access to tools and information in the portal:
 - Wellcare Contract Name and ZIP Code OR
 - If a Sub-Group for your medical group or facility exists, your Wellcare-issued Provider ID number (located in your welcome packet or on your Explanation of Payment)

- ✓ Your access: Your request will be sent to your contract or sub-group administrator, who will review the request and grant or deny access. Once action is taken on your request, you will receive an email and can then login and access tools and information in the portal.

Verifying Member Eligibility

You can search, view, save and print member-specific Wellcare eligibility and enrollment information using the Provider Portal. Access the secure portal from **www.wellcare.com** by selecting your state from the drop-down menu and clicking on “Secure Login” in the “Providers” drop-down menu.

- 1 Log in at **https://provider.wellcare.com**
- 2 Click the *My Patients* area.
- 3 Enter the Member ID number.
- 4 Click the *Search* button.

If you don't have the Member ID on hand, you can search by member name and date of birth. In addition to validating member eligibility on our Provider Portal, you may also validate eligibility and claim status through one of our real-time vendors. Please refer to the Real-Time Services section of this guide for more information.

Prior Authorizations



Requesting an Authorization

Providers must obtain prior authorizations for certain services and procedures. You can request authorizations via the secure online Provider Portal, by fax or by telephone. For details regarding services that require authorization requests and how to submit authorizations, please refer to the QRG.

The following information is generally requested for all authorizations:

- ✓ Member name
- ✓ Member ID number
- ✓ Provider ID and National Provider Identifier (NPI) number or name of the treating physician
- ✓ Facility ID and NPI number or name where services will be rendered (when appropriate)

- ✓ Provider and/or facility fax number
- ✓ Date(s) of service
- ✓ Diagnosis and diagnostic codes
- ✓ CPT codes
- ✓ Any relevant clinical information to support medical necessity of request

Via Provider Portal

Registered providers may log in, click the *Care Management* link, then select *Create New Authorization*. For authorizations, please supply your phone and fax numbers. You can attach up to 10 clinical files.

Via Fax

Complete the appropriate Wellcare notification or authorization form for the type of care needed. You can find the forms online at **www.wellcare.com**. Select your state from the drop-down menu and click on “Forms” under “Medicare” in the “Providers” drop-down menu. Fax the completed form and any supporting documentation to the fax number listed on the QRG.

Via Telephone

Emergent or Urgent Authorizations Only

Authorization requests that are emergent or urgent should be submitted via telephone. Emergent or urgent requests should only be submitted when the standard time frame could seriously jeopardize the member’s life or health. Requests for expedited authorization will receive a determination within three business days. Contact Provider Services at the phone number listed on the QRG to request an expedited authorization.

Checking Authorization Status Online

Wellcare encourages you to check the status of your authorization requests online via our secure Provider Portal at **https://provider.wellcare.com**. You may also access the secure portal from **www.wellcare.com** by selecting your state from the drop-down menu and clicking on “Secure Login” in the “Providers” drop-down menu.

Simply log in and click the *Care Management* link. You can then search by Authorization Number, Member ID, Member Name and Date of Birth or Provider ID.

Select one of the service date ranges or enter a custom date range of up to one year.

Click the *Search* button. Results appear at the bottom of the page.

Please note: Authorization/Certification determinations are made based on medical necessity and appropriateness, and reflect the application of Wellcare's review criteria guidelines. Once you complete each authorization request via the Provider Portal, you can download or print a summary report for your records.



Authorizations are valid for the time noted on each authorization response. Wellcare may grant multiple visits under one authorization when a plan of care shows medical necessity for this request. Failure to obtain the necessary prior authorization from Wellcare could result in a denied claim. Authorization does not guarantee payment. All services or procedures are subject to benefit coverage, limitations and exclusions as described in applicable plan coverage guidelines.

Claims



Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

Wellcare has partnered with PaySpan Health, a company with more than 25 years of experience in developing payment solutions, to provide EFT/ERA solutions.

 [Register for Electronic Funds Transfer at PaySpan Health](#)

Create a New Account

Wellcare has instituted additional security measures to ensure your EFT is secure. New users must first contact PaySpan Health to request a registration code. Call **1-877-331-7154** or email **providersupport@payspanhealth.com**. PaySpan Health will email instructions on how to register online.

 [Enter Your Registration Code](#)

Once you receive your code, you can register at **www.payspanhealth.com** by selecting the *Register Now* button. Follow all the prompts and complete the required registration questions. You will need:

- 1 Your Vendor/Provider Identification Number (PIN) and TIN
- 2 A valid email address
- 3 An account name (to identify the receiving account). Note: Providers typically use the account name to specify the payee designation. Each payee will have a separate registration code and can therefore have a separate receiving account established. The same routing and account number can be used for multiple receiving accounts.

4 Bank routing number

5 Bank account number

Your email address will become your username when logging in to PaySpan Health. After completing your registration, you will receive an email from PaySpan Health. In a few days, you will need to verify that PaySpan Health has made a small deposit to your bank account. This deposit amount will confirm that your electronic payments are properly set up. You do not need to return the deposit to PaySpan Health.

Filing a Claim

All claims must have complete and compliant data including:

- ✓ Current CPT and ICD-10 (or its successor) codes
- ✓ TIN
- ✓ NPI number(s)
- ✓ Provider and/or practice name(s) matching the W-9 initially submitted to Wellcare

General Definitions:

- **Paid claims** – claims that have at least one line item designated as payable
- **Pending claims** – claims that require additional review and/or claims that are held due to a member's failure to pay his/her premium (these claims remain in a pending status until the member pays his/her premium)
- **Denied claims** – services indicated on the submitted claims are not covered, did not receive authorization and/or the member is not eligible
- **Rejected claims** – claims that have missing or invalid information, such as invalid code sets or required data elements, which will not pass Wellcare's "front-end" edit process. You will need to correct the data and resubmit a new claim.

Electronic Claims

Wellcare accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to Wellcare must be in the ANSI ASC X12N format, version 5010A1 or its successor. This is less costly than billing with paper and, in most instances, allows for quicker claims processing. For more information on EDI implementation with Wellcare, refer to the Claims/Encounter Companion Guides located at www.wellcare.com. Select your state from the drop-down menu and click on "Forms" under "Medicare" in the "Providers" drop down menu.

Fee-For-Service Clearinghouse Submitters

All Fee-for-Service (FFS) providers and vendors must send claims through a clearinghouse. Wellcare has partnered with Availity.



Call Availity for submitter/client connectivity services at **1-800-282-4548**.

If your clearinghouse or billing system is not connected to Availity and requires five-digit Payer IDs, please use the following codes according to the file type (FFS or Encounters).

WELLCARE PAYER IDs	
14163 Fee-For-Service – Professional or Institutional	59354 Encounters – Professional or Institutional

Real-Time Services

Real-time HIPAA 270/271 eligibility transactions and 276/277 claim statuses are available to providers via our preferred clearinghouse, Availity.

Availity	1-800-282-4548
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These services improve data interchanges, provide innovative solutions to provider requests and will be leveraged to implement other HIPAA-compliant transactions in the future.

- ✓ Real-time eligibility and claim status information – no waiting on the phone
- ✓ No cost to the provider community
- ✓ Increase office productivity
- ✓ One-stop shopping – view eligibility and claim status information for all participating health insurance companies from a single website with a single login

Electronic Claims – Direct Data Entry (DDE)

Via **www.wellcare.com**

Registered users can log in and directly enter professional and/or institutional claims and encounters into Wellcare’s Provider Portal. Once logged in, select the *Claims* link, and then click *New Professional Claim* or *New Institutional Claim*. You can then complete your individual claims or encounters submission.

Alternative Solutions – Availity Essentials

Availity Essentials offers a web browser for direct data entry (DDE) and the upload ability to submit electronically **at no cost to you**. To register, visit www.availity.com/essentials-portal-registration. For registry questions, the submitter/clients may contact Availity Client Services at **1-800-282-4548**.

Paper Claims

Wellcare encourages electronic (EDI) claim submissions. However, we also accept paper CMS-1500 and UB-04 claim forms or their successors. Paper claims should only be submitted on original claim forms (red ink on white paper). If the paper claim is not submitted on the original red and white claim form, the claim will be rejected. Please visit www.wellcare.com for complete paper claims submission guidelines. Select your state from the drop-down menu and click on “Claims” under “Medicare” in the “Providers” drop-down menu.

For more information on claims submissions, clean claims, timely filing guidelines and encounter data submission, refer to the *Claims* section of the Provider Manual at www.wellcare.com. Select your state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu. For the paper claims mailing address, please refer to the QRG.

For further instructions for both paper and EDI claim submission, including access to the EDI Companion Guides, visit www.wellcare.com. Select your state from the drop-down menu and click on “Claims” under “Medicare” in the “Providers” drop-down menu.

Encounters Submission

Certain delegated vendors and providers are required to submit encounters. Encounters may be submitted electronically via:

- ✓ Availity
- ✓ Wellcare’s Secure FTP (SFTP) process
- ✓ Wellcare’s Direct Data Entry (DDE)

For further details about Encounter Submissions, please refer to Encounter Companion Guides located at www.wellcare.com. Select your state from the drop-down menu and click on “Claims” under “Medicare” in the “Providers” drop-down menu.

Checking Claim Status Online

Wellcare encourages you to check the status of your claims online via our secure Provider Portal at <https://provider.wellcare.com>.

Simply log in and click the *Claims* link, then access the *Search Claims* area. You can search by Claim Number, Member ID, Member Name and Date of Birth, Wellcare Control Number (WCN), Document Control Number (DCN), or Provider ID.

Select one of the service date ranges or enter a custom date range of up to one year.

Click the *Search* button. Results are displayed at the bottom of the screen.

Interactive Voice Response (IVR) System

Alternatively, you can use Wellcare's self-service IVR to check the status of a claim for full or partial payments. You can access the IVR by calling the provider customer service toll-free number in your provider state-specific QRG located at www.wellcare.com.

TIPS for using our IVR

Providers should have the following information available with each call:

- ✓ Wellcare Provider ID number
- ✓ NPI or Tax ID for validation, if Providers do not have their Wellcare ID
- ✓ For claims inquiries – provide the Member's ID number, date of birth, date of service and dollar amount
- ✓ For authorization and eligibility inquiries – provide the Member's ID number and date of birth



Claim Payment Disputes

The claim payment dispute process is designed to address claims when there is disagreement regarding reimbursement. Claim payment disputes must be submitted to Wellcare through the provider portal or in writing within 90 days of the date of denial on the EOP. Refer to the QRG for the mailing address.

Appeals



Filing an Appeal

Providers have the right to file a request for review regarding provider payment or contractual decisions. Requests for review related to the following non-authorization-related reasons are processed under the claims disputes process. Claims may be denied or reduced for the following non-authorization-related reasons:

- ✓ Untimely filing
- ✓ Incidental procedures
- ✓ Bundling
- ✓ Unbundling
- ✓ Unlisted procedure codes
- ✓ Non-covered codes

Authorization-related denials are processed by appeals. Claims may be denied or reduced for the following authorization-related reasons:

- ✓ Lack of prior authorization
- ✓ Services exceeding authorization
- ✓ Lack of supporting documentation
- ✓ Late notification

Appeals can be submitted in writing within 90 calendar days of the date of the Explanation of Payment or the Provider Administrative Denial letter. If you have questions and/or concerns about the appeals process, please contact Provider Services for assistance.

To file an appeal by mail or fax, refer to the QRG for applicable addresses and fax numbers. Claim appeals may also be submitted through the Provider Portal. Wellcare will process and finalize an appealed claim to a paid or denied status within 60 calendar days of receipt of the appealed claim.



Contacts

For important mailing addresses, phone numbers and fax numbers, refer to your state-specific QRG located at **www.wellcare.com**. Select your state from the drop-down menu and click on “Overview” under “Medicare” in the “Providers” drop-down menu.



 www.wellcare.com