



Medicaid Provider Resource Guide

Registering for Secure, Self-Service Web Access

WellCare of Florida, Inc./HealthEase of Florida, Inc. (the Plan) understands that having access to the right tools can help participating providers and their staff streamline day-to-day administrative tasks. Two free services that the Plan offers to assist with those routine tasks are the Provider Portal and Payformance's Electronic Funds Transfer (EFT)/ Electronic Remittance Advice (ERA) services. By registering for these services, you and your staff will have access to a variety of useful tools.

Provider Portal Features

www.wellcare.com

- Member eligibility and co-pay information;
- Authorization requests;
- Claims status and inquiry;
- Your own inbox, with specific messages from the Plan;
- Provider news; and
- More...

Payformance's EFT/ERA Features

www.payspanhealth.com

- HIPAA-compliant data files;
- Ability to download directly to your accounting system;
- View remittance records online;
- Design and pull reports at your convenience; and
- More...

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To Register for the Provider Portal

There are two types of users: **administrative users** and **sub-accounts**. **Administrative users** oversee additional website users (**sub-accounts**) in their practice or department.

Administrative users can register on www.wellcare.com by selecting *Not Registered? Sign Up Today!* on the *Providers* tab. You will need the following to register:

- Plan-issued Provider ID number (located in your welcome packet or on your Explanation of Payment copies);
- Primary address ZIP code (the ZIP code submitted on your credentialing packet); and
- Tax Identification Number (TIN).

After completing your registration, you will receive an e-mail from the Plan with a temporary password that is valid for 30 days. Upon your next login, you will be prompted to change your password to a permanent one of your choosing. Be sure to retain your login and password for future reference.

For questions on Web registration, or to reset your password, contact Provider Services at the number listed on your Quick Reference Guide. And as always, information such as provider directories, a pharmacy look-up tool and provider education, training and resource materials are available publicly at www.wellcare.com.

To Register for PaySpan Health

Users can register at www.payspanhealth.com by selecting the *Secure Registration* button and entering the registration code you received from Payformance.

You will need the following to register:

- A valid e-mail address;
- 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.
- Bank routing number; and
- Account number

After completing your registration, you will receive an e-mail from PaySpan Health. A few days later, you will need to verify with your bank that a small deposit has been made by Payformance. This deposit amount will be used to confirm your electronic payments are properly set up. The deposit does not need to be returned to Payformance.

For questions on PaySpan registration, contact the PaySpan Provider Support Team. Please see the *Contacting Us* section on page 6 of this *Resource Guide* for specific contact information.

Verifying Member Eligibility

Prior to rendering services, providers should verify the member's eligibility. Registered users may verify eligibility and enrollment electronically by visiting www.wellcare.com under *Show Eligibility Co-pay* and/or *Find Members*, or by phone via Provider Services.

Quick Reference Guides (QRGs)

The QRGs are documents that list important addresses, phone and fax numbers and authorization requirements. The QRGs can be accessed online at:

www.wellcare.com/Provider/Resources

The following information is needed to verify eligibility:

- Provider ID;
- Member name (last, first);
- Member identification number; and
- Member date of birth

Obtaining an Authorization

Providers must obtain prior authorizations for certain services and procedures. For details regarding services that require authorization and how to submit one, please refer to your Quick Reference Guide.

Standard authorization requests must be submitted at least **14 calendar days** prior to planned services. This ensures decisions are not delayed for pre-planned services.

Urgent or emergent authorization requests may be made via phone. These requests should only be submitted when following the standard timeframe could seriously jeopardize the member's life or health. Requests for expedited authorization will receive a determination within 72 hours.

The following information, at a minimum, is generally requested for all authorizations:

- Member name;
- Member identification 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; and
- CPT codes

For more information regarding authorizations, please refer to the **Provider How-To Guide**.

Authorizations are valid for the time noted on each authorization response. The Plan 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 the Plan 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.

Filing a Claim

Claims, both paper and electronic, should include all necessary, complete, correct and compliant data including:

- Current CPT and ICD-9 (or its successor) codes;
- TIN;
- NPI numbers; and
- Provider and/or practice name(s) matching the W-9 initially submitted to the Plan.

General definitions:

- **Paid claims**

EDI	95% clean claims in 20 calendar days; 100% all claims in 120 calendar days
Paper	95% clean claims in 40 calendar days; 100% all claims in 140 calendar days

Please note that Individual Par Provider Contracts may contain Provider-specific Prompt Pay and Interest Agreements that differ from State or Federal Requirements.

- **Pended claims** – require additional review.
- **Denied claims** – services indicated on the submitted claim are not covered, did not receive authorization and/or the member is not eligible.

Electronic Claims – EDI and DDE

The Plan encourages providers to submit claims electronically via Electronic Data Interchange (EDI) or Direct Data Entry (DDE). This is less costly than billing with paper and, in most instances, allows for quicker claims processing. Direct Data Entry (DDE) is available for Web-registered providers and **allows providers to directly data enter the claim into the provider portal.**

For EDI submissions, providers should follow the HIPAA transaction and code set requirements as found in the National Electronic Data Interchange Transaction Set Implementation Guides that are available at www.wpc-edi.com.

EDI claims should:

- Be in the ANSI ASC X12N format, version 4010A, or effective **January 1, 2012**, version 5010;
- Be on the nationally accepted 837 file format;
- **Include Payer ID 14163 on claims submissions;**
- **As applicable, include Payer ID number 59354 on claims encounter submissions.**

Fee-For-Service Clearinghouse Submitters

All Fee-for-Service (FFS) providers and provider vendors must send claims through a clearinghouse. The Plan is contracted with RelayHealth, a division of McKesson, as our sole source clearinghouse to manage EDI connectivity between the Plan and our providers. **The Plan only accepts electronic claims through RelayHealth.**

If your vendor (i.e., practice management system, billing service or clearinghouse) is not connected to RelayHealth, we strongly encourage you to contact them directly and request that they establish this **FREE** connection. Upon confirmation from your vendor of continued electronic claims submission to the Plan via RelayHealth, no further action is necessary.

If you have any questions regarding submission of EDI transactions directly through RelayHealth, refer to your Quick Reference Guide for contact information for providers and vendors.

Real Time Services

Availity, Med Data, RelayHealth and Emdeon provide real-time Eligibility (270/271) and Claim Status (276/277) services.

 EDI Preferred Partner RelayHealth (McKesson)	Payer ID 14163	Contact 1-877-411-7271
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Paper Claims

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

For more information on claims submissions, clean claims, timely filing guidelines and encounter data submission, refer to the *Claims* section of the Provider Manual, which can be accessed at www.wellcare.com/Provider/ProviderManuals.

For further instructions for both paper and EDI claim submission, including access to EDI Companion Guides, visit www.wellcare.com/Provider/ClaimsUpdates.

For inquiries related to your electronic submission to the Plan, please contact our EDI team at EDI-Master@wellcare.com.

Encounters Submission

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

- The Plan's preferred clearinghouse, RelayHealth;
- The Plan's Secure FTP (SFTP) process; or
- The Plan's Direct Data Entry (DDE)

For more information on Encounter Data Submission requirements and submission methods, refer to the **Provider Manual**.

Strategic National Implementation Process (SNIP)

All claims and encounter transactions submitted via paper, direct data entry (DDE) or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines. The SNIP validations used by the Plan are available on our website at www.wellcare.com/Provider/ClaimsUpdates, in the EDI Companion Guides, which may be a helpful resource to share with your billing vendor or clearinghouse.

Filing an Appeal

Providers have the right to file an appeal regarding provider payment or contractual issues. Non-authorization-related claims denials for:

- Untimely filing;
- Incidental procedures;
- Bundling;
- Unbundling;
- Unlisted procedure codes;
- Non-covered codes;
- Etc.

Authorization-related claims may be denied for:

- Lack of prior authorization;
- Services exceeding authorization;
- Lack of supporting documentation; and
- Late notification.

The Plan encourages providers to first contact our Provider Services team to resolve any issues that may arise before initiating the appeals process. **Appeals must be submitted, in writing, within 90 days of the date of the Explanation of Payment or the Provider Administrative denial letter.** Claims disputes must be submitted, in writing, within one year of the date of the Explanation of Benefits or the Provider Administrative denial letter.

You may file a claims dispute online or by mail or fax. Please see your state-specific QRG for applicable addresses and fax numbers.

You may file an appeal online, by mail or by fax. Please see your QRG for applicable addresses and fax numbers. The Plan processes and finalizes appealed claims to a paid or denied status within 30 calendar days of receipt of the appealed claim.

Contacting Us

The Plan and our vendors can be contacted in a variety of ways.

- PaySpan Health – providersupport@payspanhealth.com, or 1-877-331-7154; Monday–Friday 7 a.m.–9 p.m., Eastern.
- Availity – 1-800-282-4548; Monday–Friday
- Emdeon – 1-800-845-6592; Monday–Friday
- Med Data – 1-877-732-6853; Monday–Friday
- MD-Online – 1-888-499-5465; Monday–Friday

For important mailing addresses, phone numbers and fax numbers, refer to your state-specific Quick Reference Guides, which are available online at: www.wellcare.com/Provider/Resources.

Self-Service Options

The Plan is proud to offer our providers several efficient self-service options. By having valuable information and features available online and via our enhanced interactive voice response (IVR) system, you are able to conduct transactions when it is convenient for you.

All of these user-friendly self-service solutions give you immediate access to pertinent information regarding member eligibility, your submitted claims, authorization requests and more.

1. Visit our website at www.wellcare.com and register by selecting *Not Registered? Sign Up Today!* on the *Providers* tab.
2. Call the automated IVR telephone system. This toll-free number can be found at the top of your QRG.
3. Speak with a Customer Service representative by calling the toll-free number listed at the top of your QRG if you are unable to find answers on the Web or through the IVR system.
4. Contact your local Provider Relations representative if you still need assistance. Your representative can help with questions regarding contracts, credentialing/configuration and persistent claims/authorization issues.